“It has worked on all the other men, why isn’t it working on you?”

Involuntary Childlessness and Masculinity in Nepal

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Gaurav Lamichhane

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Dekan: Prof. Dr. Jürgen Leonhardt

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Prologue

A. To save or not to save one's *vansha*: Hamletian dilemma of a chemotherapy patient

During this research, I was confronted with a difficult choice. I was diagnosed with a benign brain tumor and thereby had to undergo brain surgery, radiotherapy, and chemotherapy as part of its treatment. While doing literature review for my PhD project, I had read that chemotherapy can make a man infertile or create various reproductive malfunctions or complications such as sperm duplication and other abnormalities in the child. In order to avoid the latter situation, doctors do not recommend men to have a child after they undergo chemotherapy. In those unfortunate circumstances, men are given an option of freezing their sperm before starting chemotherapy. My doctor gave me a similar recommendation the day before I began my first cycle of chemotherapy.

I did not pay much attention to the issue at that moment as my mind was occupied with things I had to do that evening—buy medicines from the nearby pharmacy, learn how to take the chemotherapy pills properly, mentally prepare myself to start the first cycle of chemotherapy *et. cetera*. I bought the medicines from a nearby pharmacy, took them to the sitting room of my apartment and kept them on the table. Maybe due to the trauma of losing one of my uncles (mother's brother) to cancer recently, and the association of chemotherapy with cancer, I was scared. Therefore, I avoided thinking about taking those pills next day.

Since my family members in Nepal could not travel to Germany because of the complications in obtaining visa during the time of the corona pandemic, my flat mate had assumed my guardianship and looked after me. She summoned me to her office room after dinner and said,

> *"You can take your time to decide whether you want to proceed with chemotherapy tomorrow or postpone it to explore the option of freezing sperm; they have that facility here in the university hospital."*

Taking the pills in her hand and pointing the bottle to me, she continued,

"Think very carefully before you decide to take these pills because there is no turning point after you take them. It is important that whatever choice you make, you shouldn't regret that later. Sleep it over tonight and I will come with the pills in the morning if you decide to take them."

Up until that point, I had not given any thought to that carefully. For some reason, I do not know why, I had always told myself and others that I did not want children of my own; so, it should have been fairly easy to take the decision and proceed with chemotherapy the next day. I went to sleep around 10 pm that night, confident about my decision. Little did I know or expect how deeply these matters are engrained in us and affect us without our conscious awareness. I woke up a little disturbed and agitated at around 3 am. Strangely, I found myself being a bit hesitant about proceeding with the chemotherapy; shall I take the pills next day or wait and start other alternative process of freezing sperm? For some unknown reason to me, I felt a strong responsibility and obligation, almost a visceral urge, to save my family lineage (*vansha* in Nepali). I felt like I would let my family down if I fail to bear children.

On the one hand was this felt need to save my *vansha*, while on the other hand, having gone through brain surgery and two rounds of radiotherapy by the time I was facing chemotherapy, I was completely exhausted and simply wanted all the treatments to be over. Although it was only the first cycle of therapy and a few more of such cycles[1] were awaiting, I did not have any patience left in me to endure more of those treatments. Therefore, I simply wanted the therapy to be over as soon as possible. Additionally, it also occurred to me that even if I would choose to freeze sperm here in Germany, it would be arduous, if not impossible, to transport the frozen sperm back to Nepal where I plan to return and settle after I complete my PhD.

As I reflect, I realize at this moment that my personal crisis has become entangled with that of my interlocutors. This reflection has profoundly changed my understanding of this research and its implications. When I started this research, I possibly had a different relation with the interlocutors and the overall research: I was a researcher and they were my subjects of investigation. In that

[1] It went until fifth cycles with a possibility of an extra cycle later.

sense, even though I tried to maintain a mutual relationship with my interlocutors, there was still some sort of power relation between us. The crisis I went through shattered the illusion of power I might have had until that point. It made me question my perception of control and power over my research, my lineage, or to say even my own life. Now when I re-read the following narrative of Anup's pain and struggles to save his *vansha*, I think, with all humility, that I can empathize with his pain even more deeply.

B. *"It has worked on all the other men, why isn't it working on you?"*: Anup Bhattarai and his relentless pursuit of a child

While visiting my parents in Chitwan, I was casually telling my uncle about my PhD project on childlessness. He immediately told me about Anup Bhattarai and his struggle with childlessness for a long time. Anup had a shop nearby our home and my uncle knew him for a long time. When I expressed interest in meeting Anup, my uncle took me to Anup's shop with him next day.

We found Anup there with his wife. A small child, about 2-years-old, was running in and out of the shop, who, I found out later, was their son. The shop was a tiny shack with a tin roof, hardly about 10 square meters; there was a room with a kitchen at the back of the shop where the couple stayed on the days, they had the shop open until late. Barely four people could fit in the shop space. It was a provisional store that sold items like cigarettes, bottled water, and biscuit, which was typical of such shops located on the highway. They had a home in a locality about 2 kilometers away but pretty much spent all their time in the shop. While Anup was busy tending to a customer, I observed him and his shop. He was a middle-aged man of average built; his wife looked worn out and older than him. After introducing me to the couple and telling him my purpose of visit, my uncle left for his shop. I sat on a bench beside the counter where Anup was sitting. His wife brought us tea and went outside to look after the son. Anup pulled out a packet of tobacco from his pocket, pinched a little amount with his two fingers and put it in his mouth before he started narrating his life journey to me.

> *"I was born and raised in Parbat[2]. I have an elder brother. As I was completing the School Level Certificate (SLC)[3] my friends told me about the earning opportunities in India. I followed my friends to Delhi in the pursuit of youthful desire to earn my own living and become a man. I spent a couple of years working there. Then I returned to my home and came to Narayangadh, which has become my home for the last 20 years. I knew a man from my hometown (Parbat) who worked at a furniture shop there. He helped me to get a job in the same shop. After working there for a few years, I opened my own shop."*

I was curious to learn more about Anup's past and intently listened to his narrative. Occasionally I interjected at the points which I found important and asked him to elaborate or clarify. When I asked him to elaborate on his pursuit of a child and how he is coping with childlessness, he continued to narrate his story.

> *"I got married at 29. My wife was 26. We couldn't have a child even after two years into marriage. Her mother suggested that she should go for a medical checkup. Her brother was working in Delhi at that time so her mother took her to Delhi for the checkup. In Delhi, my wife was told that she could conceive. She returned home and continued the treatment with a renowned gynecologist in Bharatpur[4]. She conceived one time but that "stayed" for only three and a half months* [i.e., it miscarried]*."*

Then began the couple's relentless journey from one therapy to another. Before proceeding further, it is important to comment on the gendered dimension of the treatment seeking behavior. Like most of the men who assume that the reproductive problem lies only in women, Anup did not pursue any medical treatment in the beginning:

---

[2] A district that lies about 100 kilometers south-west from Chitwan.
[3] An exam given at the end of ten years of schooling and marks a major step in determining what future career one takes.
[4] A town that is a kilometer away from the main bazar of Narayangadh,

"It did not seem to me that it was necessary for me to go to the doctor, so I stayed back and carried on with business."

Nevertheless, Anup went to India for treatment when the doctors found there was no problem in his wife. He continued to tell me about his life:

"I visited doctors in multiple places together with my wife: Bharatpur [his current hometown]*, Kathmandu, and Delhi, India. In Delhi, the doctor asked me to do a checkup of my* virya ["semen"]*. The results from all these places showed my* kamjori ["low sperm count"]*. A doctor in Kathmandu prescribed me some medicine to increase* virya *but it did not increase even after taking medicines for some time. Therefore, I left the treatment with that doctor in Kathmandu and returned home.*

In any case, I could not close my shop in Narayangadh and stay away in Kathmandu and India for a long time. Moreover, I also felt awkward to stay at the relatives' places for a long time during treatments. They might not say it directly to us, but I felt like they would talk among themselves in their family about us. They must be saying, 'look they come here for the treatment and eat all our food for free.' To stay at the relatives' place once or twice is okay but we were doing it so frequently I started to feel awkward and ashamed. Besides the infeasibility of staying away from home and shutting down my shop for a long time, that feeling was also one reason for us to return from India.

After returning, I visited another doctor in Bharatpur. That doctor also confirmed that I have less/little virya *and prescribed medicine. Despite taking those medicines, the* virya *did not increase to its required amount. At that point the doctor recommended me to try IUI*[5]*. We did that treatment seven times. But none of those*

[5] Intra-uterine insemination

attempts worked. I lost more than one lakh Rupees in the entire process. Together with travel cost and cost for medicines, I must have spent over eight lakhs' Rupees in the medical treatment."

Anup continued to narrate:

"My relatives also told me about a good medical treatment place in Shillong in India; therefore, we also travelled there. But nothing came out of it as well. I asked all these different doctors I met during my visits to the multiple places why is their treatment not working. The doctors gave me a similar answer:

'It has worked on all the other men, why isn't it working on you?'

At one place in Delhi, a medical doctor gave me a container to collect semen and asked me and my wife to have intercourse in his presence."

I asked him to clarify if the doctor was present in the room while they had sex. He recounted his experience thus:

"At first, I thought I had to collect semen like I had done it many times before in other places [through masturbation]. *But the doctor there asked us to have intercourse in one of the rooms in the clinic and ejaculate in a container he provided. I feel so ashamed even now when I recount that experience. You can imagine what must have gone through my mind then! Though the doctor pulled a thin curtain between him and us, and stayed on the other side of the curtain, I could feel his presence very clearly."*

I was quite astonished and hence asked him if the doctor gave him any reason behind that way of treatment. Anup said:

"The doctor told me that the sperm that comes out through the intercourse contains more heat and power as it resulted from a lot of passion and emotion [as opposed to the sperm collected forcefully through masturbation]. *But*

that method also did not work. The semen analysis showed that I did not have enough sperms."

In the meantime, while he was traveling in between Kathmandu, Narayangadh, and India for medical treatments, Anup was also simultaneously visiting different healers and tried various kinds of treatments at various places. He described his experience of visiting those places thus:

"When the doctor's medicine was not working, I also tried few other treatments. People give you many suggestions when they find out that you don't have a child. I also followed their suggestions and went to many healers and astrologers. A jyotishi [astrologer] *near my home in Narayangadh prescribed me to eat live fish from the nearby Narayani River. He told me that the fish increases my sperm and boosts my strength. I cannot catch fish, so I had to take help from some young boys I met at the bank of the river to catch the fish for me. I ate about 6-7 live fish for seven days. The fish were very small but still I could not eat them alive. It felt weird to eat them while they were still moving. I put them in milk then closed my eyes and swallowed everything quickly.*

Another incident is that one of my neighbors told me that yarsagumba[6] *makes body strong and increases sperm volume. I immediately sought* yarsagumba *and consumed fifty thousand rupees worth of* yarsagumba *in four months.*

At various times, both of us have gone to several dhami[7] ["shamans"] *in Butwal, Danda, Syangja, Hetauda, Gaur and even in Shillong, India. Some of these healers gave both of us some medicines."*

---

[6] It is a fungi-plant that grows in the northern highlands of Nepal and is used as a potent aphrodisiac as well as to boost virility. https://thediplomat.com/2014/08/yarsagumba-biological-gold/ [Accessed: 13/2/2019].

[7] See section 5 of chapter 5 below for elaboration

I was curious to know more about what sorts of medicines he took. He told me,

> *"Some of those medicines were liquid and some were powder. I had to take them before going to bed at night. But mostly those healers treated my wife only. I don't know where the actual problem lies. When I go to doctors, they diagnose my* kamjori *but the* dhami *show the problem in her.*
>
> *My neighbor also suggested me to go to another* dhami *who has successfully treated his tenant's childlessness. He took me and my wife to that* dhami *but the* dhami*'s treatment didn't work for us. The* dhami *simply responded as,*
>
> *"It has worked on all the other men, why isn't it working on you?"*
>
> *We also heard about a* dhami *in Gaur*[8] *and visited him too. We felt very awkward and afraid there. There were many women who were shouting and twirling their head as they were being possessed by* boksi ["witch"]. *Since the* dhami *called us frequently for the follow up treatment, we stayed in Gaur and returned home only after two months. We asked one of my distant relatives to look after our shop during the time.*
>
> *Likewise, a* dhami *in Parsa*[9] *did a* phukne *ritual*[10] *on my wife. He also asked my wife to consume chicken blood after sacrificing the chicken we had taken with us. The* dhami *told us that a spirit had closed my wife's womb. Therefore, he conducted some rituals at midnight: he poured boiling water on my wife's head and body as he chanted mantra; and he hit her bare back with a red-hot scapula in order to chase away the spirit and open the*

[8] A town in the east that is about 190 kilometers from Narayangadh
[9] A small town about 25 kilometers from Anup's home in Narayangadh
[10] *Phukne* is a practice of literally blowing air at various body parts while chanting some mantra.

womb. The dhami *explained to us that sometimes a* boksi *attacks the womb of a woman and closes it. That is why the woman cannot conceive he told us. He does not usually disclose to us who is the* boksi *but he does so if the client pays him some money. I was very tempted to pay that money and find out who was causing us the problem but did not proceed because it would be very bad/awkward if that* boksi *was someone from the family or someone we know closely."*

After attending to one customer, he continued to tell me about his visits to different therapies:

"The dhami *also did another therapy on her. He held a chicken in his hand and made several rounds of scan with it from head to toe of my wife's body. At the end of the scan, the chicken died. I was very surprised and asked the* dhami *how did that happen. He told me that when he held the chicken with his hand and ran it over my wife's body, he transferred the malevolent spirit onto it. He told me the spirit was the cause of my wife's problem. Therefore, that was the reason why the chicken died at the end."*

There were a few other practices that the *dhami* conducted on Anup's wife. He continued to describe them:

The dhami *asked her to stand and covered her with a sheet of cloth all the way from head to ankle. He had asked us to take/bring roasted millet flour with us. Then he took the wood that he had already set on fire earlier. He then held the fire at a close distance from her and, chanted some mantra and threw some millet flour at the fire; the flour would take the fire with it onto her body. Apparently, that would chase away the spirits that were clinging onto her body.*

The treatments were mostly conducted at night, sometimes extending well over 2 a.m. as well; therefore, we had to arrange for the late-night transport to return

home. It is very difficult to find a taxi that operates at those late hours. That's why I used to reserve a taxi for the entire evening, which costed us a lot of money.

I found that some of these treatments were not done exclusively to treat childlessness but also many other problems related to spirit-beings. I also got a chance to attend these treatments a few times, when they were being conducted on other women and men who came for different types of ailments. These treatments were spectacular and always left the onlookers like me and Anup in awe. Nevertheless, they left Anup disappointed. He told me:

"I do not have any faith in them because they were inefficacious. They did not work. We could not have a child after the treatments."

I asked him:

"Did the dhami *give you any reason behind that?"*

Anup:

"No. He only gave me a similar answer like many others have already given me:

'It has worked on all the other men, why isn't it working on you?'

I spent around 2 lakhs rupees on this dhami's *treatment alone. Although these* dhami *do not demand a fix fee like the medical doctors, we must bear the cost of all the ritual implements such as incenses, sacred threads, and different sacrificial birds and animals like chicken, pigeon, and goat. In addition, it is also customary to offer money to the* dhami *and his assistants*[11] *as an expression of gratitude. At the same time, it is also a charge for the treatment. The* dhami *calls us several times for the follow up treatments. This also adds to the expenses of the therapy.*

[11] If they have one, like in this case

Since I was making frequent visits to the dhami *and other treatment places, I couldn't give adequate time to my shop. Therefore, the business started to falter. At the same time, I was spending a lot of money in these visits and treatments that didn't yield anything. I was doubly at loss. Over a few years, I had to sell two shops because I could not manage to look after them. During the heyday of my business, I had managed to buy some pieces of land at different places in town. I also had to sell them gradually as the treatment cost accrued and my source of income reduced. Eventually, my business shrunk to this small shack-like provisional store that you see here.*

At this point I got curious to know how his family supported him during his hardship. He told me,

"I faced a lot of pressure from my family to remarry. My wife was also getting taunted by my mother time and again for failing to reproduce."

His wife was listening to us talking. She interjected:

"Although I take care after her day in and day out, I know she wishes that I were dead so that her son will be free to marry again and have a child,"

She told me bitterly. He also agreed to her and added,

"Yeah, it is 25 percent true that my parents wish that."

She corrected him immediately,

"No, let's say it is 75 percent true."

At this point, Anup assured his wife and told me:

"I never wanted to remarry for the sake of a child; otherwise, she had suggested that I could marry if I wanted. Had I wanted to abandon my wife and marry again for the sake of a child, why would I go through all these troubles for years in the first place?"

Anup posed a rhetorical question and added,

"I would have done so a long time ago. But how can I be fully assured that I would have a child from the second

wife? Even after the second marriage if I failed to father a child, I'd be in a trap—I couldn't be able to leave them nor would I be able to look after them properly. Others would also mock me for that."

He also revealed to me about his bitter relationship with his elder brother due to the issue of his childlessness:

"He continuously disparaged me for not having a child and kept pestering me by frequently commenting that I am not a man but a namarda[12]*. He frequently made an issue of property to mockingly tell me that I do not need parental properties because I do not have a child to inherit that property and look after me. He constantly told us it was his son who would inherit all my portion of our parental properties eventually. I felt deeply hurt by his attitude toward me. Finally, a fight broke between us and we stopped speaking to each other for four years. However, my neighbors and friends were always supportive and sympathetic toward me. They even helped me by recommending various healers to me."*

Anup continued to tell me how he encountered the healers through his neighbors and his experience of those encounters:

"That is how I met the dhami *in Parsa and other* dhami*. When the treatment from the Parsa's* dhami *failed, I went to a female medium healer known as* mata *in common parlance. I was told that she connects people with the spirits of their deceased ancestors. I visited her to find out if my condition of childlessness was caused by some dissatisfied spirits of my ancestors. I thought my great grandfathers would speak through the medium; so, I was expecting to hear their voice. But I was disappointed to find that it was the* mata *who spoke instead, haha,"*

[12] *Namarda* means a "failure," or "not-a-man." I have elaborated this below in the subsequent chapter.

He laughed quizzically and continued to narrate further:

> *"My ancestors were not so angry but asked me to conduct a puja at my ancestral home in Parbat. My wife and I visited Parbat and worshipped my* kuldevta ["clan deity"] *and asked their blessings for a child. We also fed sixteen girls and sixteen boys as part of the ritual to appease the gods. While in Parbat, we also visited a* devi [goddess] *temple nearby and stayed there for nine days, fasting, and making milk offering to the goddess.*
>
> *When nothing yielded any tangible result, I returned to Chitwan and went to another famous* jyotishi [astrologer] *in Devghat*[13]*. The* jyotishi *predicted that there was a chance for me to become a father until I am 46, after which there was no chance at all. The* jyotishi *asked me to conduct* Ganesh Purana[14] *for seven days. I arranged the priests to conduct the Purana ceremony and observed strict fasting for seven days and made* dana ["offerings] *as well. The entire ceremony costed me seven lakh rupees."*

He smiled, pointed to the child who was running in and out of the shop since the beginning of my visit, and said,

> *"Sometime after that, we brought him home from the hospital. While we were pursuing the numerous healing options, the doctor in Narayangadh, who had conducted IUI treatment, had also discussed and recommended to us about the option of adoption. One morning, I got a call*

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[13] A town about 6 kilometers away from Narayangadh.

[14] *Purana* is a Hindu scripture that contains mythology but there are certain performative aspects of purana. For example, during the month of January and February, people read *Swasthani Bratakatha*, a section from *Skanda Purana* for about an hour daily. Likewise, as I mentioned in the previous chapter, *Skanda Purana* and *Bhagawat Purana* are also publicly read for 7 to 9 days at different occasions. *Ganesh Purana* and *Harivamsa Purana*, however, are read and also the ritual prescribed in the texts are performed when a couple desires a male child. Though the childless couples might not have any preference for the boy or a girl child, they are nevertheless recommended to perform the worship of these two *Purana* as a remedy for their childlessness.

from the doctor. He asked me to come to the hospital immediately. A woman had given birth to a child at 7:30 in the morning. The family were very poor and couldn't afford to raise the child. Therefore, they were willing to give away the child for adoption. The doctor suggested that I adopt that child. I paid Rs. 45,000 (forty-five thousand rupees) to the couple through the hospital and brought the child to home by 12:30 pm. I did not get to meet the parents of the child because the person who was mediating the adoption felt that might create complications in the future. The mediator also did not tell the biological parents who adopted their child."

There are many anecdotal stories that float in town about the biological parents who contact the adoptive parents at some point in the future and ask the latter for money or ask them to return the child. Hence, the precaution taken by Anup in the process of adoption is not totally unfounded.

"The jyotishi's *prediction came to be true,"*

Anup told me. Pointing at the child, he continued,

"Although we didn't make our own child, I indeed found him just before I turned 46."

He told me that after he opted for adoption, he finally put a closure to the nearly two decades of desperate pursuit for a child.

"It has become complete now. I exhausted all my options over these years before taking this decision. I feel much relaxed now. It has been almost 3 years of respite. Finally, my mind does not think about that anymore. Now, the only concern I have is to find a way to raise this child. Since we spent all we had, in the treatment over these years, I don't have much left now to give him a good life. We might be too old by the time he is able to earn his own living and look after us in our old age, so we don't expect to be taken care by him. At this point, I will be very happy if I can raise him till he finishes his education."

He expressed his anxiety to me. I tried to give him some assurance that something or the other will work out and he need not worry too much about it.

Then hesitantly Anup asked:

> *"I have a question for you. Since you are doing research in this field, you might know this. What happens if let's say that a desire [for my own child] grew in me, and we say let's explore taking medicine for a few months, start another treatment somewhere else? Is it still possible for us* [to have a child]*?"*

I was dumbfounded and totally taken aback for what I heard now completely undid what Anup told me earlier about his closure and feeling relaxed after adopting the child. I could not think of an appropriate response but told him it depends on their age. He continued to talk:

> *"I am 48 and she is 45. I think it might be difficult for us because of our age. But in our father and grandfather's time there were men who fathered children until they were 60 or 70. That is not possible these days because men have* kamjori *due to the unhealthy lifestyle and food."*

I was still trying to make sense of what Anup was telling me when he revealed the actual motivation behind his decision to adopt the child. He continued to talk,

> *"I have heard that the adopted child's* graha[15] *automatically*[16] *brings another child with it* [i.e., adoption induces pregnancy automatically]*."*

I had overheard women in the waiting room of the infertility clinic in Kathmandu sharing similar logic among themselves. I asked Anup if he tried to make a child after the adoption, he replied,

> *"No, we didn't because we were told it happens automatically."*

I probed further,

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[15] Although it is literally translated as planet, it also means fate or power of the planetary alignment. See chapter 5 section 6 for elaboration

[16] He used this English word.

“But did you try it at home, without seeking any medical help?”

Anup embarrassingly confessed in a low voice,

“Yes.”

Chapter 1: Introduction

In the prologue, I presented a case of Anup from my hometown Narayangadh in Chitwan district who traversed through multitudes of healing options to overcome his childlessness. His therapeutic quest spanned not only the geographical boundary of Nepal, but also across the other side of the political border into India as well. Likewise, the therapeutic landscape comprised not only crossing the border or traveling to multiple places well beyond his hometown, but it also included crossing over multiple healing options that constitute diverse ontologies. Anup is only an example of the many childless men and women I met who make similar journeys into seemingly disparate healing options in their quest to overcome childlessness. Although the extent of therapies Anup has pursued and his patience while he underwent all those procedures relentlessly for seventeen years might be rare to find, it is not uncommon for a Nepali childless couple to have undergone a similar pursuit if they are childless for a long period of time. What propels childless couples, especially men, to take extreme measures in the pursuit of a child is a question worth pondering. That is precisely what my dissertation addresses.

This work explores the causes and consequences of the involuntarily childless men's desire for children in Nepal. Involuntary childlessness is a major cause of distress among men. One of the main reasons for men's anxiety and suffering due to childlessness is the strong need and obligation felt by men to save, and continue, their lineage (*vansha*) and pass on their properties (*ansha*) to their heirs. I have conceptualized these two by a borrowed term "the lineal masculinity" (King and Stone 2010)—a deeply rooted ideal of Hindu hegemony that prevails in Nepal. It is passed on to the male line of the family through the "seed" or sperm of a man. Inability to uphold and carry on the lineal masculinity is also a stigma that emasculates men, which is understood as *kamjori*. This leads men to pursue various healing options available in Nepal, such as: visiting temples in different places across the country to worship specific Hindu shrines known for fertility; biomedical treatments for curing infertility; consulting astrologers and conducting ritual solutions they prescribe; seeking help of healers

who resolve the problem of childlessness through spirits. These different therapeutic options, which are sometimes competing and even conflicting, come together to make a therapeutic assemblage. Adoption is not preferred because it exposes a man's *kamjori* even starkly and also does not fulfil the requirement of lineal masculinity, viz. purity of descent. Nevertheless, childless men who adopt unrelated children give a different meaning to lineage. Thus, such adoption creates a new understanding of lineal masculinity and reformulates the classical norm of lineage based on purity of patrilineage.

1.1 Research site and methodology

Since I was primarily interested in finding out the personal experiences and coping strategies of Nepali men who are involuntarily childless, this study was based on qualitative methods. After identifying my informants, I traced the trajectory of "healing pilgrimage" (Inhorn 1994) taken by these couples; especially focusing on gathering the experiences and coping strategies of men and their motivation to choose any particular healing therapies. I started my research pilgrimage from a biomedical clinic and not from other healing sites for the reason of convenience and efficiency. Since people visit temples for many other reasons beside healing of childlessness, it would be very difficult and awkward to initiate a conversation with everyone who visits those temples and identify childless men from the pool of those temple visitors. Contrary to that, the fertility clinics only catered to childless couples; hence, I could directly identify and approach childless men if I used this strategy.

This study is based on the field research I conducted from July 2016 till September 2018 and an additional brief follow-up field research in March-April 2019. I spent the months of July and September 2016 to explore the research sites and approach different infertility clinics and hospitals in Kathmandu. The rationale behind choosing to start my research in Kathmandu was that most technologically advanced hospitals that offer infertility treatments like IVF (in-vitro fertilization) and ICSI (intracytoplasmic sperm injection) are located in Kathmandu. Hence, conducting research in these centers would also mean that I would get to meet childless men and women from across the country. Initially, I approached three privately owned infertility clinics and a hospital. Out of them,

the doctor of one infertility clinic permitted me to conduct research in her clinic. I began my research there in October 2016 there. Later in 2018, I also conducted research in another infertility clinic that opened in the town of Bharatpur in Chitwan district. This gave me a good contrast to the clinic in Kathmandu in many ways. I will describe more about this in chapter 4.

The doctor of the clinic in Kathmandu is a prominent infertility treatment expert and features frequently in the Nepali media. I came to know about her through the many newspaper coverages of her work. The clinic also has a website through which I was able to contact the doctor via email. That is how I was able to establish my first contact with her. I visited her in the clinic after reaching Kathmandu in July 2016 for the fieldwork. She allowed me to conduct research in her clinic after I presented her my research proposal and work plan. She also introduced me to the staff members of the clinic, and I was treated warmly by all of them throughout my research for four months. I will discuss more about the physical setting of the clinic in chapter 4 as it is more relevant there for the argument I want to make in the chapter.

The clinic opened from 10 am till 6 pm with an hour of lunch break and one half an hour of tea break in between. I reached the clinic around 12 pm every day and stayed till it closed. I was invited by the doctor to join her and the staff members during the tea break, which I accepted. The tea breaks gave me an opportunity to discuss my research with the doctor and learn about her professional experiences in the field. Apart from the tea break, I spent almost all day in the waiting area amidst the patients who were waiting for their turn to see the doctor. Some of them had to wait for a few hours before they were called inside. Hence, this presented an opportunity for me to strike a conversation with them and build rapport. This also made it easier for me to ask their permission to accompany them into the consultation room and observe their interaction with the doctor.

However, as I had anticipated, it was not as easy to start a conversation with men. Most of the time they would avoid talking with others in the waiting room and would either be reading newspaper or play with their mobile phone. It was mostly only women who talked with other women. The topic of their talk revolved around their experiences of childlessness and the different treatments they have sought. It was during such talks I managed to join and engage with

them. On any given day, there would be around 20 to 25 men and women on average in the clinic[17]; so by the four months I was able to come in contact with over 200 childless men and women. Through such unsolicited talks among the patients in the waiting room, I was able to gather many valuable insights into the experiences of childless men and women such as the financial pressure, humiliation, and stigmatization they face, different therapeutic options they use to overcome their condition, and the general cultural meaning of children and childlessness in Nepal. In due course of my research in this clinic, I managed to have in-depth interview with 20 men in total. The interviews with some men lasted for about 30 minutes in one sitting and with others it went on for even more. Since most of the men came from outside Kathmandu and revisited the clinic only occasionally, it was difficult to conduct follow up interviews with most of them. Despite such practical difficulty, I could do the follow up interviews with most of them over the phone or when they revisited the clinic for follow up treatment.

The interviews were conducted privately in one of the rooms of the clinic that was used for clinical procedures. I had taken permission from the doctor to use the room for interview. Nevertheless, there were two constraints of the interviews: a) in some busy days when there were a lot of patients, the rooms would be occupied, or the interviews had to be shortened because the room was needed for the treatment; and b) the men would be in rush to leave for their home. I tried to minimize these constraints by "hanging out" with them in the waiting room. As the men had to wait for about 1-2 hours on average before they and their wives were called by the doctor, it gave me ample time to talk to them informally during when I steered the conversation to the topics of my research. Although such informal conversations were conducted in the public space of the waiting room, I asked structured, semi-structured and open-ended questions during those conversations.

Initially, I had planned to select my informants according to categories like caste, class, and region to trace the influence of these categories on the childless men and their therapeutic journey. The need and pressure men feel to

[17] This included the same patients who came for their follow up visit for checkup as well.

father a child was common to all men despite what caste, region, and class they belonged to; yet their experiences of childlessness differed according to what region they came from in the sense that men from remote areas had to travel long distances to come to Kathmandu, which required management of time, family obligations, work, and accommodation during their stay in Kathmandu for treatment.

The questions for semi-structured interviews consisted of demographic information and reproductive life history (Inhorn 2012) of the men and the open ended questions and informal discussion helped me gain insights into the meaning the men assign to their condition, how they negotiate their role in both private sphere (family, marriage) and social sphere (workplace, social gatherings, religious events, relatives), their lived experience in everyday life, and their motivation and rationale for pursuing various healing strategies. I conducted the interviews in Nepali, my native language and *lingua franca* in Nepal. I later transcribed and translated them into English. Before I began the interview, I sought the interviewees' permission to record the interview digitally. The men whom I interviewed privately in the clinic's room gave verbal consent to record the interview after I briefed them about my project and the interview goals.

The men and women with whom I engaged in the waiting room permitted me to use the content of our conversations, but many did not feel comfortable to give a recorded interview. Thereby, I wrote major points during the conversations and elaborated those points in my field diary immediately after the conversations were over. Periodically during the conversations, I reconfirmed and clarified the information with the men and women involved. I also maintained a field diary in which I wrote my reflections of the interviews and informal conversations. Hence, some of the conversations presented in the chapters are reconstruction of the interviews. Since dialogue is one useful form of ethnographic writing, I have retained the conversations in dialogic form albeit in reconstructed version. This not only transports me to the actual moment of my ethnographic encounter and presents the readers a glimpse of the moment but also gives life to the ethnographic presentation. Nevertheless, I am also aware of the possible shortcomings of such reconstruction—mostly that stems from the issues of representation, memory, and my subject position (Craig 2006: 33-34). All the

names, including the clinics', used in this dissertation are pseudonyms unless it was impossible to avoid them.

Apart from reproductive life history, I also used the life-story method. This technique is based on a premise that "stories occupy a central place in the knowledge generated by societies," and that it reveals "much about individual and collective, private and public, structural and agentic and real and fictional worlds" (Goodley *et al.* 2004: ix). Individual narratives also help challenge the hegemonic discourses and therefore are important in bringing out the lived experiences and suffering of individuals struggling with childlessness. Life-story also gives a chance for people to reconstruct their lives in a way that is meaningful for them. By focusing on the stories of my informants' childhood, young adulthood, the present and the future, I was able to understand how they have negotiated their identity while dealing with childlessness.

Moreover, another aim of this project was to trace different healing options taken by men to overcome their childlessness and to understand the dynamics of interaction between the healing options. To accomplish this, I made a strategic choice to start the research in the infertility clinic as that gave me an opportunity to meet men and women who were specifically dealing with childlessness. From these men and women, I came to know about the various other treatments and healing options that childless couples seek to overcome childlessness. These included a) certain temples of the Hindu god Shiva, also known as a fertility god, b) shamans (known by different names in local parlance—e.g., *dhami jhakri, jhar phuk garne*), c) astrologers, and d) herbal healers. I visited a few of those healing sites in Kathmandu and other towns, and conducted participant-observation in them, which I describe in detail in chapter 5. Some of the ritual events occurred at a specific time of the year and I was able to attend one of them twice during my research. In these sites, I was able to interview the temple priests, organizers of the event, visitors, locals, and childless men and women who participated in the rituals. I also collected news reports of the rituals held in the temple.

Apart from meeting men in the clinic and different sites of healing, I was able to meet a few men through the snowball method. Anup in my hometown was one of them and I was introduced to him by my uncle. The first interview with him in 2016 lasted for two and a half hours. Thereafter, whenever I was in my

hometown from Kathmandu, I visited his shop and spent few hours every day talking to him. During the 2-year period, I spent about 4 months at Anup's shop. Additionally, a relative of mine in Kathmandu also introduced me to one of his colleagues whose wife was able to conceive after being treated by a female medium healer in Kathmandu. The relative arranged my meeting with his colleague at his home and I conducted a 3-hour long interview with the man. I also conducted two follow up interviews over the phone with him. Likewise, one of my friends in Bharatpur introduced me to his colleague who was able to father a child after participating in a ritual of standing and holding a lamp outside a Shiva temple[18]. I interviewed my friend's colleague in a tea shop in Bharatpur. Similarly, the same colleague of my friend introduced me to his friend who had fathered a child through IVF treatment. I interviewed my colleague's friend in his office. All these men had already overcome childlessness successfully and had children. Thus, they were relatively open to share their experiences of the time in their life when they were childless.

Besides interviews and observation, I also collected related materials published in various print and electronic media: a)YouTube; b) Facebook; c) newspapers in English and Nepali; d) movies; e) TV serials; f) soap operas; g) infomercials; h) websites on infertility support groups; i) popular health magazines; j) adverts; k) billboards; l) textbooks on reproductive health; m) policies on health and gender; n) reports on reproductive health programs published by the government and non-governmental organizations; o) religious texts of Hinduism; p) literary works like short stories and proverbs. Although I have not used all these materials directly in the chapters, these materials informed my understanding of the discourse of masculinity, family, and childlessness in Nepal.

1.2 Researcher's positionality

This research can be called what is known as "native anthropology" (Tsuda 2015; Simić 2010) or "anthropology at home" (Mughal 2015; Fontaine 2012) in which a researcher conducts research in his own community. I was born in Narayangadh, a town that lies in about 150 kilometers southwest of

[18] I discuss this elaborately in chapter 4.

Kathmandu.[19] I grew up in Narayangadh and spent a considerable amount of my life in Kathmandu for studies. Hence, today I call both towns as my home. Doing anthropology at home has its perks and challenges as well. During the research, I realized that being a native of the place accords a lot of advantages in terms of access to the field and understanding of cultural nuances, which otherwise would skip a researcher who does not belong to the place. For example, I did not have to learn the language and hence could start my field research right away. Likewise, already knowing culturally appropriate ways of dealing with different situations and people also helped me quickly "settle" in the field (Bernard 2011; Mughal 2015).

However, I found that the very strength I had as a native also posed some methodological challenges. Scholars who have studied their own communities have described that "native anthropologists may take certain observations for granted as insiders and apparently have more difficulty maintaining 'objective' detachment from the peoples they study" (Tsuda 2015 :14). At many times, I also found myself assuming what my interlocutors meant when they used certain cultural concepts. Once I became mindful about that, I asked the interlocutors to clarify their understanding of such cultural tropes. This helped me overcome my own cultural blindness although it was more than easy to slip back to the habitual pattern of assuming that I understood what was not told by my interlocutors. I held a "double position" of being an "insider" and "outsider" in relation to my interlocutors and the research field (Simić 2010: 29). I was an insider in a sense that I already shared certain cultural background with the interlocutors; this was an advantage to me as I could establish instant rapport and gain trust of the interlocutors.

Nevertheless, throughout my encounter with the interlocutors, I was also aware that my relationship with them was marked by many differences as well; such as, I was an unmarried man in my mid-thirties and studying about childlessness, which created some amusement among the interlocutors; I was a researcher doing PhD in a German academic institute, which became a topic of interesting conversations with my interlocutors; and I was brought up in urban towns, spent nearly six years in the US during my undergraduate studies, another

[19] Kathmandu is the capital city of Nepal.

two and half years in Heidelberg in Germany for MA studies, and stayed a few more years in Tübingen for PhD and teaching. These experiences abroad helped me to develop an aware of cultural differences. Additionally, I also discussed informally with many men and women who already had children, some of whom included my friends, family members, relatives, neighbors, to gather insight into the issues like the cultural value of children, childlessness, masculinity, fatherhood. I met them in the space of my own home, marketplace, or their homes. Hence, in these situations the boundary between "home" and the "field" blurred, further complicating the neat dichotomy of my double subject position of insider-outsider.

My position as a researcher in the infertility clinic was also challenging. As it often happens with anthropologists working in the topic of health and biomedicine (Simić 2010), I also had difficulty to explain to the doctors, clinic staff, and the men and women visiting the clinic what exactly an anthropological approach entails. Many a times I was mistaken for being medical personnel. Even after I explained to them in detail about the participant-observation and casual discussions as some methodological tools in anthropology, the doctors and the staff periodically asked questions like, "where is your questionnaire?", "isn't your research over yet? How many more samples do you need?"

Additionally, some men, and women in the waiting room of the clinics would also mistake me for a journalist and would fear that I would publish their stories in the newspaper. Given the stigma around childlessness and secrecy involved in the pursuit of treatment, their concern was valid; hence, I was also very careful about that while I approached them. After explaining to them the difference between a journalist and an anthropologist, I assured them that I would not publish anything in the media. I also ensured them that I would first ask for their consent before I wrote anything about them in the dissertation and would anonymize their names. Prior to this fieldwork, I had some experience of conducting field research in Kathmandu for my MA thesis that focused on the practice of Tibetan medicine in some clinics run by Tibetan doctors residing in Kathmandu. Through that research, I gained some good insights into the possible pitfalls to avoid and proper ways of conducting research in a clinical setting, which helped me navigate the current field research.

1.3 Research Questions

What is the primary reason for men in Nepal to desire for children and how are these men affected by childlessness? How do involuntarily childless men in Nepal deal with their condition? What kind of remedies—biomedical, non-biomedical, ritual—are they (as couple and especially men) seeking for their condition? How do the involuntarily childless men make sense of the various—sometimes competing and sometimes even conflicting—treatment choices available to them? How are their understandings of being involuntarily childless influenced by the definition of infertility (and involuntary childlessness) by the various treatment options that they seek?

Chapter 2: Lineal Masculinity and Childlessness in Nepal

2.1 Introduction

The notion of masculinity is defined by the dominant ideology of a particular society and therefore the idea of what it means to be a man in a particular society differs. In a nutshell, manhood can be understood as "the approved way of being an adult male in any given society" (Gilmore 1990: 1). Gilmore argues that although the ideals of masculinity are not universally same, "ideas and anxieties about masculinity as a special-status category of achievement are widespread in societies around the world" (1990: 4). While describing South Asian masculinities, Osella and Osella (2006: 2) argue that in South Asia, "the production of the normative household through the institute of marriage is the ultimate outcome of processes of gendering." Therefore, for this reason they argue that the processes of gendering and sexuality should be studied together in the context of South Asia and not be delinked as some scholars have proposed (2006: 2). This holds true for the case of Nepal as well; family and fatherhood lie at the core of normative adult masculine identity of Nepali men. This becomes ever more prominently visible among the married men who are struggling with childlessness. I encountered numerous men during my research who expressed the feelings of pressure to father a child and the anxiety they experienced when they were unable to perform fatherhood. This chapter, therefore, is written with an overall motivation to comprehend the reasons behind such pressure and anxiety felt by the men when they failed to actualize fatherhood. Borrowing from the concept of lineal masculinity by King and Stone (2010), I argue that the fear of failure to enact lineal masculinity is the primary force behind the Nepali men's desire for children, especially male children. The failure was conceptualized by the men I met as a man's *kamjori*, which is an emasculating term that denotes a weakness or defect.

2.2 *Santaan, vansha*, and need for a child

During my research, when I asked why one should have a child, men regardless of whether they were unmarried, married with no children, or childless

married men, all gave univocally similar answers that involved ideas of passing on or inheritance of some substance, either biological or material. The remark of a healer I spoke to echoes the general ethos of the men I met:

> *"Why have* santaan*? you might ask. To continue one's* vansha *and pass on the* ansha *(property) that one accumulates over his lifetime, so that the property stays within one's own family."*

Santaan has multiple meanings which, depending on the context, means son, son and daughter, family, kin. *Vansha* is a word that translates to lineage in English and carries a meaning of continuity or flow in the Hindu patriarchal context. Likewise, *ansha* is the property that comprises of the wealth a man earns as well as "the immovable, ancestral property of land and houses" (Kunreuther 2009: 548) that he inherits from his father. It is not surprising, thereby, that the word that denotes children, *santaan*, in Nepali language also means continuum[20]. Therefore, understanding these cultural concepts provide some clue to the men's experience of childlessness and their coping strategies.

2.3 Lineal Masculinity, Patriliny, and Reproduction of a Man

Involuntary childlessness in Nepal, hence, can be better understood in light of these cultural mores of masculinity, or what King and Stone (2010) call "lineal masculinity". King and Stone describe lineal masculinity as a concept of "(bio)cultural reproduction" that is passed on through sons in patriliny. Patriliny, patriarchy, and masculinity are all interlinked in a sense that patriliny not only confers "name, kinship status, family wealth, and so on, but also specifically male identity, a quality of masculinity that applies to individuals and to groups of patrilineally related persons" (King and Stone 2010: 327). Patriliny is found in many parts of Asia, including in Nepal. Das Gupta *et al.* have found a striking similarity between the patriliny in India, China, and Korea where son preference was high because "only *men* constitute and reproduce the social order…the significant social reproduction is that by the father of the son" and that the

[20] As defined in the *Nepali Brihat Sabdakosh*, a standard Nepali dictionary. Among many definitions of *santaan*, *vansha*, family, continuum, series are a few (NPP 2067 (2010): 1226).

women in these societies "[…] want sons to continue the *husband's* lineage" (cited in King and Stone 2010: 325).

Likewise, masculinity is strengthened by the characteristics that co-occur with patriliny: "[…] patrilocality; relatively high fertility; or son preference, or both; and patrogenesis (the idea that a fetus is created by a man and deposited in a woman; a synonym is *monogenesis*)" (King and Stone 2010: 327). Descriptions of reproduction using the agricultural metaphor of seed and field—patrogenesis or monogenesis—is also a feature of many patrilineal societies, such as Turkey, Japan, India, Greece, Sudan, Egypt, and Palestine (Inhorn 1994, 1996, 2006; Delaney 1987, 1991; King and Stone 2010; Kanaaneh 2002; Boddy 1982; Loizos 1994; Robertson 2005; Dube 1997). Dube (1997) elaborates this metaphor of procreative substances prevalent in India as "[t]he seed is contained in semen, which is believed to come from blood; hence, a child shares its father's bloodline…Males are the transmitters of the blood of a patriline. The mother's role is to nourish and augment what her womb has received" (76; cited in King and Stone 2010: 331). Additionally, Fruzzetti and Östör (1976) also describe similar conception of blood and seed in their analysis of kinship in Bengal, India. According to them, "*[r]okto* is a Bengali construct which refers to blood as a substance, enduring and persistent, a permanent attribute which is recognized in the male line, transmitted by men through the reception and acceptance of the male seed [*sukra*, *bij*] by women after marriage" (1976: 111). Similarly, they describe the relationship between blood, seed, and semen as thus:

> *Sukra* is the specific word for semen, *bij* may refer to grain as well—both terms meaning 'seed'. Seed is the characteristic of the 'male element'. Another term for semen is *dhatu*, also meaning bone, metal, hard things. Seed is produced in the bone marrow (*majja*) of men, and among other things, builds the bone structure of the child. In the womb the seed becomes blood and grows through the mother's nourishment and blood. Blood (*rokto*) creates semen, several drops of the former to one of the latter. (1976: 121)

Accordingly, in patriliny, masculinity is connected to ontology in a sense that "[…] only men are considered generative persons who can create other persons through the procreative act" (King and Stone 2010: 323). Although a woman is

necessary for reproduction and continuity of a man's lineage, her reproductive role in patriliny is diminished to that of a mere means to produce a male child who continues the man's lineage. A man receives the lineal masculinity from his father and can "build on, maintain, or diminish" it (King and Stone 2010: 323). The father also received the lineal masculinity from his father and so on, the origin of which usually is traced back to a male member in the past.

Moreover, King and Stone build upon Craig's notion of the vertical transmission of a man's "substance", to argue that semen has ontological properties in the sense that it is also a kinship generating substance, and therefore, a man directly transmits kinship, and lineal masculinity, to his children through his semen (2010: 332). According to Craig, "[t]he exact nature of that substance is defined differently in different cultures, but the important thing is that it is passed on to someone in the next generation" (1979: 95). He further describes kinship as an ontological system that "enables an individual to assemble an "estate" comprising values and morals as well as property, material wealth, social status, and action sets (friends and kindered) that one can pass on to one's heirs…It is transmitted by the parents, along with their "substance," to the following generation and, one hopes, to generations after that," (1979: 95). Thereby, such vertical transmission of the substance and estate is a way of achieving immortality for a man, argues Craig. Using this same notion, King and Stone therefore argue that "[…] lineal masculinity can be seen as part of a man's 'symbolic estate'" (2010: 332). Hence, the authors conclude that "[l]iving on, passing on one's semen and transmitting one's collective and individual lineal masculinity are considerable inducements for men to reproduce, especially to reproduce sons, indeed, many of them" (2010: 332). Here it is important to emphasize that although King and Stone use Daniel Craig's idea of kinship as an ontological system generated by the vertical transmission of a man's "vital substance" and a "symbolic estate," they fail to highlight the importance of property inheritance as an integral aspect of lineal masculinity. Whereas they discuss the way lineal masculinity is carried on to the subsequent generations of a man's lineage, they only emphasize the role of semen as a substance that carries lineal masculinity. Although Daniel Craig's formulation of estate also includes property, King and Stone's formulation of lineal masculinity focuses on the passing of lineal masculinity through reproduction. However, as I have

mentioned above, *santaan* or children, that denote continuum of a man in Nepali context, are needed to inherit a man's lineage and property both. Thus, the concept of lineal masculinity should be expanded to include, in addition to a man's lineage, the flow of property onto the subsequent generation as well. I will discuss how this form of lineal masculinity, that encompasses both *vansha* (lineage) and *ansha* (property), was institutionalized during the Nepali nation-state formation and continues till today later in this chapter. In the immediate section below, I will continue to discuss the Hindu patriliny prevalent in Nepal and its link to lineal masculinity.

In Hindu patriliny, lineal masculinity is also linked to the prevalent notions of purity and pollution where "purity of descent is of utmost importance to the patrilineage," (King and Stone 2010: 330). Nepal claimed to be the only officially declared Hindu kingdom in the world until 2006 where Hindu ideals are still hegemonic over other religions; thus, the discourse of Nepali manhood and childlessness today is also largely shaped by Hindu ideals. For instance, some of the men and women in my study alluded to the religious terms like *karma* and also narrated stories of childless characters from Hindu mythologies to come in terms with their condition of childlessness. Thus, some of the cultural imperatives pertaining to reproduction, childlessness, and masculinity that I encountered in the field and their relationship to lineal masculinity is better understood in terms of the Hindu patriarchal concepts of descent and lineage.

A Brahmin, Chhetri person in Nepal belongs to certain descent categories *gotra*, *thar*, and *kul*. Every patrilineage among the Brahmin and Chhetri castes in Nepal traces its origin to one of the founding *rishis*[21], or the sages, of *gotra* and all men become members of their father's *gotra* (Bennett 1993: 16). Although there seems to be a lot of debate about what *gotra*[22] actually is, all of the scholars agree on a point that *gotra* is an "exogamous agnatic descent category" (King and Stone 2010: 330) that serves an important function while choosing a marriage partner. The *gotra* founding rishi are epitome of male purity in Hindu patriarchy, argues Bennett; as discussed above, the maintenance of purity is of utmost

[21] These *rishi* were male ascetic forest dwellers in Hindu mythology; see Madan 1962: 69) for their names and discussion on the ways gotra-names are eponymous to these sages.
[22] For a detailed discussion, see Madan (1962) and Gray (1980).

importance to the continuity of patriliny. Thus, according to Bennett, it is for the reason of maintaining the male purity that the *gotra* exogamy is strictly observed among the Brahmin and Chhetris. Women's sexuality, on the other hand, is potentially threatening to the purity of men's lineage as the women can introduce a breakage, and thereby impurity, to the husband's family line by bearing children of other men (Bennett 1983: 126). King and Stone also found that this notion of purity is still pervasive among the Brahmins in contemporary Nepal where it is a duty of a man to "maintain or enhance his purity through numerous religious observances and rituals, meticulous worship of lineage gods [*kul devta*[23]], a proper marriage, and production of "pure" children" (2010: 331).

Thar is a lineage unit that signifies the last name of a person, which also is more or less a marker of caste to which the person belongs[24]. Although a *thar*-name may be shared by many persons, they might not necessarily be agnatically related. It is however vaguely considered to be an extended patrilineage (Bennett 1983: 18). A man assumes the *thar* of his father and retains the same *thar* throughout his life. Likewise, his son also acquires the same *thar*. However, a woman also acquires a *thar* from her father but appropriates her husband's *thar* after marriage[25] and moves from her natal home into the husband's home.

Likewise, those who share the same *thar* and *gotra* are further grouped into a larger agnatic unit called *kul*, which can also be loosely understood as a clan or lineage (Bennett 1983: 18). Lecomte-Tilouine schematically describes the overall Hindu caste system in relation to *thar*, *gotra*, and *kul* thus: "Ideally a varna or class is subdivided into different *jats* or castes. These *jats* are made up of *thars* or clans, which are again subdivided into different *kuls* or lineages," (1993: 3). The members belonging to a same *kul* have the obligation to observe death and birth pollution within their *kul* and to perform a communal worship of their

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[23] The *kul devta* is a generic term to denote a pantheon of deities that could be comprised of the ancestors, lineage gods, malevolent spirits of the lineage etc. See Lecomte-Tilouine (1993) for the detailed descriptions of *kul devta* and the worship of *kul devta* in Central Nepal.

[24] For example, in case of inter-marriage, a man's children might retain his *thar* but their caste status is downgraded from Brahmin to Chhetri; hence blurring the boundary of *thar.*

[25] Though not very common, there are some women who retain their natal *thar* even after marriage. Some women write both their natal and husband's *thar* after their given name. These are more of an exception than a norm.

common lineage gods (*kul devta*). *Kul devta* are the tutelary deities of the lineage that need to be worshipped by the lineage members periodically to propitiate them lest the *kul devta* create misfortunes to the living members of the lineage (Bennett 1983: 49). One of the major functions of the *kul devta* is "to protect the family from catastrophe and to assure that it will attain wealth, prosperity, and male descendants," (Bista 1972: 58; cited in Bennett 1993: 132). For King and Stone, the worship of *kul devta*, in which the women cannot participate, by the community of men who belong to the same *kul*, or lineage, in Nepal is a celebration of lineal masculinity (2010: 331).

Accordingly, Bennett argues, "[…]in Hinduism the patriline is the epitome of continuity: it links the individual to his ancestors and the ancient sages or rishis as well as his descendants on whom his own hopes of heaven and future rebirth depend. Through its members' meticulous performance of the arduous death pollution and annual commemorative ceremonies, the patriline represents that part of Hinduism which seeks salvation through progeny and conventional ritual" (1993: 126). Since it is through the male descendants that the patriliny flows and continues, to beget male descendants is one of the most important duties of a Hindu man[26] and, thus, a defining feature of his masculinity. As discussed above, male descendants are considered to be the continuum of a man and inheritors of his properties—masculine and material both. In patriliny, not only intangible essence like masculinity, but tangible assets like property and citizenship are also passed on to the sons by the father. It is a duty of a son to perform death rituals of his father and make periodical ritual offerings to the ancestors, who in turn bless the son with prosperity in worldly life; this prosperity includes material wealth and children.

2.4 Hindu Hegemony and prescriptions of normative masculinity: A case of *Manusmriti*

Similar ideals of patriliny shape reproductive mores in Nepal as well. Despite its current secular status, the institutions of marriage, family, and other cultural mores of Nepal still reflect the vestiges of its recent Hindu past. The

[26] I will elaborate this below

Hindu law books like *Manusmriti*[27], which is popularly known as the Laws of Manu, provide insights into the cultural discourse of patriarchal mores about a Hindu man and lineage. Doniger (2014: 268) argues that "*Laws of Manu* is the cornerstone of the Brahmin vision of what human life should be, a vision to which some Hindus have always paid lip service and to which, in many ways, many still genuinely aspire. It influenced expectations, tastes and judgments, beneath the level of direct application of given cases" I will now summarize the relevant sections from *Manusmriti* on the patrilineal ideals that still influence the everyday social performance of masculinity in Nepal.

2.4.1 Personhood, Adulthood, and rite of passages of a Hindu Brahmin, Chhetri male child

Manusmriti ascribes the origin of humans to the self-existent Lord who created four categories, or *varna*, of humans from his body: Brahmin, Chhetri, Vaisya, and Shudra from his mouth, hands, thighs, and legs respectively, to propagate life on earth (Olivelle 2006: 89). A Hindu man's life is temporally divided into four distinct stages or ashrams: a) *brahmacharya* (celibate); b)

[27] *Manusmriti*, otherwise also known as the *Manava Dharmasastra*, is considered to be a preeminent treatise among the group of treatises known as *Dharmasastras* in ancient India. These are the texts that form the code of Hindu laws. *Manusmriti* had already been established as an authoritative law treatise by the fifth century CE and was also famous outside India in the countries of Southeast Asia (Olivelle 2006: 3). It was first translated into English by Sir William Jones in 1794 for the purpose of colonial administration of the Hindu population in British India (Olivelle 2006: 62). Discussing whether *Manusmriti* is merely a text that reflects the ideal prescription of how a society should run or if it is based on the practices of the ancient Indian society, Olivelle argues that "[a]lthough it presents the "should" more often than the "is" and may occasionally engage in pious wishes and wishful thinking, the amount of detail it presents with regard to diverse areas of human activity—ritual, food, marriage, inheritance, adoption, judicial procedure, taxation, punishment, penance—shows that it was not divorced from reality" (2006: 37-38). This text has been used in the past to educate young Brahmins and princes (Olivelle 2006: 38). Moreover, Olivelle also points out that the commentators of the puranas like *Bhavishya* and *Skanda Purana* cross-refer to *Manusmriti* in their works (2006: 55, 69). *Skanda Purana* is a common purana that is read in public in different occasions across Nepal even today; thus, the ideals expressed in *Manusmriti* also get disseminated through these types of religio-cultural activities, making *Manusmriti* still relevant in contemporary Nepal as well. Therefore, investigating the traces of patriarchy and masculinity in *Manusmriti* provides useful insights into some of the imperatives of masculinity I encountered in my study.

grihastha (householder); c) *banaprastha* (forest dweller); d) *sanyaas* (renouncer) (Olivelle 2006: 153). The first stage is that of study where a young child spends considerable number of years at his teacher's abode in learning and acquiring skills specific to his caste. Then he marries and raises children in the second stage as a householder. The forest-dweller stage is a life of a retiree when a man goes to the forest with his wife; in the last stage, the man renounces even his wife and spends his last days in solitude and working on his liberation or *moksa*. In the beginning, these stages were different alternatives lifestyles that a man could choose to live, which later, by the time *Manusmriti* was written, got solidified into distinct sequential stages through which a Hindu man passed (Doniger 2009; Doniger 2014: 28). Among these four, the householder is considered to be the best because "he supports the other three" and sustains the patriarchal societal order (Olivelle 2006: 153). Although in practice, people I met in the infertility clinic do not follow these prescriptions to organize their lives, nevertheless they expressed similar temporal logic of life to explain the pressure they feel to have a child.

A Brahmin, Chhetri male child undergoes various rites of passage rituals from birth until death to become an accepted social person. There are sixteen different *sanskars*[28], or rites of passage rituals, for different stages of life starting

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Garbadhan sanksar is performed when a couple intends to conceive a child. The auspicious days for conception are determined according to the menstrual cycle of a woman. There are 10 days in the cycle when conception is permitted; rest of the days are deemed inauspicious and hence must be avoided (Olivelle 2006: 110). Once the conception is successful, *punshavan* is performed after 2-3 months and *simantonayan* is performed in 3-5 months. These rituals are performed to ensure a safe physical and intellectual development of the fetus. *Jatakarma* is conducted after the child is born to formally establish and acknowledge that the child belongs to the father's clan/*jaat*. It is done after the umbilical cord is cut. On the sixth day after the birth, a ceremony is held for the longevity of the child. Similarly, the child is given a name in the *nwaaran* ceremony on the eleventh day after its birth. The child is taken out of the home for the first time on the fourth month after it is born, a ritual known as *nishkraman*, and is fed solid food on the sixth month during what is called *annapraashan* ceremony. For a female child, the annapraashan is conducted on the fifth or seventh month after her birth. The male child's head is shaved for the first time, a ritual called *chudakarma*, when he is one or three years old. The child's ears are pierced either on the third or fifth year. The piercing, *karnabhed*, is compulsory for a Brahmin male child. The child is introduced to formal learning or education, *vidyaarambha*, at the age of 5.

from the conception till death: *Garbadhan*, *punshavan, simantonayan, jatakarma, nwaaran, nishkraman, annapraashan, chudakarma, karnabhed, vidyaarambha, bratabandha, samavartan, keshaanta, godaan, vivaha, antyesti* (Olivelle 2006: 96-98, 108)[29]. In contemporary Nepal, only a few of these rituals are observed: *nwaaran*, *annapraashan*, the sixth day ritual, *chudakarma*, *karnabhed*, *yagyopavit* (*known as bratabandha*), *vivaha*, and *antyesti*; *niskraman* is conducted together with the *nwaaran*[30]. Out of these rituals, *bratabandha* holds a significant place; it is through this ritual that a young boy transforms into an adult man and a full member of the society. Osella and Osella describe that this ritual creates "an adult male uniquely qualified (by belonging to a Brahminical caste (*jati*) and participating in its rituals and the transmission of sacred and esoteric knowledge) to perform certain Hindu rituals on behalf of his own family or—when acting as paid priests—for others" (2006**:** 31-32). It is also a ritual that qualifies a young brahmin to start studying Vedas and enter *brahmacharya*. The initiated man is then called twice-born after undergoing this ritual—first is a

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In between 8-12 years, a male Brahmin child undergoes another ritual of *yagyopavit* or *bratabandha*. It is a ritual after which the child is eligible to perform fasting, recite mantra and read Veda. Then the formal student life (or brahmacharya ashram) of a Brahmin child to study the Veda begins after the *bratabandha* and lasts for 12 years. The child leaves his home and stays at his teacher's home throughout the learning period. He returns home as a young adult after completing the studies. The returning is marked by *samavartan* ritual that involves bathing with ritually purified auspicious water and a vow to leave *bhramacharya* ashram and enter householder's life (*grihastha ashram*)[28]. This ritual is followed by *keshaanta*, shaving the beard and hair ritual, and cow gifting ritual (*godaan*). Then the man enters householder life through marriage (Olivelle 2006: 96-98, 108).

[29] Although I found that there are slight variations in the description of each of these categories, I have used the description provided to me by a priest who has a MA in Sanskrit from Benaras Hindu University; he also conducts *Purana* (books of hindu mythology) recitation ceremonies. I met him at an infertility clinic in Bharatpur, near my hometown, where he had come for the treatment. I have also used the information I found in the Nepali and English translations of *Manusmriti* and few other sources: https://hinduism.stackexchange.com/questions/410/what-are-the-16-sanskaar-sacraments-of-life-and-how-do-you-complete-them

[30] Even among these rituals, the details and particularities might differ across the region and family because of various factors such as how the priests performing those rituals in a household interpret and perform certain texts or parts of the texts, financial constraints of the family that determines how elaborate or truncated the ritual is conducted, how much time the family (and the priests) can spare to conduct such rituals etc.

biological birth and the second is a ritual birth; it is a "second birth to a male parent [*guru*], which removes young Brahmin males from women in general and specifically from the taint of birth pollution passed on by the biological mother" (Osella and Osella 2006: 30). According to Osella and Osella (2006: 35), this way the initiated man is an "unequivocally and essentially masculine—stripped of female birth pollution, set apart from domestic life and womenfolk, offered esoteric knowledge by senior menfolk, and subject to rituals available only to males" This status is symbolically displayed by wearing a sacred thread across the shoulder and performing *puja* rituals such as daily chanting of *gayatri* mantra and offering of water to ancestors and gods.

2.4.2 Debts of a male child

According to *Manusmriti*, a Hindu man is born with three debts or *rin*. Debts are "fundamental religious obligations of a Brahmin" (Olivelle 2006: 277). These debts are: i) *pitri rin*; ii) *dev rin*; and iii) *rishi rin. Pitri rin* is a debt towards the ancestors and his father that is acquired by a man for giving him life. This is repaid by begetting offspring, usually sons. *Dev rin* is a debt towards the gods and is repaid by performing fire rituals, *yajna*, fasting, sacrificing, and worshipping the gods. Likewise, *rishi rin* is a debt towards the founding sages of the Hindu lineages. This is repaid by continuing the lineage by begetting a son who will learn Hindu scriptures and rituals to perform his daily householder rituals (Olivelle 2006: 277-278). Olivelle argues that "the obligation to marry, to perform sacrifices, and to beget offspring was used by Brahmanical theologians against the ascetic ideals of anti-ritualism and celibacy" (2006: 278). After ending the brahmacharya stage of life, a Brahmin man enters the householder's life and maintains the Hindu world order by performing Vedic rituals. Only through marriage can he repay the *pitri rin*, which is paid by begetting a son who will continue the lineage and perform *pinda* offering rituals to the deceased ancestors (Doniger 2014: 23). Pinda is a ball of milk and cooked rice that serves as food to the ancestors (Olivelle 2006: 114). It is offered in a special ritual of *shraaddha* at least twice a year in Nepal.

Failure to propitiate the ancestors might result into various kinds of troubles in a man's life, inability to father a child being one of them. However, not all the sons eligible to make the *pinda* offering to the ancestors; only the son

born of a marriage between the same varna is legitimate for this ritual. What kind of sons are born is also determined by the type of marriage of a couple. *Manusmriti* describes eight different types of marriages depending on how the marriage was performed (Olivelle 2006: 109-110). The sons born from the four types of legitimate marriages can help the many generations of deceased ancestors and future progenies to escape from getting trapped into hell (Olivelle 2006: 110). Hence, the word for son—*putra*—is derived from this role, which means "the one helps the ancestors to cross the hell named *put* ["childless"]" (Olivelle 2006: 197).

The marriage should be held between the same *varna* categories; that is, a Brahmin man should marry a woman from his own *varna*. At times of adversity, he is allowed to marry women from other *varna* as well, except from that belonging to Sudra. However, the progeny from such union is degraded from the varna hierarchy and is prohibited from performing the *shraaddha* ritual because the deceased ancestors, or the *pitri*, cannot receive the *pinda* offerings made by such children of mixed blood (Olivelle 2006: 109); consequently these children will destroy the purity of the man's lineage.

The man who performs the *shraddha* rituals will be blessed with children by the ancestors (Olivelle 2006: 112, 115). The ancestors wait/wish/hope that a son would be born in their clan/family/lineage who will offer them honey, *ghee* (clarified butter), and rice pudding made from the cow's milk on the auspicious days of the lunar calendar. Depending on the days such offering is performed, a man will reap different benefits, i.e., when performed "on even days and constellations, he obtains all his wishes," and "on uneven days and constellations, he obtains distinguished children" (Olivelle 2006: 122). According to *Manusmriti*, after a man repays the three debts by giving birth to a son, regularly performing ritual offerings to the ancestors and gods, and grows old to see his grandson, he can retire into solitude. Then he should pass on the responsibilities of householder's life to his son and retreat to the forest, the stage known as *banaprastha ashram* (Olivelle 2006: 137, 148).

2.4.3 Maintenance of the lineal masculinity at the times of adversity

Agreements can be reached in certain circumstances such as the inability of the husband to father a child or death of the husband, which threatens the

lineage of the man. Hence, in such "time of adversity" the laws regarding sexual mores are laxed. It is an arrangement called levirate, or *niyoga*, when another man, usually the brother-in-law of the woman, is allowed to have sexual union with the woman for the sake of reproduction and to maintain the man's lineage: "If the line is about to die out, a wife who is duly appointed may obtain the desired progeny through a brother-in-law or a relative belonging to the same ancestry" (Olivelle 2006: 193). Other than under such adverse situations "if an older brother has sex with his younger brother's wife or a younger brother with his older brother's wife, they become outcastes" (Olivelle 2006: 193). Since this act is strictly performed for the sake of creating a progeny, it should be devoid of any emotional ties between the woman and the man; the couple becomes an outcaste if they act lustfully with one another. This arrangement can continue until a son is born (Olivelle 2006: 193). Hence, the need to continue one's line through children was so important that the rules of social conduct between kin was rendered flexible to overcome childlessness.

Likewise, *Manusmriti* also describes that the "[w]omen were created to bear children, and men to extend the line" (Olivelle 2006: 195); thereby, inability of a man to beget a son and give continuity to his family line would mean that he has failed to repay his debts to the ancestors; this also makes him a failure as a man in general. *Manusmriti* even grants a man to replace his wife by marrying another woman if she cannot produce a child for eight years after marriage or replace her in the eleventh year if she gives birth to girls only (Olivelle 2006: 194). The idea of second marriage for a child sanctioned by *Manusmriti* was not merely a fancy of the mythical past but was also endorsed by the *Legal Code*, or *Muluki Ain*, of Nepal until recently[31]. A man could divorce his wife and remarry if she did not produce a child in ten years after marriage. Additionally, similar to the women in the study of Das Gupta *et al.* (2000), I also found that many women

[31] I will discuss about the *Muluki Ain* below but here it is important to note that the state also supported the patrilineal ideology through legal institutionalization of these cultural mores. The clause "if it is certified from the medical Board recognized by Government of Nepal that no child has born within ten years of the marriage due to the reason of the wife" from the Chapter 12 On Husband and Wife of the *Muluki Ain* was amended in 2006 for the reason citing gender inequality; see the Act to Amend Some Nepal Acts for Maintaining Gender Equality, 2063 (2006).

who are struggling with childlessness in Nepal feel guilty of being the cause of potential demise of their husband's lineage, or *vansha*; therefore, they insist their husband to remarry so that the latter's *vansha* would continue. Some men in my study expressed similar sentiments about their need for a child and hence were considering the possibility of second marriage. For instance, 38-year-old Subash, whom I met in Bharatpur's infertility clinic, expressed his desperation to have a child and frustration that resulted from the many years of trying; when I met him in 2017, he had already initiated second marriage in the recent past. According to him, his wife's medical condition of polycystic ovarian syndrome, commonly known as PCOS, was the reason of childlessness. He had already found a suitable partner for second marriage but decided to cancel the marriage on the ground that it would be difficult for him to manage two wives, both emotionally and financially.

2.4.4 Women in *Manusmriti*

Scholars have argued that women, especially those from the upper castes, have an ambivalent role in Hindu patriarchy. They are essential as a ritual partner to their husbands, but they are also considered to be a polluting agent because of their association with blood during birth and menstruation. A woman's loyalty to her husband's family remains a suspect until she gives birth to a son. Moreover, in a patrilocal Hindu society, a woman is also potentially dangerous and poses threat to her husband for the possibility that she can introduce impurity in the lineage of her husband by giving birth to someone else's child (Bennett 1983). Hence, according to Bennett (1983), it is utmost important for men in the Hindu patriarchy that they should tightly control and regulate their women's sexuality to ensure their caste and lineage's purity. Therefore, we find similar prescription in the *Manusmriti* as well:

> Women in particular should be guarded against even the slightest evil inclination, for when they are left unguarded, they bring grief to both families [her natal and husband's family]. Seeing that this is clearly the highest Law of all social classes, even weak husbands strive to guard their wives; for by carefully guarding his wife, a man guards his offspring, his character, his family, himself, and the Law specific to him…. For, a wife bears a son

> resembling the man she loves; to insure the purity of his offspring, therefore, he should carefully guard his wife (Olivelle 2006: 190).

According to Manu, a woman, at all stages of her life—as a child, young adult, and at old age, should not conduct household chores at her own will. She should never be free and independent. As a child, she should be controlled by her father; as a young adult, she should be controlled by her husband, and if her husband dies, she should be controlled by her sons. If she wishes for independence from either of those three categories of men, she will only bring shame and defamation to both her natal home and husband's home (Olivelle 2006: 146).

There are no separate rituals to be done by a woman like those done by the men to repay the three debts and acquire heaven after death. The only way for a woman to acquire prosperity in life and heaven after death is to serve her man with unfailing loyalty and devotion (Olivelle 2006: 146). For a woman, marriage, serving her husband, and taking care of his household chores are equivalent to the ritual of serving the *guru* and performance of offerings to the gods (Olivelle 2006: 98). She must remain faithful to her husband even after his death; a woman cannot remarry and must remain a widow for life by maintaining her chastity. Only then will she acquire heaven after her death even if she has not given birth to a son (Olivelle 2006: 147). Otherwise, the woman who, for the sake of bearing a child, has extramarital sex will be shunned by the society while living and will be born as a fox and suffers from horrible disease like leprosy (Olivelle 2006: 147). Children born out of such wedlock are not legitimate. However, the same rule of marriage does not apply to a man, who can remarry and carry on the householder stage if he is widowed (Olivelle 2006: 147). Nevertheless, if the women prescribe to the norms assigned to them, they are also commendable and deserve honor for they bear children. To give birth to children, rear them, and take care of the home, partake in religious activities to ensure that the ancestors and herself will attain heaven are all the activities of a woman according to Manu (Olivelle 2006: 191).

2.4.5 Patrogenesis in *Manusmriti*

Interestingly, there is a similar description about male procreative role and a man's right to progeny in *Manusmriti* as well. Using the agricultural metaphors, Manu likens a woman to a field and a man to a seed and describes the

reproduction accordingly: "all embodied beings spring from the union of field and seed" (Olivelle 2006: 191). The strength of the field and seed determines the quality of the offspring; if the parents are socially eminent, the children are also eminent accordingly and that the seed, or father, is biologically superior vis-à-vis the field, or mother (Olivelle 2006: 325). In this worldview, seed is considered superior to the field as the seed determines the nature of its progeny. Although the field provides the essential environment and nurtures the seed to grow, "yet the seed, as it develops, does not manifest any of the qualities associated with the womb" and "[w]hatever kind of seed is sown, that same kind sprouts forth" regardless of the field (Olivelle 2006: 192).

Therefore, in the worldview based on Hindu patriliny, it is the man who is reproduced through his procreative substance planted into the woman, as can be discerned from the verse in *Manusmriti*: "The husband enters the wife [as semen], becomes a fetus, and is born in this world" (Olivelle 2006: 323). Elsewhere, Olivelle discusses that in Hindu patriliny "The son is one's very self-born again in the wife" (1993: 41-46). Hence, it follows that children become the carrier and transmitter of the lineal masculinity onto next generation that they inherit from their father.

It is possible to argue that the passages from *Manusmriti* are only norms of the past with no practical relevance in the construction and performance of today's Nepali masculinity. *Manusmriti*, itself a part of the ancient law books *Dharmashastras*, was not consulted directly for the matter of governance in Nepal. Nevertheless, the patrilineal ideals propagated in this text were incorporated into the legal structure and governance of Nepal in the 19th century. The country's first written legal code *Muluki Ain* of 1854 was heavily influenced by the Hindu law books like *Manusmriti*[32] in terms of the ways criminal and civil offenses were dealt (Michaels 2005; Sharma 2005; Höfer 2005). The first Rana

[32] See Rupakheti 2017 for his discussion, and disagreement, of the Orientalist reading of the scholars who trace *Muluki Ain* to the traditional Sanskrit sources like *Dharmashastras* and term it as inferior to the Western legal practice of the time. Although he disagrees with such reading, he however mentions that the sources of the *Muluki Ain* are not clear and speculates that the Ranas "too were turning to Brahmins and classical texts to mould their newly acquired power" (2017: 187). This is not to say that the classical texts were the only source used to create the Muluki Ain. Sharma (2005) discusses the influence of Mughal court system from India and the laws of the East India Company as well.

prime minister Jung Bahadur Rana, who appropriated the state power from the Shah monarchs and created his own hereditary rule of the prime ministership, promulgated the *Muluki Ain* in 1854 after his visit to England[33]. The *Muluki Ai*n, albeit various amendments at different times, served as a basis for governance of civil and criminal offenses in the country until 2018[34]. Therefore, some of the basis for the contemporary construction of masculinity that I encountered in the field is better understood in the light of the Muluki Ain, to which I turn below.

2.5 The *Muluki Ain*, hegemony of the Hindu ideals, and lineal masculinity

The Rana polity defined itself to be a Hindu kingdom and fashioned the *Muluki Ain* to reflect that by institutionalizing the Hindu caste system. In this document that was used to govern the entire country, different populations were put under a strict caste hierarchy, with Bahun[35] and Chhetri occupying the topmost tier (Höfer 2005, 1979). Despite the heterogeneity in their composition, various populations such as Gurung, Magar, Rai that did not follow the prescriptive Hindu caste order were also brought under the fold of the caste hierarchies in the *Muluki Ain*. Everyone was put under one of the following categories: a) caste group of the "Wearers of the holy cord" (*tagadhari*); Brahmins, Chhetri, and certain groups of Newar among others formed this group. They were also called the "twice-born" caste; b) caste group of "non-enslavable alcohol drinkers"; c) caste group of the "enslavable alcohol drinkers"; d) "impure, but 'touchable' castes"; and e) "untouchable castes". Interestingly, even non-Hindu groups like Muslim and foreigners were subsumed under one of these five categories. These groups were further categorized based on the purity-impurity ideal. The groups that belonged to the first three categories were considered to be pure castes or "water-acceptable castes," whereas the latter two

[33] Some scholars have argued that Jung Bahadur was influenced by the *Code of Napolean* in France and saw a need of a similar document in Nepal as well (Höfer 2005; Malagodi 2013: 80). However, others disagree that there was such a linear influence (Sharma 2005).
[34] In 2018, *Muluki Ain* was replaced by two different legal codes for civil and criminal offenses (*Muluki Devani Samhita Ain* and *Muluki Faujdari Karyabidhi Samhita Ain*).
[35] Brahmin and Kshatriya are commonly called Bahun and Chhetri in Nepal.

were called impure castes or "water-unacceptable castes". The former group was not allowed to accept water from the latter group (Höfer 2005: 10-11). Various strict regulations were put into effect to ensure the caste hierarchy and the maintenance of the purity of the caste. Likewise, the punishments, and their severity, varied according to caste and gender (Höfer 2005; Tamang 2000: 129). However, the *Muluki Ain* recognized the customs and traditions of various ethnic groups but regulated them if such customs conflicted with the Hindu ideals subscribed to by the state. For example, killing of cows was banned and the practice of levirate sanctioned by *Manusmriti* was also banned among the Brahmins but allowed among other caste groups (Sharma 2005: xxv; Höfer 2005: 152).

Two ways the *Muluki Ain* sought to maintain the purity of the caste hierarchy was by the rule of commensality and regulating the sexual relations between, and within, various caste groups. The sexual relation between the members of the "water-acceptable" and "water-unacceptable" (pure and impure) castes was forbidden; likewise, sexual relations between a man and a woman of a higher caste than the man was also restricted (Höfer 2005: 35). In case a man had sexual relations with a woman of a higher caste than his, the children born of such union would lose the purity and caste status (Höfer 2005: 56). Höfer argues that such practice of hypogamy, the act of sexual relations with a higher-ranking woman, is "incompatible with the patrilineality principle and with the male's striving after preservation or even increment of his purity" (2005: 56). Digression from these caste rules based on the maintenance of purity not only resulted in the downgrading of caste status, but it also came with a penal punishment like a monetary fine and in some cases even capital punishment for a man[36] (Höfer 2005: 38-40). Depending on the caste status and nature of digression, either a man or his children would have their caste degraded (Höfer 2005: 35-59). Hence, together with the commensality rule, woman's sexuality and its control formed

[36] Höfer (2005: 38-40) has tabulated various combinations of the sexual relation between the women and men of different caste groups and the legal consequences and punishments faced by men and women. Detailed discussion of such provisions is beyond the scope of this chapter. It is sufficient to highlight that the *Muluki Ain* went at length to legally regulate the purity of caste categories through different kinds of punishments.

the basis of maintaining the purity of caste, and, in turn, lineal masculinity, in 19th century Nepal.

After the change of regime back to the Shah monarchs in 1951, King Mahendra promulgated the Panchayat system that lasted from 1961 to 1990. He issued another legal code, the *New Muluki Ain*, in 1963. Like its predecessor, the new legal code also defined Nepal as a Hindu Kingdom. Nevertheless, a significant change in the new legal code was that the state now regarded everyone equal before the law and the caste specific punishments, degradation of caste status as a penal punishment, and regulations of sexual relations according to caste were abolished. However, such changes did not mean the total abolishment of the caste hierarchy and the relations that maintained the hierarchy, which were tacitly kept intact (Höfer 2005: 187-88). Not only was caste hierarchy implicitly maintained in the *Muluki Ain* during the Panchayat era, Tamang (2000: 136) has argued that the state, through the *Muluki Ain*, regulated the matters of marriage, family, and property inheritance along the Hindu patriarchal values by taking the family form of Brahmin-Chhetri as a hegemonic ideal template of a Nepali family. She further argues that there was a shift from the family patriarchy to the state patriarchy in which the state "[…]not only actively [regulated] women's sexuality but also [maintained] and [reproduced] gender hierarchy" (2000: 143). For example, in the earlier version of the *Muluki Ain* of 1853, if a man committed adultery with a married woman, he had to pay a fee to the husband of the woman; in the new *Muluki Ain* of the Panchayat era, the fee for the same offense had to be paid not to the husband but to the court, which Tamang argues, "[…] implies that the "wronged" is no longer the husband but the state" (2000: 144). Implicit in this shift is the assumption of "[…]who in fact "owns" women's bodies and thus is "wronged," whereby even after the shift the status of the women was relegated to that of "the personal property of the husband" (Tamang 2000: 145). Despite many socio-political changes after the end of Panchayat in 1990 and many amendments to the *Muluki Ain,* patrilineal ideals and caste are still a social reality in many facets of contemporary Nepali society. It is poignantly seen especially in matters of marriage, which is largely governed by the practice of caste endogamy and gotra exogamy.

2.6 *Ansha* and the lineal masculinity

As mentioned above, another defining aspect of lineal masculinity, beside the *vansha*, is the inheritance of parental/ancestral property, called *ansha* , which until 2006 only passed onto the male children of a man[37]. The right to inherit parental property is connected to the duty a man has toward his parents. Bennett describes the four obligations of a male child to his deceased parents and ancestors. The obligations were: a) the thirteen days mourning rituals and observation of death pollution after the death of the parent(s), b) the year-round mourning and monthly commemoration rites, *shraaddha* during the first year of parents' death, and c) annual *shraaddha* after that, pertain to the rituals conducted for the deceased parents; and d) a commemoration rite conducted to collectively propitiate ancestors beyond just the parents (Bennett 1993: 92-93). According to Bennett, it is the fulfillment of the first three obligations that give the sons a birth right to the parental property, or *ansha* (1993: 95). In case a person does not have a male child, the death rituals are conducted by close male kin of the man but no women in the deceased man's family, wife, or daughter, are allowed to perform the death rituals[38]. This also potentially means that the person who performs the death rituals for the man would inherit the man's ancestral property. I found similar anxieties among the childless men during my research as well. As mentioned in the opening of the last chapter, Anup was constantly threatened by his elder brother that since Anup lacked an heir to pass on his share of parental property, his son would inherit Anup's properties. As he told me,

> *"My elder brother continuously pestered me for being childless and not having an heir to the parental property. That is why I wanted to adopt a child so that my elder brother's children would not usurp my share of the parental property after my death,"*

[37] I will discuss about the inheritance of parental property by women in the later section.

[38] This is the normative order but there are cases of women performing funerary rites of their parents. However, these are more exceptional cases that draw a lot of resistance. See Kunreuther for an example of a lawyer who performed funerary rites of her mother and how she dealt with the social consequences of that (2009: 555).

Nevertheless, to borrow from Bennett (1993: 97, even though such scenario of property inheritance could occur, "[…] in the absence of a spouse or direct male descendant, sentiment and sheer politics come into play" and determine how the inheritance process actually occurs (1993: 97). Setting aside such an exceptional scenario, Bennett argues, the "order of precedence for *kriya* [death ritual] responsibility itself gives clear expression to the Hindu ideals of parent/son bond and of patrilineal solidarity" (1993: 97).

The regulation concerning the inheritance of property was formalized in the new *Muluki Ain* of the Panchayat era and applied uniformly to all castes and ethnic groups. Until then, the inheritance of property was a matter of custom, which was practiced differently by various groups residing in the country (Kunreuther 2009: 548). The patrilineal law of inheritance of ansha directly created gendered subjectivity in the sense that for men, as Kunreuther describes, "[*ansha*] has been a declaration of ownership and a material mark of their name,"[39] whereas, "[f]or daughters, who leave their parents' home in marriage, [ansha] has been their father's family property from whom they have been excluded, unless they never marry" (2009: 548). According to Kunreuther, *ansha* became a "defining feature of masculinity" as it is "a mark of what all men possess at birth" (2009: 548). Married women could only claim their right on the husband's share of the *ansha* but not on the *ansha* from their father's property. An unmarried daughter who was over 35 also had rights to the *ansha* from her father but she was only eligible to inherit half of what a son would inherit (Khanal 1970: 154); she had to relinquish her right if she married after 35 (Kunreuther 2009: 549). Kunreuther, therefore, argues that the creation of such restrictive regulations of property inheritance was a means by which the state controlled women's sexuality: "A wife who slept with her husband and bore him children had rights to her husband's property should he die. But if this widow remarried or was even seen with another man whom others found suspicious, she lost her rights to her deceased husband's property" (2009: 549).

During the 1990s, there was a major challenge to the property inheritance laws by the advocates of women's rights which resulted in a major amendment to

[39] Similar patrilineal rule of property inheritance was prescribed in the *Manusmriti* as well. See Olivelle (2006: 345-380) for the details of how the property should pass on in a family.

the *ansha* inheritance laws in 2006. According to this law, the daughters, both unmarried and married, were granted rights to inherit *ansha* from their father, which they did not have to return even after they married and moved to their husband's home (Kunreuther 2009: 549). This marks a crucial turning point in the understanding of *ansha* and *vansha*, which hitherto were exclusively defining features of masculinity. By claiming the right to inherit their father's *ansha*, the women were also indirectly claiming their entry into the *vansha* of their father. As mentioned above, in the Hindu patriliny that is hegemonic in Nepal, women do not have a separate *gotra* from their father or husband, nor do they inherit their father's *gotra* like men; they assume their husband's *gotra* after marriage and hence are only known vis-à-vis their husband's gotra, and *vansha* at large. However, this new provision of the inheritance of *ansha*, in principle, transforms the very structure and basis of Hindu patriliny[40] by creating a condition of possibility to include daughters into their father's *vansha*. However, legal sanction might not immediately translate into changes in the prevalent social practices of property inheritance and the overall understanding of the link between *ansha* and *vansha*, as was seen in the case of men and women in my study.

2.7 Discourse of masculinity in Nepal vis-à-vis the lineal masculinity

Even though there is significant research on South Asian men (Osella and Osella 2006; Bharadwaj 2003; Alter 1992; Kakar 1982, 1989; Srivastava 2004; Gilmore 1990), studies on Nepali masculinities is a relatively new field of inquiry

[40] Similar to the longstanding debate of the women's right to inherit *ansha* from their father, there has been a long struggle by women's activists for granting the citizenship to the children under the mother's name, which for a long time has been passing on under the father's name only. Since property is also a marker of citizenship in a state (Kunreuther 2009: 547-548), the women's struggle for the right to *ansha* and the demand for the citizenship of descent under their name are interlinked. Although now the laws have been amendment and there is a provision in law to grant citizenship to children under the mother's name, it is still undergoing a lot of debates and controversies (FWLD 2022; GoN 2006)). Both the changes have been very ineffective when it comes to implementation and practice; there still exist a lot of institutional and cultural barriers for a woman to inherit her father's property and for a child to get citizenship solely under his or her mother's name. This further illustrates that despite some changes, the patrilineal ideals are still deeply rooted in Nepal at many levels of society.

(for example, Onta 1996b; Uprety 2011**;** Poudel 2012). In the rest of the chapter, I will review the existing literature on Nepali masculinity and explore if and how they relate to lineal masculinity.

2.7.1 Gurkha soldiers and the colonial construction of Nepali masculinity

Caplan's (1995) important work gives a good insight into the construction of Nepali masculinity vis-à-vis colonial power during the 19th and 20th century. In his *Warrior Gentleman*, Caplan focuses on the Nepali men recruited in the Gurkha regiment of the East India Company's army that was formed after the 1814-1816 Anglo-Nepal war. Caplan argues that the East India company's militaries who fought in the war acknowledged the bravery of the Nepali soldiers during the war and therefore later recruited the men who had left the Gorkhali army[41], or were from the territories that Nepal lost in the war, into the Company's

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Modern Nepal's formation is closely tied to the colonial encounter in the 18th century. When the East India Company had established itself in India, current Nepali territory existed as smaller kingdoms, which were divided into two confederations of *baise rajya* (twenty-two kingdoms) and *chaubise rajya* (twenty-four kingdoms). These kingdoms were annexed into a larger kingdom by the king Prithvi Narayan Shah of Gorkha, a kingdom in the west of Kathmandu, during the late 18th century. Prithvi Narayan's ultimate victory came after the conquest of Kathmandu Valley, which he made his new state capital. This was the start of the rule of Shah dynasty in Nepal (Whelpton 1991). The Shahs belonged to the Parbatiya ethnic group, which comprised of upper caste Hindus from the mid-hills of the newly formed state. The Parbatiya were further categorized along the Hindu caste division comprising of Brahmin and Chhetri at the top and a few "untouchable" artisan castes at the bottom. Gellner argues that it is this group that dominated the rest of the diverse ethnic groups from multiple cultural regions of the new polity, such as the culturally Tibetan population on the north bordering the Himalayas and Tharu and Maithil population on the south bordering India (1997: 4). Other existing ethnic groups[41] were subsequently brought into the folds of the newly formed Hindu polity, which until 1909 was not defined as a single nation-state as Nepal. According to Burghart, Kathmandu Valley was only known as Nepal before that, to which all the rest of the territories within the Gorkhali Kingdom were subjects (Gellner 1997: 5).

Gorkha kingdom's expansionist mission continued after the death of Prithvi Narayan Shah and by the early 19th century, the Gorkhali troops had annexed Kumaon and Garhwal in the west and Tista in the east. This started the tension between Nepal and the East India Company, who had its own interest in these territories, which resulted into a war between them in 1814. The war ended in 1816, with Nepal, the losing party, signing the now famous Sugauli Treaty. The Treaty determined the current state borders of Nepal and establishment of the

army. The image of bravery displayed by the Gorkhali soldiers during the war thereafter served as the basis for the construction of a stereotypical image of the brave, fearless, and fierce Gurkha soldiers that is currently prevalent in the western world (1995: 1-19). Once the Gurkha regiment was established, the British Army commanders started recruiting men from the hilly regions of Nepal[42]. These groups of Nepali men, who belonged to specific hill ethnic communities of Gurung, Magar, and Rai, were labeled as the "martial race" by the British recruiters. The men belonging to the martial race were valorized for traits like aggression and physical strength. The martial quality, these writers deemed, was bred from the harsh life in the hills (Gurung, 2014

The labeling of the certain ethnic groups in Nepal, and India, as belonging to a martial race was a strategic agenda in part of the British India after the Sepoy Mutiny of India in 1857 in which the Indians revolted against the colonial power. This revolt was led by the Bengali soldiers recruited in the British Indian army and later expanded to various other parts of India. After suppressing the revolt, the British Indian authorities then revised their recruitment policy by labeling Bengali men as effeminate and unsuitable for recruitment in the army; whereas they created the category of "martial race" using the rationale of the race theory popular at that time and defined the men from the Northeast India and the Nepali men from certain ethnic groups as the martial races. This gave them justification to recruit these specific groups of men into the army who they deemed did not pose any threat and instead complied to the colonial mission (Caplan 1995: 89-96).

Ironically, although the Gurkha soldiers were praised for their valor and masculinity, they always remained subordinate to their British officers who likened the Gurkha soldiers' brute physical strength to that of the lower-class British men. Thereby, the British officers considered Gurkha soldiers as lacking a full-fledged masculinity like theirs. Instead, Nepali soldiers in the Gurkha regiment were considered to be adolescents who needed the guardianship of the

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British Residency in Kathmandu. The defeat of Nepal also resulted into an establishment of the Gurkha regiment in 1815, a wing in the East India Company's army comprising of Nepali men recruited as soldiers (Onta 1996c: 3).

[42] This did not happen smoothly as there was resistance from the Nepali rulers in the beginning to send their men to fight for the foreign power (Caplan 1995: 20-21).

British commanders (Caplan 1995: 102-106). While the Gurkha soldiers' physical strength and raw bravery was a matter of praise, the British officers despised the Gurkha soldiers for lacking intelligence and mocked their slow aptitude to learn (Caplan 1995: 108). Hence, we see that there was a dual construct of Nepali masculinity in the 19th and 20th century British Indian army. On the one hand, the Gurkha soldiers were praised for their physical strength and fierce bravery vis-à-vis the effeminization of the Bengali men and, on the other hand, the strength and bravery of the Gurkha soldiers was not at par with that of the British officers who likened the former to the lower-class British adolescent that lacked maturity and rational acumen.

Despite such subordinate masculinity in relation to the colonial officers, the Gurkha soldiers evince lineal masculinity at home in a sense that in many cases a man's recruitment in the army is followed by his son and grandson later (Caplan 1995: 40). Together, they produce a family legacy that valorizes the bravery and achievements of its male members. Along with the intangible capital of family legacy, the recruitment also results into the considerable increase in tangible socio-economic capital of these men. Both capitals are inherited by the men in the subsequent generations of a family.

2.7.2 Rana rulers and mimicry of the colonial rulers

Uprety's *Masculinity and Mimicry: Ranas and Gurkhas* is another important work on the study of Nepali masculinity. He presents the complex construction of Nepali upper-caste, and upper-class, masculinity that was informed by the discourses of western modernity, Nepali nationalism, and Hindu caste system (2011: 42). Using the postcolonial concept of mimesis, Uprety discusses the different orders of masculinity that was constructed in the representation of the two Rana rulers by the historians of Nepal and the British media during their visits to England in the 19th and 20th century. Jung Bahadur became the first South Asian ruler to visit England in 1851. His visit drew large attention from the British newspapers that published the stories of his physical courage and heroic deeds at home. Some of the stories that circulated about him included how he tamed wild animals like elephants, how he survived after jumping into a running river on horseback etc.; stories like these created an image of an exotic hypermasculine oriental hero. On top of that, he also performed

exotic otherness through the manner he and his entourage dressed during the visit: he wore royal costumes made of silk embroidered with gold and headgear studded with expensive gems and jewels, which were in sharp contrast to the colonial rulers' mode of dressing (Uprety 2011: 13-16). As Uprety argues, such construction of Jung Bahadur's masculinity in the British press portrayed him "as an oriental ruler whose masculinity made him seem to approximate the model of English masculinity, but who at the same time fell short of that model because he was perceived as lacking the moral rationality of the middle-class English" (2011: 15). Nevertheless, in contrast to the Indian Maharajas, who were regarded as feminine due to their mimesis of the colonial rulers, Jung Bahadur was represented as having proper masculinity, which "based upon a rejection of the mimesis of imperial models—was seen as royal and pre-modern and hence different from the modern, rational middle-class British masculinity," (Uprety 2011: 17).

What is important to my study from Uprety's work is his discussion of Jung Bahadur's careful performance of masculinity in relation to caste. One of the highlights of the news in the British media was about Jung Bahadur and his entourage's mannerism in relation to commensality during their visit. Although they participated in the public events organized for them by their British host, they ate separately and prepared their own food. They also performed special rituals of purification of their body as per their caste rules such as bathing and creating a symbolic circle around them to maintain their caste purity and prevent themselves from the cultural contamination resulting from mingling with, or imitating, the English and Christian ways. Likewise, while returning home he stopped by Rameshwaram in India to perform purification rites to absolve himself from the cultural pollution he might have accrued due to his visit to a foreign land (Uprety 2011: 20-24). Through such performances, he displayed to the orthodox Hindu courtiers at home that he had remained a good Hindu who maintained his caste purity without any compromises. Otherwise, losing his caste purity would mean that he would also lose his caste status as a Kshatriya, which according to Uprety, is connected to the loss of masculinity at large: "While upper-caste Brahmins and Kshatriyas, by virtue of their mastery of certain knowledge and martial virtues respectively, could claim proper forms of

masculinity, a loss of caste could make a Brahmin or Kshatriya masculinity deviant, even effeminate" (2011: 25).

In contrast to the pre-modern oriental exotic masculinity of Jung Bahadur in the 19th century, his descendant Chandra Shumsher, represented by Landon in his book *Nepal*, portrayed a different type of masculinity in the 20th century. By the time Chandra Shumsher assumed office of the prime minister in 1901, Nepal had completely come under the British influence so much so that its foreign policy was determined as per the political will of British India. Chandra Shumsher received English education in Calcutta University in British India and willingly offered Nepali armies to the British government during the World War I (Uprety 2011: 28). Unlike Jung Bahadur who performed pre-modern exotic oriental masculinity through his exotic dressing style during his England visit, Chandra Shumsher publicly wore British style army outfits during his visit to England in 1908. Hence, Uprety (2011: 34) argues, he enacted not a pre-modern royal oriental exotic masculinity like that of Jung Bahadur, but "combined that exotic model of exotic oriental manliness with the model of British imperiality" Interestingly, this type of mimicry of dressing style and eating habit did not possess any threat to his masculinity and loss of caste (Uprety 2011: 32). At home as well, he continued to alternate between his native royal regalia, which symbolized his Kshatriya masculinity, and British style dresses. Not only was his dual masculinity represented through the switching between dresses, it was also reflected through his daily performance of the caste rituals and purification rites. Though the switching between the dresses made him, as Uprety argues, to be "modern and masculine at the same time" (2011:36), the strict maintenance of his caste duties "protected him from the charges that his masculinity was compromised due to his imitation of the English" (Uprety 2011: 41).

It is important to note that even when Chandra Shumsher freely imitated the British imperial ways in the public and projected a modern rational image of himself, the maintenance of caste purity, nevertheless, was paramount for the upkeep of his masculinity. As I have argued above, loss of caste purity entailed loss of one's caste status in the hierarchy proposed by the Muluki Ain; that would also transpire to overall degradation in a man's social status. Since caste purity is interlinked with the lineal masculinity in a sense that a man passes down his

"estate," such as property and social status, to his heirs, such a loss for a man would result into diminished lineal masculinity as well.

2.7.3 Reconstruction of Nepali masculinity in the nationalist historiography

Although not directly a study of Nepali masculinity per se**,** Onta's work (1996b, 1996c) also deals with how the authors of Panchayat regime[43] created a nationalist history in the 20th century based on the trope of bravery of the Gorkhali soldiers during the 1814-1816 Anglo-Nepal war. In contrast to the image of brave Gurkha soldiers of the British Indian army, the bulk of which was composed of the men from ethnic communities of Rai, Magar, and Gurung, the Panchayat polity strategically appropriated the image of bravery and redefined Nepali masculinity by focusing instead on the upper-caste war heroes. This was partly done, according to Onta (1996a, 1996 b), by creating the narrative of bravery of a few national heroes who fought in the Anglo-Nepal war and the dissemination of the nationalist history through school textbooks in the 1960s.

The rewriting of history involved creation of a narrative of the nation that, despite its ultimate defeat, fought off the British army at the famous Nalapani fort

[43] Nepal went through a volatile political period after the death of Prithvi Narayan Shah. There was a lot of internal conflicts in the palace and contention between the royals and their councils of ministers and army. One such army general, Jung Bahadur Rana whom I mentioned above in the discussion of the Muluki Ain, took advantage of the situation and, in a manner of a coup, seized the political power in 1846 to establish himself as the Prime Minister and the supreme commander of the army. Thereafter, until 1950 when the Rana regime ended, the kings were relegated to a mere ceremonial position while the Ranas ruled the country as heredity prime ministers (Whelpton 1991). Jung Bahadur was able to garner support for his political move from the East India Company, through their representative Regency in Kathmandu, who found in him a complicit ally. He consolidated his power through a continued support from the East India Company by allowing the recruitment of Gurkha soldiers into the British army. The British support of the Rana regime continued until the British were ousted from India in 1947. A popular mass movement against the Rana regime in 1951 eventually ended the 104 years of autocratic Rana rule in Nepal. This was followed by a brief period of multiparty democracy when Nepal opened its border to the outside world and also became a member of the UN in 1955. However, the multiparty democracy did not last long as King Mahendra promulgated the partyless Panchayat Democracy, another autocratic system, in 1962. Like its predecessor, Panchayat also was a Hindu polity led by the hill-based upper castes (Poudyal 1984:77).

near Dehradun in the 1814-16 Anglo-Nepal war. The Gorkhali army, led by Balbhadra Kunwar, succeeded in killing General Gillespie who was leading the East India Company's army. The Panchayat nationalists took up the story of bravery and might of Balbhadra Kunwar and constructed a *bir* (brave) history of the nation; such *bir* history was disseminated for almost three decades through textbooks produced by the carefully planned education system, argues Onta (1996a). Elsewhere, Onta (1996b) has argued that during the Rana regime itself, a few Nepalis living in India had already begun the construction of Nepali nationalism based on the valorization of a few *bir* soldiers from the Anglo-Nepal War and promoted Nepali language as the national language. The Panchayat polity selectively appropriated that by pruning the narratives that did not fit its agenda of national pride and virility—the parts that were contradictory to its imagination of a homogenous nation based on bravery of its upper-caste soldiers[44]. This was a history exclusively based on *bir* upper-caste men in which the contribution of the women and children in the Nalapani war became merely a passing footnote (Onta 1996a: 222-230). Hence, like in the patrilineal system in which the lineal masculinity passes on down to the future, the story of the nationalist heroes and their valor and bravery during the Nepal's nation-building process will continue to pass on whereas the women's contribution in the nation building process will be forgotten with time.

It is interesting to note that the developers of Panchayat polity considered that the state had lost its virility and, therefore, its restoration was one of the principal aims of Panchayat polity. The loss of virility was perhaps an allusion to the fact that the Rana rulers had, for over a century, relegated the Shah kings to a mere ceremonial status while they practically ruled the country. Now after the restoration of power to the Shah monarchs, it was in King Mahendra's best interest to also rewrite that period of history when Shahs were emasculated by the

[44] For example, the textbooks that were used prior to the creation of the national history contained a narrative of the Gurkha soldier Gaje Ghale who was awarded with the Victoria Cross for his contribution in the Second World War. The textbooks written after the 1960s and later omitted the story of Gaje Ghale who belonged to the ethnic communities deemed "martial race". Likewise, the story of Balbhadra's joining the army of the Punjabi King Ranjit Singh after the defeat in Nalapani and his death while fighting against Afghanistan also was left out as it did not fit the nationalist fervor of the Panchayati imagination of the brave nation (Onta 1996a: 227-231).

Ranas. Mahendra's brainchild Panchayat polity did just that—it rewrote the history in which the Rana era was termed as a period of darkness in Nepali nationalism (Onta 1996a: 217-221). This move also served a few other purposes as well: it paved way to justify modernization drive based on the rhetoric of *bikas* (development and progress) and it also allowed reassertion of the nation-state's virility in the global stage, as it had taken the UN membership as an independent sovereign nation-state.

Moreover, it is also noteworthy that the Panchayat polity used the trope of bravery, or *bir*, to rewrite the nationalist history. The cultural notion of *bir* or *vir* that define attributes like physical strength and bravery are also metonymically intertwined with virility and sexual prowess; the latter two are captured better by the term *virya*, a word for semen. *Nepali Brihat Sabdakosh* defines *virya* as, "a substance, produced in a man's body, which is created from the essence of food consumed, and that which increases strength and virility and produces *santaan*,"[45] (NPP 2067 (2010):1170). Since *virya* is a substance that increases strength and virility, the lack of semen is equated to the loss of virility and physical strength; and therefore, there is a cultural prescription in South Asia that semen should not be squandered (Alter 1992). For instance, a section in *Manusmriti* that describes the rules for young Hindu Brahmin in the brahmacharya (celibate) stage, a student is strictly forbidden to voluntarily ejaculate his semen. If it so happens involuntarily in his sleep, he should "bathe, worship the sun" and recite the verse, "[m]ay the virile strength return again to me…" (Olivelle 2006: 104). Thus, the use of the term *bir* by the Panchayat state to rewrite its history is not coincidental in a sense that it is a carefully chosen word to denote the virility of the state vis-à-vis virile male soldiers.

2.7.4 Studies on the contemporary men and lineal masculinity

After reviewing the historical construction of masculinity, I will now explore the studies that focus on the enactment of masculinity in contemporary Nepal. Some of the studies show how masculinity manifests at various sites: a) among street children in the public space (Poudel 2011); b) in public transport (Poudel 2012); c) in legal institutions and political space (Uprety 2012); d) in

[45] My translation

relation to sexual behavior and gender-based violence (Khati 2011; UNDP and MenEngage 2014); and e) in the desire for male children (Nanda *et al.* 2012). The UNDP and MenEngage report published in 2014 found that traditional understanding of Nepali masculinity is associated with "physical attributes such as height, physical strength, muscular body and fertility" (10). This study has also found that "caste and sexuality shape people's perceptions concerning masculinity," and reports "how social stigmas are generated via those perceptions" (UNDP and MenEngage 2014: 6). This is in keeping with the previous sections above where I discussed the salience of caste in the historical construction of masculinity in Nepal.

In a study conducted in Kathmandu among various groups of men, Uprety (2016) found that traditional social norms and stereotypes of masculinity persists in the contemporary time too. His respondents termed "height and physical strength", "muscular body", "fertility or ability to impregnate a woman", "rationality/intellectuality", "bread winning ability", "forming family through marriage" as the markers of masculinity (Uprety 2016: 511). One common term that is used by men in Nepal to define a "real man" is *marda*. Marda is a Persian loan word in Nepali language that means a man; other synonyms of *marda* include, *bir* (strong, courageous, brave) and *pumsatva bhayeko* (the one who has a power/ability to impregnate a woman and beget a child[46]). Hence, all these words are metonymically connected. As I have discussed above, the concept of *bir* was used by the Panchayat polity to rewrite the nationalist history based on the bravery of Gorkhali soldiers.

The opposite of *marda*, or the man who isn't a "real man", is called *namarda*. It is a real insult for a man to be called a *namarda*, which can be discerned from Uprety's study (2016) as well. Through interviews with a few couples, Uprety (2016) found that the ability, or lack thereof, to earn and become a breadwinner was extremely important to define a *marda* and *namarda*. One of his interviewees, a 25-year-old man, opined that "a man is real man who works for the family," (Uprety 2016: 517). Likewise, another informant, Kumud, is a teacher by profession whose husband Bijaya does not have a stable earning career. She gets ridiculed by her friends who sarcastically suggest her "it is better

[46] My translation

to be the mistress of a real *marda* than be a wife of a *namarda*" and further tell her that "a man who cannot make money for the family is not a real man" (Uprety 2016: 516). Bijaya has also been called *namarda* by his male friends, which led into a fight with one of them (Uprety 2016: 516). Ironically, Bijaya had told Uprety in the interview that he does not have any problem with his wife earning for the family. However, despite what he told Uprety, Bijaya seems to have internalized the social ideals of what a real man means for him to retaliate his friend who called him *namarda*.

Uprety's finding highlights a very important aspect of the lineal masculinity, viz., a man's link with property and wealth. As I have discussed above, a man is measured by his ability to pass on his personal wealth along with the ancestral property to his children. This attribute of a man is founded on his role as a householder with family. Thereby, his earning capability becomes one of the defining features of his masculinity, which can be gauged by the way Bijay in Uprety's study was emasculated by being called a *namarda*. Not only was he called *namarda* by other men, even the women thought of him as a failure for not being able to earn for the family.

Other studies conducted elsewhere outside Kathmandu also found that the breadwinner attribute of a man, along with physical strength and bravery, is one of the core components of Nepali masculinity. For example, Maycock et al.'s (2014) study report from the research[47] in the two demographically different towns of eastern Nepal also found that similar notions of masculinity prevailed among the 16-25 years old young men in these towns. The study's aim was to understand the notions of masculinity among the young men in the study sites and the link between masculinity and violence. One of the major findings of the study was that the young men held a patriarchal notion of masculinity and saw it fit to exert control over the women in their life—sister, wife, or girlfriend—in order to protect their family honor (Maycock et al. 2014: ii-iii). The discussion of *marda* also came up frequently among these young men. Some of the qualities that made a *marda,* for these young men, included physical aspects like bodily

[47] It is a study conducted by the authors for a NGO in Nepal that works on the issue of gender violence. The authors, both of whom are academic anthropologists based in the UK, have used the mixed method approach with ethnographic bent.

strength and muscle as well as attributes like "bravery, courage, and guts (*himmat*)" (Maycock et al. 2014: 9). Interestingly, in an exercise to make an ideal man using a playdough, they made models of Bhakti Thapa and Prithivi Narayan Shah, of whom they learned about in school[48] (Maycock et al. 2014: 10-11). Both these historical figures are known for their bravery during the Nepali nation-building process during the 18th century. Likewise, the young men also described a marda to be a risk-taker as well; men who failed to take risk are termed as "*kathar* ("coward") or *chhakka*[49] ('not man enough')" (Maycock et al. 2014:12). This shows how contemporary young men have been socialized to link aspects of violence, bravery, and masculinity together.

Similarly, the role of being a breadwinner as an essential attribute of masculinity was also felt by the young men in Maycock et al.'s study. Although marriage marked an important transition point between boyhood and adult masculinity for these young men, they reported reluctance to get married prior to ensuring that they had a stable employment and source of income. Even their desirability as marriage candidates is determined by their ability to earn and provide for their future family (Maycock et al. 2014: 14). Additionally, as discussed above, the breadwinner role is based on the assumption of a man as a householder with a family. Thereby, if a man is unable to form a family, by fathering children to be specific, he is seen to be a failure as a man and is called a *namarda*. For instance, a man who cannot have a child and "produce a (usually male) heir to continue the family" (Maycock et al. 2014: 15) was also deemed *namarda* by people in Maycock et al.'.s study site. One teacher they interviewed talked about a man in his village whom everyone considered to be a *namarda*. According to the teacher, although the man is good but because he does not have a child "[e]veryone makes fun of him and satirizes him. They try to dominate him" (Maycock et al. 2014: 15). Bijay, in Uprety's study, was also called *namarda* for his inability to assume the role of a breadwinner of his family.

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[48] This could be the effect of what Onta's study (1996) shows in terms of the Panchayat polity's reconstruction of Nepali history around the trope of bravery of the heroes who fought in the Anglo-Nepal war of 1814-1816 and dissemination of that history through carefully planned school textbooks.

[49] This term is also used for transgender persons and is a condescending way of emasculating/effeminizing a heterosexual man.

Hence, as these two examples demonstrate, breadwinner capability, ability to father a child, and masculinity are all intertwined with each other.

Additionally, the studies of Sharma (2018) and Maycock (2015, 2017a, 2017b) describe the link between migration and masculinity. In his studies of the young men's migration from western Nepal to India for work, Sharma has argued that although their low socioeconomic status might be a strong influencing factor for the young men to migrate, it may not be the sole reason for their migration (2018: 5). For many men from the low socio-economic strata, migration serves as a 'rite of passage' into their adulthood (Sharma 2018: 150). It also provides them freedom from the constraints of village life and gives them an opportunity to actualize their masculine identity as successful breadwinners who fulfill responsibility toward their family (Sharma 2018: 24). The mobility also brings them respect and ability to command others in their village.

However, Sharma points to an underlying paradox of such masculinity based on mobility: "men must migrate to provide for their family and experience a distant world, but to do so, they have to be away and thus unable to perform their duties as men" (2018: 151). Similarly, the mobility also comes at a cost; the very act of migration that brings about respect and provides a masculine identity to men is also equally emasculating and restrictive. Instead, the exploitation these men face at the hands of border officials in India only exposes their vulnerability. Likewise, as Sharma argues, "[g]iven that Nepali society still primarily defines a man's value in terms of his job (or, more specifically, permanent, full-time employment and stable income), the precarious and low-income nature of migrant work in Indian cities challenges men's sense of manly pride" (2018:151-152); this also does not necessarily help them attain upward social mobility (2018: 152).

Similarly**,** Maycock (2015, 2017**)** also found that Kamaiya men, who were former bonded labors in the far-west Nepal, also have reformulated their masculinity in recent times through migration and remittance they are able to send to their family. Like the young men in Sharma's study, Kamaiya men have been able to assert their masculinity through migration to India. Although the hegemonic ideal of the responsibility to become a breadwinner and provide for the family might be the motivating factor for the young Kamaiya men to migrate, Maycock argues that mobility "in and of itself [becomes] an important marker of

adult Kamaiya masculinities" (2017: 189) as it also creates newer opportunities for these men to assert and perform their masculinity (2017: 189).

Despite his claim that migration in and of itself is a marker of masculinity, Maycock shows that the success of the Kamaiya men in the context of his study lay, however, in the ability of these men to remit enough money back home to uplift their family's socioeconomic condition. This was measured by their ability to consistently "[…] remitting handsomely to [their] family or by consuming conspicuously, for example through clothing or possession of a mobile phone" (Maycock 2017: 187). Like in the Maycock et al.'s study (2014) among the young men from the eastern Nepal whose desirability for marriage increased with their stable income and earning ability, Maycock (2017: 188) found that the higher earning capability of a Kamaiya man also "had implications for marriage prospects". Maycock argues that the precarious nature of these migrant Kamaiya men's work and the exploitation they face at their work renders their masculinity subordinate in India while their ability to remit successfully might allow them to perform hegemonic masculinity at home; thereby, the space and context of such performances also determine how masculinity is constituted. Hence, while mobility adds value to the men's performance of masculinity, it is the need to perform the role of a breadwinner and a householder that motivates these men to migrate.

2.8 *Kamjori*: failure of a man to uphold the lineal masculinity

In this section, I will further discuss the ways men conceptualized their childlessness and its relation to the other concepts used above to understand masculinity. One term that all the men I met in the clinic used in my study to denote a lack, or inadequacy, of sperm was *kamjori*. "It is my *kamjori*," or "I have a little *kamjori*" is how they explained the low sperm count to me[50]. Scholars have found that *kamjori* is a common health related term found across South Asia and signifies different things for women and men. In the case of women, *kamjori* is used to define a cluster of symptoms such as "pain with

[50] No men I met in the clinic told me that they do not have any sperm at all but only told me that they have "some" or "little" problem in their sperm count. I would not know if the men who did not have any sperm at all also told me that they have low sperm count to save themselves from the shame and stigma.

menses, joint pain, dizziness, loss of appetite and chronic fatigue" (Graetz 2008: 3). It is generally seen as a ''weakness'' that manifests as "a series of bodily complaints including general pain, headache, dizziness and lack of energy" (Kostick et al. 2010: 532). In their study of poor urban women in Mumbai, India, Kostick et al. (2010) have found that women's illness condition of white discharge from vagina (called *safed pani*) was also considered to have been caused by weakness. Rashid also found a similar conception of white discharge among the urban poor adolescent married women in Bangladesh who linked the cause of their condition to weakness (2007: 108). Scholars have argued that these physical symptoms are indicators, and expressions, of social and psychological distresses and other inequalities that women face (Nichter 1981; Jejeebhoy and Koenig 2003; Patel and Ooman 1999). In India, according to Graetz, women with *kamjori* or fatigue are "often clinically diagnosed with anemia in the absence of laboratory results and treated with iron supplements" (2008: 3). Likewise, in their investigation of the cultural meaning of bleeding during pregnancy, delivery and postpartum period in rural Nepal, Matsuyama and Moji have found that *kamjori* in women also was attributed to the excessive bleeding after delivery (2008: 201). Moreover, *kamjori*, in this context, was a result of "a lack of rest or lack of nutritious food during pregnancy" (Matsuyama and Moji: 2008: 203).

However, *kamjori* manifests differently in the case of men. It is mostly conceptualized as sexual weakness that manifests in varieties of symptoms such as impotence, erectile dysfunction, and inadequate sperm quantity and quality (Verma et al. 2001; Khan et al. 2006). Moreover, even though impotency and childlessness, or infertility, are two different medical conditions, the use of a common term *kamjori* to conflate them also is a reason why men I met in the clinic felt stigmatized. I will elaborate on this aspect of *kamjori* in chapter 4 where I specifically discuss the way *kamjori* is enacted in an infertility clinic during the semen analysis process. Here, I want to stress on the broader social meaning of *kamjori* and discuss its relation to sexual weakness. In Nepali *kamjori* is a polysemic noun which, in colloquial usage, broadly means weakness, defect, and lack of strength. Weakness could be both physical, bodily weakness or a flaw

in one's character, for example, lacking courage[51]. Hence, in that sense weakness also denotes defect, failure, or inability at large. This is synonymous to what the term *namarda* discussed above also signifies. All these contrast with the normative ideals of masculinity, such as virility, bravery, and courage, described above. Thus, when a man has *kamjori* by way of the inadequate sperm quantity and quality, it also transpires to him being seen as a social failure, with a defective social (and physical) body that fails to perform biological fatherhood—one of the integral aspects of lineal masculinity in Nepal.

2.9 Conclusion

To sum up, this chapter was written as an attempt to comprehend the reason behind men's desire for children in Nepal. Biological fatherhood and family are two core components of normative adult masculinity in Nepal; thereby, childlessness becomes a great source of anxiety and panic among men. The primary reason behind the men's desire for children involved Hindu patrilineal ideas of inheritance of property (*ansha*) and continuation of their lineage (*vansha*); both of which are better understood by the term lineal masculinity. Lineal masculinity is maintained through purity of descent, which in the context of Hindu patriliny entails caste purity as well. The purity of descent was regulated by institutionalization and regulation of caste system by the Nepali polity in the 19th century. The contemporary discourse of masculinity in Nepal also revolves around the ideals of lineal masculinity. Men in my study conceptualized their inability to enact lineal masculinity by a term *kamjori*. When used in the context of sperm count, *kamjori* not only denotes the plain lack of sperm or inadequacy of sperm but, by way of that, it also signifies the overall lack of strength, weakness, and impotency of a man. It also broadly alludes to the failure of a man to be in command or control of his situation as well, all of which are the opposite of what normatively a "man should be." Thereby, childlessness for a man in Nepal is directly related to his masculine identity as it questions the very being of a man.

[51] *Nepali Brihat Sabdakosh* defines kamjori as "the state of lacking bodily strength," "slim-thin [body]" "the state of being deficient with wealth, intellect etc." (NPP 2067 (2010): 187, 690). My translation.

Chapter 3: Men and Childlessness in Nepal

3.1 Introduction

Even though there is a plethora of literature on various aspects of involuntary childlessness, men's experience of childlessness has been underrepresented in the social sciences. Alluding to de Beauvoir's famous work, scholars have argued that men are the 'second sex' in the study of reproduction and childlessness (Inhorn 2012; Culley, Hudson, and Lohan 2013). Most of the works on childlessness and infertility have been centered on women and their experience. This marginalization of men in the studies of reproduction could be due to the assumptions about the centrality of biological reproduction in women's lives, which thereby also gets compounded by the focus of biomedical interventions on women's bodies for reproductive failure. Since women's bodies are probed frequently in the infertility clinics, women are more often present in the clinics than the men who might only occasionally accompany their wives during the treatment; even the men who are available might not be willing to participate in the studies of childlessness (Culley, Hudson, and Lohan 2013: 226; Laborie 2000). Moreover, the prevalent ideals of masculinity that necessitate men to appear strong and in control of his life, the mandate to become the "emotional rock" (Thorsby and Gill 2004) for their wives, and their supportive roles—financial responsibility, breadwinner, and the like, might be some of the barriers that make the study of men's experience of reproductive failure and childlessness methodologically challenging.

Despite these challenges, the focus on men in the literature of reproduction and involuntary childlessness has now slowly gained traction (for e.g., Inhorn 1996, 2002, 2003, 2012; Halcomb 2018; Wischmann 2013; Wischmann and Thorn 2013; Schick et al. 2016). Greil et al. (2010) have observed two trends of research that exist on childlessness and infertility: a) the one that studies infertility as a medical condition and thereby focuses on the psychological distress caused by infertility on men and women. These studies use quantitative methodologies and largely ignore the sociological aspects of involuntary childlessness. They were mostly conducted with a goal to improve medical services, such as psychological counselling, provided by the clinics; b)

the second group of studies focuses on the social construction of infertility and employ qualitative methodology. These studies are focused on various cultural settings around the world and have yielded numerous insights into the consequences of childlessness, treatment options, and coping strategies (Greil 2010: 153-154).

Nevertheless, there is a dearth of information on the impact of childlessness on men in South Asia. This chapter is an effort to fill the gap in the existing literature of childlessness in South Asian men. In this chapter, I will explore the ways men experience involuntary childlessness in Nepal. I found that the normative patriarchal gender roles and ideals of masculinity guide the experience of childlessness among men. Failing to actualize biological fatherhood, which is an integral aspect of adult masculinity in Nepal, makes a man fail in many other domains of his life as well. For example, childlessness makes men vulnerable to social ridicule, exposes them to social scrutiny, strains their breadwinner capability, and adds extra pressure to perform masculinity. Moreover, the failure to uphold the patriarchal normative ideal of a man as a breadwinner who has control and command over his and his wife's (sexual) life marks a man as the one with *kamjori*, or weakness, an attribute that is emasculating experience for a man.

3.2 Difficulty in finding childless men to share their experience

Since childlessness is a sensitive and personal topic for men in Nepal, when I started my research in 2016, I feared that I would have difficulty finding men, who were struggling with involuntary childlessness, to share their experience of childlessness with me. Until that point, I did not know of anyone in my family or immediate relatives in Nepal who had struggled with childlessness. But while in the field, it was a surprise to me how ubiquitous the problem was. More than that, I was really taken aback by how visible childless couples were, i.e., anyone I talked to about the topic of my project would tell me about at least one childless couple they knew personally or have heard about. However, trying to meet these men was a different story. Many times, the people who would tell me about the couples would shy away from introducing me to the men for the obvious reason that talking about it with the men, especially when those men were relatives or neighbors, might create an awkward social situation. Therefore,

I chose to start my research in an infertility clinic in Kathmandu first. There, in the span of 4 months, I was able to meet and talk to over 200 men and women who were struggling with childlessness. Even in the clinic, it was not very easy to approach the men as they almost always remained quietly seated, either talking only to their wives or reading the newspapers and browsing their cell phones. In addition to that, at any given time, there were less men than women in the clinic, which I will discuss below.

Interestingly, hardly any of these men and women whom I met in the clinic and built-up good rapport wanted to meet me outside the setting of the clinic. They would politely dodge my request to meet them somewhere in town over a cup of tea by citing various reasons; the most common reason being that they were busy at work. Saroj Khanal was one such case. I had met him at the infertility clinic in Kathmandu where he had come for the treatment with his wife. He was from Tandi, a town 12 kilometers away from my hometown Narayangadh in Chitwan district. Over the two days that I met him in the clinic, I was able to build a good rapport with him. He invited me to visit him in Tandi whenever I would be in Narayangadh. A few months later I went to visit my parents in Narayangadh. Recalling what Saroj had told me in the clinic, I called him. It was 4 pm. When I told him that I was in Narayangadh, he said,

> *"I'd love to come to Narayangadh and meet you over a cup of tea if it were not late."*

I had a scooter with me at the time, so I told him I did not mind driving to Tandi to meet him. We could go to some restaurant for a cup of tea, I suggested. Then he sounded a bit hesitant and told me,

> *"Well, I'd love to see you, but I have some work I need to tend to, how about we see each other in the clinic next time I come to Kathmandu?"*

Although I was taken aback by how quickly Saroj changed his stance, I did not insist further and hung up the phone after making the arrangement to see him during his next visit to the clinic in Kathmandu. It could have been that he did not want to see me in his hometown where if anyone spotted him with me, a stranger, he could be scrutinized. However, when he neither proposed any alternative place to meet nor accepted my proposal to meet in Narayangadh some other day, and instead said we would meet in the clinic during his next visit, I took that as his

reluctance to meet me and discuss his experience anywhere else outside of the clinic space. I did not see him after that.

Nevertheless, unlike Saroj who clearly wanted to avoid meeting me on the pretext of work, I managed to meet Sunil Sharma, a 39-year-old man from Kapilvastu, a town 330 km west of Kathmandu with a travel time of 9 hours, out of the clinic. I had first met Sunil at the infertility clinic in November 2016. During the first introduction, he told me that he owns a fish feed industry in Kapilvastu that he had started two years ago. He also told me that he had to come to Kathmandu frequently for his business:

> *"I will meet you whenever I am in Kathmandu next time. I want to discuss about your research findings and my own experience* [of childlessness]*."*

Having heard similar responses from many men already until then, I was not hoping that Sunil would keep his word; so it was a pleasant surprise when he called me on my phone one day in February 2017 and expressed his desire to meet me. That afternoon, we met in Thamel, a popular tourist enclave of Kathmandu and walked around to find a restaurant where we could sit and talk over a cup of tea. Being new to the area, Sushil asked me to recommend a restaurant. I took him to Himalayan Java, a popular coffee shop and meeting place in the area. However, when we took a table at the corner of the coffee shop, it was clear to me that Sunil was not happy with my choice as the place was crowded and he seemed to need some private space for just two of us. I could sense his discomfort as he was hesitant to talk freely and was self-conscious while he spoke. I suggested that we find another place, to which he happily agreed. We left Himalayan Java and strolled on the road while searching for a coffee shop with less crowd. We made a small talk to fill up the awkward silences in the conversation. This was the second time I was meeting him, so there was unease between the two of us. Throughout the walk, which lasted for about ten minutes, our talk became a bit punctuated, and I was wondering if it was a good idea to have met him outside the setting of the clinic. After hopping in and out of two more restaurants, we finally settled on New Orleans Café nearby where we found a secluded corner and nobody would interrupt us.

Men like Sunil, who willingly approached me to share about their experiences of childlessness outside the clinic setting, are more of an exception

than the norm. But unlike Sunil, most of the men who traveled to Kathmandu for the treatment could not meet me outside the clinic because they were in Kathmandu only for the treatment; so, they were always in a rush to return home after they were done with the treatment. At least, that was what they told me when I approached them to schedule a meeting outside the clinic. This could also be their strategy to politely decline my request.

At various times, some other men also agreed reluctantly to my request for a meeting outside the clinic but only one among them, 31-year-old Prem Rijal from Kathmandu, of whom I will discuss more below, met me after four months of frequently postponing the meeting. While meeting him, I could sense that he had only come to meet me because he felt embarrassed for pushing me away for so long and therefore wanted to get it over with and move on. When I called him, he was really embarrassed for having previously canceled so many requests for a meeting; so, he consented right away to meet me at 8 am the next day, a Saturday, in a teashop near the infertility clinic. Ashe lives near the clinic, he came quickly after I reached there at 8 am the next day. Since he came from his home, he was wearing a casual t-shirt and jeans, which made him look much younger than when I'd seen him in the clinic in October 2016. At that time, he had come to the clinic from his work.

We entered a small teashop across the clinic and ordered two cups of tea. Except for the shop owners, there was nobody in the teashop; they were busy with their own work and did not bother us very much so we could talk as freely as we pleased. After about fifteen minutes, a man came in and took the table beside ours. I noticed that affected Prem a bit as he continued to look at the man while he was sharing his stories with me. I did not see any serious hesitation on his face while he spoke then, but he was cautious, and conscious too, of what he was saying. He often lowered his voice when he spoke after that.

Prem was not the only man who hesitated to speak to me in public about his condition. Surprisingly, some men like Bijay who had already successfully fathered children through clinical treatment also hesitated to speak to me about their experience of childlessness. I met Bijay in my hometown Narayangadh through a friend. Bijay was an accountant in a hospital in Narayangadh and agreed to meet me at his office one early morning in 2018. He called me at 8:30 am to his office so that he would have time to talk to me before his colleagues

arrived around an hour later. He was already in his office when I reached there. After a brief introduction, I explained my research to him and my plan to hear about his experience of childlessness. Although he was affable, he gave brief replies to my questions and did not seem to entertain questions regarding the personal details of his treatment. He only told me,

> *"I struggled with childlessness for a few years. I visited a hospital in Kathmandu for the IVF treatment in Kathmandu."*

While we were talking, a cleaning staff arrived at the hallway. He walked in and greeted Bijay while proceeding to clean Bijay's office room. The cleaning staff went in and out of the room a few times. I noticed that Bijay would stop speaking while the cleaning staff was in the room and would resume only after the latter left. He was visibly uncomfortable to talk and lowered his voice as he spoke even when the cleaning staff was not present in the vicinity of the room. Bijay concluded the meeting in a short while and did not seem to be interested in any subsequent follow up meetings.

I later found that Bijay was not the only man who hesitates to openly discuss about their experience of childlessness in detail. Chandra Bhattarai, a man in his 40s, from my hometown is a good friend of my maternal uncle. He owns a shop nearby my uncle's shop and visits my uncle's shop frequently for business and informal personal talks. He knows my family very well too. I have spoken to him many times at my uncle's shop and whenever I met him elsewhere in town. My uncle, and few other people with whom I discussed about my research topic to find out if they knew any involuntarily childless men in town, told me about Chandra's long struggle with childlessness. They also told me that Chandra had finally succeeded to father twin girls through the "test-tube baby"[52] treatment. Although none of them were certain about the exact medical treatment Chandra had taken, everyone speculated that it must be "test-tube baby" because they had heard that twins are born after the test tube baby treatment. I found that such hearsay and rumors about the childless men and women are very common. However, when I asked my uncle if he could connect me with Chandra so that I

[52] This is a common word, spoken in English, for the In-vitro fertilization (IVF) treatment.

could talk to him about his experience of childlessness, my uncle told me that although he was very close to Chandra and they discussed many matters of their personal lives openly, Chandra had not spoken to him about his struggle with childlessness and had not disclosed to him about the medical treatments he had undergone. Therefore, my uncle hesitated to bring that up with Chandra lest it might make him feel uncomfortable. I did not insist further and hence I never spoke to Chandra about his experience of childlessness.

These two cases, along with a few other similar encounters I had during my field research, provide a glimpse of the perception of the assisted reproductive technologies, treatment of childlessness in general, and their effects on men. In the case of Bijay, as I reflected while returning home after meeting him, I thought it was not unusual that he hesitated to speak while his staff was around. It was his office space and therefore he might not have been comfortable. However, when he was reluctant to give me time for the subsequent meetings, I realized it must not just be the office setting that caused him to be cautious in our first meeting. Nonetheless, I was also surprised that Bijay was reluctant to share his experience of the period of his life that was already over, which he had even already successfully overcome by begetting a child. He probably did not want to discuss about his experience of childlessness, especially when it involved treatments like IVF as I found that there is a common (mis)conception among people that treatments like IVF and IUI entail making children by using donor sperm. For instance, in the clinic in Kathmandu, I met 32 -year-old Keshav from Urlabari (in Morang district), who expressed a similar threat of being stigmatized if he disclosed to his villagers that he had pursued medical treatment for his childlessness.

"Kathmandu is systematic[53]"

he said, and continued,

"It is not like that in the village. If people find out that we have done test-tube[54], people in the village spread rumor

[53] His word

[54] I found that despite receiving a long explanation of treatment procedures from the doctors during the first clinical consultation, many patients in the clinic did not fully understand what exact treatment they were being offered and hence they interchangeably used words like IUI and test tube (for IVF).

that someone else's sperm was used. Even the wives tell the same thing to others because they do not fully understand what test tube is."

Hence, childless men were potentially threatened of stigma while pursuing treatments; one of the ways they deflected such potential threats was by keeping their treatment a secret from their family and friends. Even if Bijay had used his own sperm for the IVF treatment due to such negative perceptions of IVF among people, he would be stigmatized if others found that he had fathered a child through IVF treatment. The same is true for Chandra as well.

Another reason why men like Bijay and Chandra might not have disclosed to others about the use of assisted reproductive technology is to do with the normative patriarchal gender ideals prevalent in Nepal. Since the ability to father a child is a taken for granted attribute of a man, not being able to father a child on his own and thereby having to take recourse to assisted reproductive technologies is an emasculating experience for men. This is still true despite the increasing medicalization of reproduction and normalization of medical treatments and rising use of assisted reproductive technologies to treat childlessness. The use of assisted reproductive technologies by men reveals their inability to impregnate their wives and father a child without any medical assistance; hence, this marks these men as the ones who have a *kamjori*, or defect, which is a matter of shame for them. Therefore, the men's hesitation to meet me and openly discuss about their condition was also their strategy of avoiding the risk of being exposed and labeled as the ones with *kamjori*; by doing so, they were also protecting themselves from emasculation.

3.3 Normative timeline of marriage and family creation in Nepali society, social scrutiny, and childless men

In a social setting in Nepal, it is not uncommon to get unsolicited advice by strangers and kin alike on the need to marry and produce children by a certain age. I was 34 years old, and unmarried, when I started my field research in 2016. Although the norms have changed quite a lot in recent years in Nepal regarding the age of marriage and its social reception, remaining unmarried and not having a family until 34 years, even for a man, becomes a matter for people to raise their

eyebrows. People see this as a failure on the part of the parents as well. Even though there is a variation in the age of marriage, I found that generally an urban adult man in Nepal gets married between the ages of 25 to 30 whereas that age for women is generally around 24-26. The legal minimum age for marriage for both men and women is 20. However, child marriage is rampant as a report from the 2016 shows that "thirty-seven percent of girls in Nepal marry before age 18 and 10 percent are married by age 15" (HRW 2016: 3). Thus, this issue of age becomes a prominent point of discussion in social interactions between people, especially if one is in the age group that is considered marriageable.

Likewise, it was also taken for granted by everyone I met during my research that a person marries in order to reproduce and create a family; hence marriage and desire for children are taken as an obvious life trajectory of adulthood. Therefore, it is quite common for anyone who delays getting married to hear comments like, *"when are you going to marry and have kids?"*; *"if you don't have child on time, later you will look like a grandfather in front of your child"*; *"if you don't have a child early, you'll end up rearing them at your old age when you don't have energy to do so"*; *"who will look after you at your old age if your children are still young?*" I noticed that most of the men have internalized this normative prescription of the temporal order of life and hence are under tremendous pressure if their life does not follow a set pattern. Men who are struggling with childlessness are directly affected by this pressure to follow a normative trajectory of adulthood.

I was talking about the current trend of migration of Nepali men to the Gulf countries with a group of men in the waiting area of the clinic one day. Padam, a man in his early 30s and himself a returnee from Qatar, said that men like him are compelled to go abroad for work because of the scarcity of job opportunities in Nepal. In due process some start a family later than others in his opinion. Therefore, he argued,

> *"A man should only go abroad to work after he marries and makes a child."*

He further argued that a man should get married at 28-29. It will be late after 30.

> *"If we get married at 30, and want to keep a gap of two to four years [to have a child], we'll already be 34,"*

and further opined that by the time a man has a son, he will already be old. He thinks that by the time a man is fifty his children should already be able to earn for themselves.

> *"What is the use of marrying late? When will you have a son* [you'll be too old to have a child if you marry late]*? When will you raise him? When will you enjoy his earning?*[55]*"*

he asked.

In Padam's opinion, one marries to make children.

> *"Either one should have a business and a thriving career for him to postpone making babies for one or two years. Otherwise, if one is going abroad, he should get married and make a baby right away."*

He also regretted not following his own advice. He blamed himself for not planning for a family on time, which is why he claimed that he was "suffering" due to childlessness.

> *"We say we've to do something first,* [i.e., make a career, earn enough money] *and that ruins everything*[56]*. Time doesn't wait for anyone. We don't care about time and we end up like this. Everything should be done in the right time,"*

he argued. After marriage, he postponed planning for a child because he wanted to earn enough money first. Besides, he also did not anticipate that he would have difficulty in fathering a child:

> *"I said making a baby is not a big deal but now this is what happened."*

As everyone else, he also took it for granted that he would be fit to reproduce at his will. Padam has three brothers and a sister. Two of his brothers and the sister have children and the youngest brother was getting married soon. Thus, together with the traditional beliefs about a man and the right age for marriage and having

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[55] *Kahile chhora paaune? Kahile hurkaune? Kahile tyasko kamaai khane?*
[56] *Kehi garaunla bhaninchha ani tyasle bigaarchha*.

children, being the only sibling without a child also perhaps adds that extra pressure on Padam.

Likewise, I met Kamal Lamichhane from Syangja, a town about 270 km west of Kathmandu with a travel time of 8 hours. Kamal has two younger brothers. The second brother has a daughter and the youngest one has a son and a daughter. When I asked him if that affects him, he said:

> *"Obviously, when I play with my nieces and nephew, I wonder what it would be like to play with my own child."*

Kamal also feels like he has fallen behind[57] as all his friends' and siblings' kids have grown up and are attending schools already. I sensed similar pressures felt by many other men who did not achieve certain life goals within certain timeframe. Childlessness thwarts their sense of linear progress in life.

With such normative prescription of age and reproduction at place, one can imagine the agony faced by the childless couples when they are constantly reminded, and pestered (both overtly and tacitly), through various means about their childlessness. I met many couples in the infertility clinic I visited in Kathmandu for whom such reminder and pestering was an everyday reality. In the waiting room, there would be a group of patients waiting for their turn to see the doctor. At such times, they would share their tribulations among themselves; most of them had a common story to share and such sharing itself acted as a soothing balm in their otherwise lonely pursuit of medical treatment. Many found the waiting room to be a comforting space where they were reminded that they were not alone in their quest and that there are many others like them who are also suffering the same plight. This sense of community they felt in the waiting room made them open up to the others easily, which otherwise they would not do in their own home and social spaces.

3.4 Suffering of childlessness due to the financial burden of the treatments and uncertainty

A prominent gynecologist and IVF expert in Nepal, Dr. Bhola Rijal, was quoted in the Nepali media saying, "he agony of infertile couples is more severe than that of those with HIV/AIDS, cancer or uterine prolapse" (Sunuwar 2011)

[57] *pachhi pare jasto*

and “Fertility is more of a social priority than an individual’s need” (Maharjan 2012). This remark hints toward the underlying social stigma attached to the childlessness and reflects the pressure to bear children that involuntarily childless couples face in Nepal. Dr. Rijal’s remarks have some truth to them as I also observed that childless men and women suffered tremendously due to childlessness. The men who were struggling with involuntary childlessness in my study were dealing with a lot of anxiety, resulting mostly from: a) the financial pressure they were facing due to the compounding treatment costs, and b) the uncertainty involved in the entire process of their treatment, which aggravated the former. Most of these men were spending on the treatment costs from their own savings; even the ones whose work provided some health insurance, the high treatment costs meant they would not be able to sustain their treatment.

Among the few medical treatment options available to treat childlessness, intra-uterine insemination (IUI) was routinely performed in the clinic where I conducted my study. Since the success rate of the assisted reproductive technologies like IUI is about 40%[58], it is highly likely that the women will have to undergo IUI procedure multiple times before they can conceive; and even that is not a guarantee. I met many women who had been through the IUI procedure at least 6 times. Since this procedure is performed once every month when women ovulate, those women had been to the clinic for half a year at least. Prior to insemination, these women are injected with hormones and given medicines to regulate the size of their egg. Depending on the size of the egg and the day of ovulation, the IUI is usually performed (i.e., the uterus is inseminated) for two to three consecutive days in order to increase the chances of conception. Once the IUI is completed for that cycle, the woman has to wait until her regular menstruation time, usually around two weeks after the IUI is performed, to find out if the IUI was successful. If she menstruates—the indication of the failure of conception—the couple returns to the clinic to initiate another round of IUI treatment. This entails not only loss of time, but also compounding financial loss for the couples; this loss becomes a source of great anxiety for childless couples.

As the treatment requires women to visit the clinic frequently, I found that many women who worked had given up their career in order to pursue treatment.

[58] https://attainfertility.com/understanding-fertility/ivf-101/ivf-success-factors/

The loss of a source of household income meant that their husbands alone had to bear the cost of the treatment in addition to managing the regular household spending, which added considerable pressure on the husbands. In the households where women did not earn money or have a career, their husbands resumed the role of a breadwinner for the family and had to bear the burden of the treatment cost as well.

Ram Poudel from Parbat, a hilly district 262 km west of Kathmandu, was one among many men who expressed his frustration that childlessness had brought him. He has a Master's degree in Political Science and is a lawyer, priest, and an astrologer. When I met him, he had been visiting the infertility clinic for a few months. His wife had undergone four unsuccessful IUIs so far.

> *"One spends all his earnings in the treatment yet there is no guarantee that it will succeed,"*

he said, and expressed his despair:

> *"Even the doctors can't tell what exactly is the right way to fix the problem."*

He further argued,

> *"One gets totally frustrated when even after four or five years of spending all his earnings in the treatment, the results are negative."*

Additionally, he explained that for a government worker like him who barely gets four or five days off in a year from work, it is impossible to sustain t work and treatment simultaneously. Therefore, in his opinion,

> *"Many of the childless men are in the verge of giving up the idea of having a child at all, but cannot completely give up because one cannot not have a child. He needs someone to maintain his* vansha*."*

Ram had already spent four hundred thousand Rupees and, with such looming uncertainty of the IUI's success, he was mulling over whether to continue with the treatment. It is too costly for him to repeatedly come to Kathmandu from Parbat and stay in a hotel for the duration of the treatment. He was skeptical about the medical technology that could not give him any concrete result.

> *"They tell two eggs have formed and perform IUE (sic), we spend thirty to thirty-five thousand rupees, the* [women's] *period starts and all that money is lost. If we'd put all those packets of medicines in a* bhakari[59]*, it would fill up that* bhakari*. How long should one take the medicine? If this continues, all our remaining property will also deplete,"*

He further expressed his displeasure with the uncertainty involved in the treatment:

> *"this is a treatment that one cannot trust at all. They tell you that the second IUI will surely succeed when the first one fails; then they say the third attempt will surely succeed and the like hehe."*

Ironically, he had abandoned the treatment at another renowned doctor's hospital and come to this clinic after he got tired of getting the same explanation there. For Ram, infertility

> *"is not a 'disease' but desperation drives people to pursue treatments in the infertility clinics."*

He furthered claimed:

> *"These childless men feel a deep necessity or a burning compulsion to have a child by any means possible. Thus, everyone who has come to the infertility clinic is suffering immensely."*

One interesting insight Ram provided was that infertility is such a condition that the childless couples do not garner any sympathy from others like a person suffering from cancer would:

> *"There is nowhere childless couples can go to for financial assistance. People donate money for the cancer patients*

[59] A traditional container made of the bamboo splits used for the indoor storage of paddy. https://unfccc.int/files/adaptation/application/pdf/fao_indig_nepal.pdf. Although it varies in size, most of them are big enough to store about a ton of paddy. Ram wanted to point out at the enormity of monetary expenditure when he used this word.

> *but who lends us money* [for the treatment] *if we say we don't have a child?"*

he asked.

> *"Nor can we even tell anyone that we are undergoing treatment for infertility,"*

added his wife from the side who was silently listening to Ram until that time.

Ram believes the situation of a childless couple is worse than that of a beggar. He lamented that

> *"people say he is a priest and does not have extravagant spending,* [i.e. he does not eat out, spend on meat and drinking alcohol etc.] *but if someone comes to borrow money from me, I have nothing to give. I feel that they might suspect I have saved all my money in the bank. But contrary to that, I have borrowed money from all the cooperatives*[60] *in his town."*

If he decides to continue the treatment, he might eventually have to take out savings from his *sanchayakosh*[61] as well. He has encountered people who have had to sell their land to pursue this treatment and shared an interesting incident:

> *"I met a person in Om* [Hospital] *who had to sell two pieces of* ghaderi[62] *to pursue the treatment; he has a son and now he summons his son jokingly by saying, 'hey* ghaderi*.'"*

This is an interesting anecdote that directly ties up the link between the desire for children, property, and lineal masculinity that I have mentioned in chapter 2. Thus, masculinity, children, property, and lineage are all interrelated in a sense that across cultures children serve as a proof of a man's virility and masculinity; whereas, fatherhood, a defining feature of a man in Hindu patriarchy, is "[…] defined in terms of ownership of children," (Pujari and Unisa 2014: 22). Thus, failing to father a child, for a man, means that he has failed to

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[60] Small scale banking system
[61] Retirement fund of the government and non-government employees http://nepalhomepage.com/karmachari-sanchaya-kosh/
[62] Land suitable for housing https://www.fig.net/resources/proceedings/2015/2015_11_nepal/T.S.6.5.pdf

produce "a commodity" that will continue his name and lineage (Pujari and Unisa 2014: 22). In the anecdote above, the child and property have been conflated whereby *ghaderi*, or the land, metonymically stands for the child itself. Both are owned by the man and thus are commodities that are used to serve the purpose of upholding his masculinity. Seen in this light, one can argue that the anecdote above demonstrates a paradox: the primary reason for the men's desire for children is inheritance of property; however, the childless men lose a big portion of their property during the treatment, leaving them with little to no property to pass on to their children. Thereby, a man's desire for children cannot be understood only in terms of rationally explainable facts but is tied to various social facts and entanglements such as expectations and pressure from family, friends, as well as cultural and religious ideologies, which, as Hadley and Hanley argue, may all "[…] be seen as latent forms and methods of reinforcing and maintaining patriarchal hegemonic masculinities" (2011: 64).

3.5 Vulnerability of childless men and their coping strategy

In addition to the distress caused by financial pressure and the uncertainty of the treatment outcome, the childless men were also constantly haunted by a potential threat of being shamed and emasculated by others for their condition. This was illustrated by Prem Rijal, of whom I will discuss below, with a pithy comment he made about childlessness:

> *"This is such a condition that you could have a very good career and a successful professional and social life, own a house, land, and car, another man says 'even though I might not have all those material possessions that you have, I have a child while you don't.' He wins, and I lose!!"*

In Prem's view, masculinity is a competition whereby each man is in a race with other men to reach the life-goals soon and prove himself to others; as discussed in the previous chapter, creating a family and fathering a child is one of the major life-goals of a Hindu man. Childlessness, therefore, renders men vulnerable to abuse by other men (and women); and thus it puts pressure on childless men to prove their masculinity. Therefore, this vulnerability and

desperation to have a child is a driving factor that takes men to myriads of healing options available to them, despite whether they personally approve of such therapies or not[63].

For instance, 28-year -old Ramesh BK from Waling in Syangja district, who was married for 10 years but was childless at the time of my research, confessed that his male friends teased him by asking if he even had a penis. They even questioned if he was a *marda*.

> *"I know they are saying it jokingly, so I don't pay any heed to such sarcasms, but it pinches at times,"*

Ramesh had also concealed from his parents that he was pursuing treatments in Kathmandu because he did not want them to worry.

> *"Whenever my parents call me, I tell them I am in my shop even if I am in Kathmandu for treatment. I live in the market center of Waling with my wife. My parents live in a village that lies at quite some distance from the market center. People in the village have a lot of free time to gossip about others. Therefore, these things spread like a wildfire there. That's why I don't want to tell even my parents about the treatments I am pursuing. I will them after I complete the treatment and have a child,"*

Living away in town and separately from parents also strategically protected them from over-scrutiny of their family and neighbors. Likewise, keeping his treatment a secret would also mean he would not face unnecessary probing from them and potentially his villagers who could find out about the couple's condition through his parents. They could also nag him to remarry if they found out. He, however, plans to reveal to his parents about the treatment once treatment succeeds and he has a child.

Like Ramesh, the childless men had different ways to cope with their anxiety but all of them strategically hid their pain and anxiety because, they told me, as a man they should defer their anxiety and be strong to support and take care of their wives' emotional pain. 35-year -old Nabin Lama's case is one of many men that I met. Nabin was married for 7 years when I met him in the

[63] I present this at length in Chapter 4

infertility clinic in Kathmandu. I met him two times in the clinic and talked a few more times over the phone as well. He comes from Kavrepalanchowk district but lives with his wife in Kathmandu. He and his wife are both musicians and periodically travel abroad to perform in musical programs as well. He has 2 brothers and a sister, all of whom are older than him. His eldest brother has a daughter and a son, the second brother has two daughters and the sister has a son and a daughter. At the time I met him in 2017, he had been in a pursuit of a child for 5 years.

When I asked if he felt pressure because of his siblings, he told me

> *"Everyone in my family is educated and therefore do not put any pressure on me or my wife. They instead support me in whatever way they can."*

Despite the support he gets from the family, Nabin once claimed,

> *"I'm representative of all men who are suffering and have immense pain* [due to childlessness]*."*

According to him, this pain is a result of the intense desire to have something that one doesn't have—in this case, a child:

> *"You feel the importance of that* [children] *when you do not have it; so the feeling that you are lacking something intensifies the desire even more. Maybe because of that, we become so desperate that we are willing to try anything and everything to have it. I am usually socially engaged and busy at work but I feel the same level of desperation when I am alone."*

He confessed that this desire for children is generated by the social pressure, and the child is a means to continue one's *vansha*. This pressure also resulted in the childless men trying any treatment measures despite whether they trusted the treatment or not. This made the childless men vulnerable not only to social gaze and ridicule but also to emotional exploitation by various healers as well. Nabin shared his own experience regarding this. He and his wife have been to a *jyotishi* (astrologer), and a *dhami* (shaman) in his village in Kavrepalanchowk.

> *"I usually don't trust such healers; these days science has already proved that body is made of chemical processes*

and childlessness is also a result of the imbalance in the chemicals, which can be treated with (bio)medicine."

He, nevertheless, decided to visit *jyotishi* and *dhami* when he was not able to father children after a few years of trying.

"Maybe we can call it my hubris that I did not believe in supernatural powers or god when I was young. But when crisis befalls on a person, any kind of hubris gets destroyed and the person is bound to take recourse to such powers. I do not fully believe in these options but it is hope and desperation that makes me try such measures,"

Nabin also posited that some healers take advantage of the desperation of the childless couples and exploit them emotionally to sell their treatments. He narrated an instance when he fell prey to a healer:

"Once we visited an astrologer. While waiting for a bus on our way back, we saw a woman nearby who was selling some buti ["talisman like objects"]. *My wife approached the woman and inquired about those* buti*. The woman claimed to be a healer, so my wife told the woman that we were returning from a visit to an astrologer. She also told the women about the purpose of our visit. The woman immediately held my wife's hands and told her that the* buti *will cure our childlessness if we both wear the* buti *around our neck. I was hundred percent sure that the woman was saying that purely with an intention to sell her product. But at that time what she said struck so deeply that I started thinking what if she is right. The* buti *looked like it does not even cost 200 rupees but she asked for 2600 rupees, which I did not hesitate to pay. I knew she was taking advantage of my situation but I was only buying it with a hope it works and a wish that her words may come true."*

He and his wife wore that *buti* for about a month and took it off as it did not seem to give them any concrete results.

Nabin further argued that husbands are suffering more than wives due to childlessness but that is not spoken about because, in his words**,**

> *"Men are the pillars of support for their wives and bear the pains of their wives by empathizing with them while dealing with their own suffering by themselves. My wife also suffers from the feelings of isolation and anger due to childlessness; therefore, I take on the supportive role to soothe her pain by consoling her. As a man, we must be strong and hide our pain in order to support our wives."*

In addition to the emotional support they have to provide, Nabin argued,

> *"Men feel the extra pressure to manage financial needs that accrues from the treatments as they are the ones who pay the medical bills. Therefore, if the doctors were a bit kind to us and accommodate our needs in their treatment, it would be a great relief to us."*

This remark resonates with many men who felt alienated in the clinic as they did not feel that their needs and pressure felt by them was not considered by the doctors who, in these men's opinion, only aggressively pushed them to comply with the expensive treatment procedures.

Sunil also was one of those men who was frustrated by the treatment in the clinic. In his opinion, more than being a *"physical issue",* childlessness is a *"psychological issue".* He further clarified that he does not doubt the treatment at the infertility clinic.

> *"It has worked for many,"*

he said, and continued,

> *"but the treatment fails, and is incomplete, because the doctors there fail to address the pressure* (financial, societal, work etc.) *and distress felt by men. They need to also incorporate such psychological aspect in their treatment instead of just giving us and our wives pills."*

This, however, is found in the holistic therapy like naturopathy, he argued.

> *The naturopathy doctor I know in Kathmandu enquires about my* ahar*,* bihar*, and* bichar ["diet, lifestyle, and mental well-being"] to *diagnose and manage treatment accordingly.*

He then gave an example:

> *"Such therapies explain that issues like sitting posture also might cause problems such as gastritis and hence that might affect the mental balance."*

He believes that the biomedical treatment lacks such holistic treatment logic. Although the doctors in the infertility clinic started their consultation with an elaborate counselling session, which I will describe in chapter 4, to explain the treatment procedures to their patients, such counselling and description is heavily focused on treatment of the women's body and hence men expressed to me that they felt left out during the treatment.

For many men, work and social engagement became a way through which they could forget their pain and anxiety. 38-year-old Girish Poudel was one of those men who opined that his work keeps him so busy that he does not have time to sulk in his pain of childlessness. I first met Girish in an infertility clinic in Bharatpur, near Narayangadh, and later visited him in his shop. I found out that he had also pursued treatment at Dr. Sweta's infertility clinic in Kathmandu for a few months before the road condition deteriorated due to the onset of monsoon. He has a mattress shop in Narayangadh. His two brothers also help him in the business. The second brother is married and has two daughters. He pointed out that even during the time he was talking to me, he had to take his time off from his work. Instead, it is the wives who feel the urgency to have children he argued; according to him,

> *"Usually they do not work and stay home; they are free, which gives them time to ruminate over their condition. Besides, in their free time they meet other women who ask them about children."*

Girish was not alone in having such sexist and stereotypical views of women.

Similarly, Keshav had also given me a similar answer when I asked him about his way of coping. He has five brothers and 2 sisters. His 2 brothers have 5 children in total. Hence, he must be facing a lot of pressure himself Perhaps it is the reason he does not hesitate to travel 11-12 hours in bus to get to Kathmandu for the treatment. Although he agreed that he sometimes feels that pressure, he said even though the husbands might face similar torture than their wives, they conceal it.

"Men do not bring up the issue of their childlessness when they meet people in public,"

said he.

"But women bring up those issues quickly,"

he argued, because, for him

"since women do not have anything much to talk about, they focus on marriage and who has how many children."

According to him, the most common question women ask other women is how many children they have and if the other women don't have any children, they do not hesitate to ask them why they haven't been able to conceive.

"We mostly talk about business issues when we meet other men,"

Ram also held similar stereotypical view of women when it came to explaining his experience of childlessness. He argued that,

"Women face more scrutiny about their condition because they stay home and talk to other women in the neighborhood whereas men go to work and therefore in public setting they can deflect the focus of others onto topics of their work and avoid talking about childlessness. It is the women who pester other women about childlessness.

Nevertheless, Ram's case points that childless men are also not spared when it came to social scrutiny. He revealed that he had faced some level of scrutiny from other men in his hometown. One day his 80-year-old landlord, himself a childless man even after four marriages, approached him and said,

"You're not a man. You don't have a child yet, so now you should marry again."

Ram didn't pay any heed to the old man but his wife felt hurt when she found out. The old man even went to her and asked her to allow her husband to remarry. She reprimanded him and chased him away. Ram said,

"More than us who's worried about our condition, it's the others who are more concerned about us,"

Otherwise, he is not worried too much. He is trying his best to do what he can to resolve the situation:

"we are visiting the doctors and it is also up to the god to give us child when it is the right time for us to have one."

But it annoys him that the others do not stop pestering him and leave him in peace. His friends and family, luckily, are supportive and are even willing to lend him money for the treatment.

Likewise, sometimes even the ones who empathized with the suffering of childless men conflated suffering caused by other unrelated life events, such as domestic gender violence, with childlessness. Ram told me about one woman who gets beaten and abused by her husband came to him and said,

"I've been suffering a lot due to abuse from my husband; you have also become like me because of your childlessness. Ours is a similar suffering[64]".

He laughed and said,

*"How could she compare her situation with ours? Others perceive us as being in pain constantly (sufferers/*dukhi*) but one thing I want to make clear is that we don't always carry its burden and sulk all the time."*

Ram provided an important insight into how childlessness affects men. They try to overcome their condition by pursuing treatments and might get frustrated because of the uncertainty and heavy financial burden they face; however, childlessness does not totally consume their lives as they have found ways to carry on with their lives.

Nonetheless, even those men who told me they had different ways to defer their pain could not remain unaffected and sometimes lashed out their own frustration at their wives when fight broke between them. This was the case with Prem as well. Prem was married for 5 years and had been visiting the infertility clinic since October 2016. His wife was diagnosed with PCOS (polycystic ovarian syndrome), while he was not required to undergo any treatment procedures except for occasionally giving his sperm for the IUI. In the time, his wife has undergone IUI four times without any success. He plans to go to Delhi with his wife for the treatment if the treatment in the clinic continues to fail.

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[64] *Babu maile ta dukkha paayen paayen, tapaiko ni baccha nabhayera ta ma jastai hunu bhayechha*

Although he trusts the treatment his wife is receiving at Dr. Sweta's clinic, he is dissatisfied with how little the doctors share information about, and make patients understand, the procedures of treatments. He feels he is only going to the clinic as part of a routine check-up and most of the time does not even know what (and why) his wife is being treated for in a particular visit. However, like other patients who come to the clinic, Prem also cherishes the network and relationships that builds up among the patients in the waiting room of the clinic during the multiple visits.

Prem has two sisters—one elder who lives in Canada and another younger who is also married and has a daughter; he is the only son, like his father.

> *"That must put a lot of pressure on you to have a child then?"*

I finally initiated the topic for which we had met to discuss.

> *"Yeah, it certainly does but I have learned to handle it well by now,"*

he told me, and continued:

> *My parents have travelled abroad and have seen the world. They are very understanding when it comes to matters like this and, therefore, they don't pester me much about the child. They've understood that there's more to life than just producing children."*

In general, nobody in Prem's family talks about the issue of childlessness at home. But once in a while someone, be it neighbors or relatives, tells Prem's parents that their old age is unfulfilled as they don't have grandchildren to play with. That's how this issue creeps into Prem's home and his mother nudges his wife about it. It bothers his wife very much as she cries a lot and blames herself for the failure. At such times he tries to console her by saying,

> *"Look we can either sulk and get depressed or accept our condition and get on with our life."*

He mentions that he has learned to manage this issue well by now. He reminds himself there's only so much he can do:

> *"I am trying and will continue to go to better places like Delhi in India for better treatment. I have heard the success rate is better there. Although going there might be*

costlier than here, once we will have a child, all the cost will be justified. I have started saving money for that already.”

In this situation, he told me,

“I can only save my own mental wellbeing and not succumb to the family’s frustrations. They have to deal with that themselves, I can only help”.

But he knows he can say that because he knows his parents well, they will accept him as their own no matter what. However, he also knows that his wife cannot feel the same, as she is an outsider to his family and is always fearful of being rejected by his parents (and him) until she bears a child.

“Even the society is in favor of men and supports men who want to leave their wives and remarry for child,”

argued Prem.

“I love my wife though we had an arranged marriage and it took me two years to know her fully. Despite that I need to be honest,”

he confessed,

“Sometimes I have also considered remarrying. I’ll not do it, I don’t want to, but that thought does creep in; I shouldn’t lie. Especially when the social structure has made it easy for us men to do that.”

Even though he says he loves his wife he indeed has mulled over leaving her for the sake of a child. However, he also expressed that:

“If I eventually decide to leave my wife I will make sure she is well settled and taken care of. If that happens, it’ll be many years down from now and that too, if I still will have a desire to have a child until then. For now, I am young, I want to continue to try with the treatment.”

Prem lit another cigarette and confessed to me that sometimes during arguments with his wife, he brings out the issue of childlessness and blames her for not being able to conceive. He said:

"Like anyone, I lash out my anger by hitting the most sensitive emotional spot of my wife—by pointing out that the problem lies in her, and later apologize for it,"

This comment by Prem reflects the patriarchal attitude of a man who has comparative social advantage over women. He can choose to abandon her if she does not give him a child and the society will side on his favor. He can also blame her for inability to reproduce a child while he enjoys his masculine entitlement by not being scrutinized or held responsible for childlessness. Instead, as a man, he has an upper hand to decide if he wants to continue his relationship with his wife or terminate it on the ground of childlessness. I encountered two cases that illustrate remarriage as an option for overcoming childlessness, is not only a perceived threat but a concrete reality.

The first case is of 38-year-old Subash, whose case I described in chapter 2. He said,

"You know how our society is, my parents and relatives started giving me pressure to remarry when they found out that my wife had medical problems in her ovaries."

He also gave remarriage some serious thought and allowed his parents to search for a suitable woman for him. He said:

"At the last minute, I decided not to remarry because I realised it would be really difficult, emotionally and economically, to manage two marriages,"

It is important to note that instead of first considering how his wife would suffer and get affected if he remarried, he was only concerned that it would be difficult for him to manage two wives.

The other case is of a woman whom I met at the Santaneshwor Mahadev temple, a Shiva temple in Lalitpur near Kathmandu where a ritual of distributing rice pudding as a treatment for childlessness is held once a year[65]. 22-year-old Sarita told me that she was diagnosed as having a blocked fallopian tube in a hospital. Instead of supporting further treatment, her husband and the in-laws had initiated another marriage for the husband. She was living separately at the time I

[65] I have explained this more in the fifth chapter where I discuss variety of options, beside biomedicine, used by the childless men and women to overcome their condition.

met her and owned a shop nearby the temple. For a long time the Nepali state also supported remarriage by men if their wives failed to reproduce 10 years into the marriage[66]. The state also followed the Hindu patriarchal logic that considers women as a means through which a man's lineage is perpetuated. This law has been amended on the grounds of being discriminatory toward women. However, as I found, it is still being practiced.

3.6 Secrecy, social gaze, stigma and childless couples

For those couples who do not have a home in Kathmandu, coming to Kathmandu every month for the treatment is cumbersome, especially if they have not revealed to their family that they are seeking treatment for childlessness. I found that many couples keep their treatment as a secret from even their family for the fear of being under unnecessary scrutiny. Thus, they had to strategically manage their travel to Kathmandu. One day, I met Saroj Khanal and his wife in the waiting room. They were visiting the clinic for the intra-uterine insemination (IUI) procedure that was conducted over a period of two days. When they were about to leave after their treatment on the second day, Saroj's wife asked him:

> *"This time we managed to tell* [the parents and other family members at home] *that we are traveling to Pokhara on a holiday, what will we tell them if we have to come here again next month?"*

Everyone laughed. Though it sounded funny, but it is a sad reality that resonates with the everyday experiences of many childless couples who most likely keep their treatments hidden from their family and relatives.

The case of Durga, who also hails from a town outside Kathmandu, was similar. Every time she came for the check-up in Kathmandu, she had been telling her in-laws that she was visiting her "friends and relatives" (*aaphno manchhe*). Now her in-laws were getting suspicious of her frequent visits to her *aaphno manchhe* so they have started passing sarcastic comments like

[66] See Tamang (2000) for a detailed analysis of the involvement of the Nepali state in legalizing patriarchy by controlling marriage and property rights through various statutes.

> *"How many* aaphno manchhe *does our daughter-in-law have in Kathmandu for her to go to visit them so frequently? And what for?"*

Though Durga giggled while she shared that with everyone in the waiting room, she said she is worried that she cannot keep her secret for long and her in-laws will eventually find out that she had been pursuing IUI treatment in Kathmandu. She said with a nervous smile,

> *"I don't know what to tell them if they find out, which eventually they will. I am not prepared to deal with that,"*

The above examples provide a glimpse at how childless couples manage to seek their treatment whereby secrecy becomes their strategy to deflect the scrutiny they face. Scholars like Bennett (1983: 169-170) have argued, in the patrilocal context of Nepal, women are considered to be a threat to the agnatic solidarity because of their outsider status in the husband's family until they bear children and hence their behavior is "[…] most critically watched and controlled" by the in-laws, especially their mother-in-law. I also found this to be true with many women I met in the infertility clinic. These women would narrate their plight at home and ill treatment by their mothers-in-law. In many visits to the clinic, I met 35-year-old Urmila who was frequently present for the treatment. She was locquacious and always busy sharing her woes with the other women present in the waiting room. She lived in a rented apartment near the clinic with her husband so she was not in a hurry to leave even after she had finished seeing the doctor for the day. Women agreed to many things she shared, such as the pressure to bear a child, the financial toll of the treatment, unsolicited advice they receive from relatives and neighbors about the need for a child and unwanted inquiry about the cause of their childlessness. After spending two months in the clinic's waiting room among many other childless men and women, I was already familiar to many issues women discussed and shared openly among themselves in the waiting room. However, one particular information that Urmila shared struck me as quite alarming. She told the others in the room:

> *"My husband and I live here* [in Kathmandu] *and the in-laws live in Dhading* [a district that is about 50 km away from Kathmandu]. *We only visit them during the major festivals or few other times in a year. We haven't told them*

> *that we are pursuing the treatment here. Every time my mother-in-law asks why are we not having a child, I only tell her that we are trying. Still she doesn't stop to nag me. To the extent that she calls me every month around the time when my period usually starts and asks if my period has stopped yet. That's her way of asking if I am pregnant. Yes, she tracks my menstruation cycle (*mahinabari*)!"*

Urmila went on to say that her sister-in-law, who is younger in status than her but has a child, gets more lenient treatment from her mother-in-law during the times when family meets for festivals as she is exempted from the household chores then; whereas, Urmila has to do more household chores despite her being senior in status.

This was true for Saroj's wife as well who said that her husband tries to protect her from the controlling mother-in-law who demands she do all the household chores even when she feels sick. The doctors strictly advised these women to take complete bed rest after the IUI for the treatment to be successful. Additionally, many women complained that the hormonal medicines they take during the treatment also incapacitate them so they cannot perform their household chores well. Women present in the waiting room would console each other but also would complain that it was impossible for them to take full bed rest after the treatment as the doctors prescribed them. They could not avoid household work, especially if they were living with the in-laws in the same house. Beside, taking complete rest and avoiding household work also meant that they would come under suspicion and attract scrutiny from their mother-in-law. This risks the revelation of the secrecy of treatment that they strategically maintain.

The control of women by their in-laws, specially mother-in-law, in patrilineal-patrilocal context is a feature of classic patriarchy that prevails across South Asia, argues Kandiyoti (1988). According to Kandiyoti, women enter the husband's home "[…] as an effectively dispossessed individual who can establish her place in the patriliny only by producing male offspring" (1988: 279). The subordination of the women in the patriarchal household is twofold—one from the senior men, including the husband, and the senior women, viz. mother-in-law, in the family. However, this changes over the life course of a woman as,

according to Kandiyoti, "The deprivation and hardship [a woman] experiences as a young bride is eventually superseded by the control and authority she will have over her own subservient daughters-in-law" (1988: 279). Women, hence, strategically accept the subservient position for the security they receive in their marriage in order to gain that authority to control their daughters-in-law. Kandiyoti terms this tendency of women to "strategize within a set of concrete constraints" as a "patriarchal bargain" (1988: 274). Thus, as can be seen in the case of Urmila, whose mother-in-law tracked her menstrual cycle, the daughters-in-law were still controlled by their mothers-in-law even if they did not live together in a joint household. Therefore, in an attempt to regain some control, these women exercised their agency, albeit within their constraints, by keeping their treatment as a secret from their in-laws, whereby their husbands acted as accomplice by being the keeper of their secrets or in some cases even asking their mothers to not taunt their wives.

At another time, I met Rupak and his wife from Jhapa, a district about 450 kilometers from Kathmandu, in the clinic. They too, like Saroj and his wife, spent two days in the clinic for treatment. When I asked them if they have told their family about their treatment, the wife answered,

> *"Yeah, of course they know. It is impossible to not let them know when you have to travel this far and stay out of home for many days."*

It was only Saroj and his wife who faced that problem at home I thought to myself. I inquired curiously:

> *"What do they say about your condition? Do they support your treatment?"*

Rupak's wife answered:

> *"Oh they are very supportive and tell us that it is not our fault that we have this condition. They asked us to get the best possible treatment in Kathmandu,"*

After a brief pause, she continued,

> *"It is not the family that bothers us but the nosy neighbors who don't let us sleep in peace. They always ask me when I am going to have a child whenever they see me. So, this time while coming here, I asked my husband to carry our*

luggage and take the backdoor to leave the house. He waited for me at the bus stop a little further away from our home while I exited alone through the front gate of the house. We met at the bus stop and took the bus. Luckily, nobody saw us at the bus stop. Otherwise, the neighbors would not spare me with hundreds of questions had they seen me with my husband together while we had a big luggage with us. They would obviously suspect that we were leaving the town for treatment."

From these examples, it might seem like that the childless women are under a strict social gaze, but their husbands are also facing similar gaze that affects their behavior too. Dinesh Pokharel, who was childless for 9 years before he could father a child, suffered a similar plight. He comes from Sindhupalchowk and has been residing in Kathmandu for work. At one point, he and his wife stopped visiting Sindhupalchowk even during the festive season of *dashain*[67]. Dashain is one of the major Hindu festivals that falls in the month of Asoj of the Bikram Sambat calendar (in between September and October) used in Nepal. It is a fifteen-day ceremony during which various forms of goddess are worshipped for nine days. The tenth day, Vijaya Dashami, is an especial day when people receive blessings by receiving tika, rice mixed in vermillion power, on the forehead from their elders and relatives. The celebration continues for five more days after Vijaya Dashami. It is customary for people living away from the family to travel home, even from abroad, to be with their extended family for this festival. Therefore, it was unusual that Saroj and his wife stopped visiting his family in Sindhupalchowk during *dashain*. They would make some excuse to their family and not go. Later, after a few years, only Dinesh started going back to Sindhupalchowk during *dashain*. His wife would stay back in Kathmandu. When I asked him the reason behind such a move, he answered:

"I was fed up with people always asking why I was not having a child and when I would have one. At least in

[67] See Forbes (2008) "Dashain" (https://www.hinduismtoday.com/modules/smartsection/item.php?itemid=1486) for the details of the celebration and Chamberlain (2002) for the discussion of the practice of goddess worship in the region and its connection to dashain.

Kathmandu, a few people ask us that and we had learned to gracefully avoid that situation. But back in our village, everybody was interested to know about my personal life. So, they would not stop asking us two as soon as they saw us. Especially, during the festivals when all the family members gather together and the village is filled with a lot of children around. Thus, it was better to not go to the village at all and avoid all those taunting that was in store for us. Later on, I started going back alone to spare my wife from being bothered with unnecessary questions from people there. I could handle the situation very well, but my wife would be really hurt and cry. She was already suffering from her condition; I didn't want any additional suffering for her."

In addition to Ram and Ramesh's case discussed above, the cases of Rupak and Dinesh further illustrate how childless couples strategically deal with social stigma of childlessness. Rupak and his wife's case is a little different than that of Saroj, Durga, and Urmila in a sense that their parents know that they are seeking treatment for their childlessness and even encourage them to get the best treatment. However, they still have to deal with the neighbors and the social stigma and one of the ways they dealt with that was to not appear in the public together.

Many studies across different cultures show that not being able to reproduce often marks a person as deviant. The inability or the lack becomes the person's identity. The stigma of childlessness often results in blaming the childless individuals for their faulty body parts and inability to produce children (Greil 2002). Women who are unable to bear children are labeled as "incomplete" and "abnormal" (Yebei 2000). Not only is stigma psychologically felt and internalized by the individuals, it also originates through social interaction and interplay of (social, economic, and political) power dynamics of various social groups in a local moral context (Kleinman and Hall-Clifford 2009; Link and Phelan 2001). Despite its medicalization, involuntary childlessness is highly stigmatizing condition in many parts of the world—the brunt of which is experienced differently by men and women (Sundby 1999; Gannon et al. 2004;

Bela 2012; van Balen 2000; Inhorn 2003, 1994). Nevertheless, scholars have argued that women's body are more stigmatized for the reproductive failure than that of men. For instance, in patriarchal society such as Egypt, it is the women who are usually blamed for the failure of their body to function properly or even respond to the therapeutic interventions without considering that the problem might lie in their husband instead (Greil 2002); this further stigmatizes women and causes them immense suffering.

However, studies among men in Europe have shown that men also suffer as much as women although their coping strategies might differ from those of their partners (Wischmann and Thorn 2013). In my study, Ram also confirmed that childless men also are stigmatized just as much, if not more, as women. He proceeded to tell me about two instances when he was taunted by women for his childlessness. One woman came from Beni, a town near his hometown Parbat, with her astrological birth chart (*cheena*) to discuss about her problems with him. He first told her he was busy but consented to give her time when she insisted. Before leaving she said,

> *"if you can tell me about my life so accurately, then why can't you find out the cause of your own problem* [of childlessness]*?"*

Ram laughed and said if he knew she'd say that he would have just sent her away without reading her birth chart. Before she left, he angrily told her to mind her own business and leave him alone:

> *"my problems are mine and such things are beyond my control,"*

he told her. Another time, Ram was called out in public by a young widow while he was reciting *purana*[68]. She asked him,

> *"Why is it that you cannot have a child but yourself professes that spiritual practices and conducting public reading of such purana will help in conception."*

[68] Public reading of religious Hindu mythology. See chapter 5 for more details but to contextualize, there are some *purana* that are recommended to be recited as a remedy for childlessness.

He shut her mouth by angrily asking how she'd raise her child as a widow. Basically, he was taunting her by pointing at her stigmatized identity as a widow. Feeling humiliated, the woman left the hall after offering flowers at the shrine.

Few studies, like that of Miall (1986) and Riessman (2000), explore how childless couples across different cultures deal with the stigma associated with childlessness. Miall found that there are a few strategies that the involuntarily childless women in Canada employ in order to deflect the stigma associated with their condition. These women considered their inability to reproduce as "a deviant behavior in marriage, a violation of prevailing norms of acceptable conduct" (Miall 1986: 268), which is a stigmatizing condition or "a discreditable attribute" (Miall 1986: 272). The women managed the information about their condition as per the need, i.e., some women selectively disclosed the information to others and "did not always reveal the exact details of their conditions" and some "[gave] inaccurate answers to questions about their childlessness" (Miall 1986: 273). Likewise, they avoided the people who made them feel uncomfortable about their condition and primarily concealed the information about their condition from others while secretly visiting the doctors for treatment (Miall 1986: 274-279).

However, Riessman, whose focus is on the childless South Indian women, is critical of the studies of stigma after Goffman (1963) that seem to suggest that an individual has the agency to "control what others know about them by selective disclosure or concealment" (2000: 113). She argues that the theory of stigma, which she calls as "a product of Western thought", "assumes a self-determining, autonomous individual with choices and a mass society that allows for privacy;" these, according to her, are "problematic assumptions in Asian contexts" (2000: 113). Riessman shares her own experience while conducting research in Kerala, India during 1993-1994 where she was constantly asked about her personal life such as "How many children do you have? Why aren't they married? Where is your husband?" by strangers in public spaces (2000: 115). The childless women she met told her that they also encountered such questions by strangers and neighbors. The neighbors passed harsh and insulting judgments on them, which upset the women (Riessman 2000: 118). These women also had to face intrusive questions from the kin when they attended marriage or other family events. In Riessman's study as well, the mothers-in-law of the women scrutinized

them and held them responsible for reproduction (2000: 121). Nevertheless, Riessman argues that instead of the "stigma theory's language of interpersonal management strategies," the South Indian women's response to stigma is complex and contradictory, which is better understood by the feminist description of resistance (2000: 122). These women fought back when they were blamed or made an effort to destigmatize themselves. Their resistance was more informal and covert at times. For instance, they reinterpreted the intrusive comments by saying it did not matter much to them or strategically avoided the context where they would be stigmatized. Some women avoided visiting temples or attending family functions at their husband's families (Riessman 2000: 123-124). However, these women also did not divulge the information if their husbands were the cause of childlessness, thereby, conforming to the normative gender ideal of male privilege (Riessman 2000: 130).

The men and women I met al.so employed similar strategies of resistance. For instance, Urmila humorously shared to other women that depending on her mood, she gave various answers to those who asked questions like *"how many children do you have?" "Where are your children?"* She would answer*:*

> *"I have a daughter and a son; the daughter is 9 and the son is 7;"*

or

> *"Oh, their school is off for a month so I have sent them to their maternal uncle's home for a few days."*

This was her strategy to deflect further scrutiny, and a form of resistance against being stigmatized, as she argued,

> *"People keep quiet after I answer that way; otherwise, they don't let me be in peace if I tell them I am childless even after being married for 10 years."*

Likewise, Rupak and Dinesh also strategically avoided public scrutiny by not being seen with their wives in public and, in the case of Dinesh, not attending festivals and family functions together with his wife.

3.7 Travel for treatment and vulnerability of men

Figure 1: Research sites in red dots and travel distance covered by some men shown in arrow

Here, it is important to discuss about the travel to Kathmandu and road conditions, which affects the childless couples' travel for treatment. Kathmandu lies 146 kilometers away from Narayangadh, where Girish resides. It is connected to Narayangadh via a major highway, the Prithvi Highway, that was built in 1975 with the Chinese assistance. The two-lane road runs along the mountainous terrain by the Narayani and Trishuli rivers. The road condition has always been very precarious in general; incidence of accidents is very common whereby the vehicles veer off the road and plunge into the river, which results into huge casualties. Road blockages due to frequent landslides are also a common occurrence for 3-4 months during the monsoon season that makes the travel on that highway very risky. On top of that, at the time of my research it had been four years since the Narayangadh-Mugling 36 kilometers stretch of the two-lane road was being upgraded to four-lane. A large section of mountain had been

chopped off to create the extra space for the road. As a result, many fatal accidents due to the landslides from the chopped portion of the mountains have occurred in those four years. The risk increases by manifold during the four months of monsoon.

Additionally, the entire 36 kilometers stretch of the road was blocked for the construction from 10 am till 4 pm daily. People adjusted their travel time accordingly. What normally used to take about 4 hours travel from Narayangadh to Kathmandu, took up to 9 or 10 hours due to the extensive traffic jam and poor road conditions caused by the construction[69]. That resulted into a surge in the travel via air as an alternative. But this option is too expensive and therefore not accessible to everyone. Given that the childless couples are called for multiple follow up visits to the clinic frequently, not all the couples can afford to travel via air. Hence, they are left with little choice than to travel in bus, which compounds their suffering. Additionally, as in the case of Girish who did not continue his treatment in Kathmandu, factors like the poor road condition and distance also deter childless couples from seeking medical help.

In the beginning of February 2017, I also had an opportunity to travel to Sikkim and Darjeeling in India. Since I had to traverse through the entire eastern region of Nepal to reach there, I took this chance to also educate myself about the sense of distance that the patients I met in the infertility clinic have to cover in order to come to Kathmandu for their treatment. The distance from Kathmandu to the furthest point Kakarbhitta in the east, where some patients come from, is about 500 km. Some patients travel from even further distance. It takes them

[69] Various parts of the highway to Kathmandu are always under construction at different times. Recently, in September 2019, another stretch of the highway, about 30 kilometers from Kathmandu, was being blacktopped. Since September-October is a time of biggest travel of the year for Dashain, a major Hindu festival, the obstruction due to the roadwork created a long 30 kilometers traffic jam. On September 28, Rup Lal Sah, a 35 year old kidney patient was traveling from his home in Janakpur with his mother to get dialysis treatment in Kathmandu. The bus got stuck in the traffic jam for a few hours. Rup's condition deteriorated in the meanwhile and he died on his seat next to his mother. Although the bus driver and other passengers tried to arrange for an ambulance, they could not find one; but even if they had managed to find an ambulance, there was no way for it to pass through such a thick traffic jam that stretched to 30 kilometers (Shrestha 2019). Although this news got national attention, incidences like these are very common as people have to travel through the same highway for treatment purposes and the road conditions are always unpredictable.

overnight's travel in a public bus to cover that distance. Eastern region of Nepal covers the vast flatland known as Terai. Though the road is smooth and mostly straight and flat, unlike the winding mountain roads that lead to Kathmandu, the travel itself gets exhausting. I was traveling in the comfort of my private car with my brother and cousins. We could stop the car wherever we pleased and take rest when we wanted, the luxury that the most couples who come to the clinic did not have while traveling in the public transport. Although my hometown Narayangadh is not as far from Kathmandu as some of the places that the childless couples come from, I can attest to the experience of traveling in the public bus as I have been traveling in the same highway in public transports since my childhood. The buses stop only for a short time at a few designated eateries on the highway, which might not cater to the taste of the travellers. The food at these shops is also very expensive as compared to regular eateries. This travel gave me a good perspective to understand the scope of many constraints faced by the couples in the quest for children. The travel and the various arrangements needed for it in itself became a cause of distress for many couples who traveled from outside Kathmandu for the treatment.

Since the women are summoned to the clinic for different treatments frequently, sometimes in a short span of four days, it is very inconvenient for those who come from outside Kathmandu to travel back and forth from their home so frequently. Therefore, the couples usually stay in Kathmandu for the entire duration of their treatment, which might run up to ten days per visit. They might sometime stay with their relatives, if they have some, while they are in Kathmandu. However, staying at the relatives' place becomes awkward in many grounds: a) like the couples discussed above, many childless couples keep their treatment a secret from their family. Therefore, staying at a relative's place during the treatment period only increases the chances of exposing their secret. The couples have to manage their behavior tactfully to maintain the secret, b) even the relatives might be living in a small, rented space and hence the couples feel that they are becoming burden to their host; and c) staying at the same relative's place so frequently only adds to the awkwardness and increases the chances of being scrutinised. Thus, the couples avoid such a situation by renting a room in the vicinity of the clinic or by staying in a hotel for the duration of treatment, which strains their budget.

Ramesh was one of many men who faced similar problem during the treatment in Kathmandu. He was living in a hotel that was in about ten minutes walking distance from the clinic. He and his wife left the room early in the morning for the clinic and stayed in the clinic until their treatment for the day was over, which most of the time took up entire day because of the long waiting period in the clinic for their turn. The couple would only leave the clinic for lunch and snacks. When I met him, he had already been in Kathmandu for eleven days. It was his first time in Kathmandu; he was shocked to see how polluted and crowded the city was. He still felt difficult to navigate his way around in the public transport and felt disoriented. He had not anticipated that the treatment would last that long, so he did not bring extra clothes with him. After a few days in Kathmandu, he ran out of a clean pair of clothes to wear and therefore he had to buy new clothes. In the meanwhile, his work at home was also suffering. He is a carpenter and makes furniture on a contract basis. He had delegated his work to his three assistants before coming to Kathmandu. However, since he had planned to return in two days, he had not allocated enough work for eleven days. Thereby, his assistants had run out of work. It was difficult for him to coordinate the work over the phone.

For many men like Ramesh, coming to Kathmandu for the treatment meant double loss: they were spending extra money for the living during their stay in Kathmandu while their source of income at home suffered. This, however, was not the case for the men who lived in Kathmandu. They would drop their wives in their vehicles at the clinic and leave for work. Most of the time, their wives visited the clinic by themselves; therefore, the men did not have to drop them at all. The men were only present in the clinic if they had to provide semen sample for analysis or to consult the doctors. Their work did not suffer much because they arranged to visit the clinic during their lunch time or, if they had to wait for long to see the doctor, they took at most only half a day off from their work.

Coming to Kathmandu for treatment at the infertility clinic is just one example of the ways travel affects and adds to the childless men's suffering. Biomedical treatment is only one among many other treatment options that the childless men and women pursue. I will discuss about the various treatment options beside biomedicine pursued by these men and women in the fifth chapter.

Here it is sufficient to mention that many treatment options—such as temple visits and conducting rituals there, shamans, astrologers and the like, entail travel to various places at different times. Thus, childless couples are on the road frequently, the condition of some of which is like that of Narayangadh-Mugling road. Since Narayangadh-Mugling road is one of the major thoroughfares, many couples I met had to pass through this section of the highway to travel to places like Lamjung to participate in a ritual held at a Shiva temple there[70]. Thereby they organised their travel plan to skip the time of road construction, which only added to their woes of managing the treatment.

3.8 Living in Kathmandu for treatment, *ijjat*, and vulnerability

Additionally, the management of travel and treatment in itself created conditions for the childless men's vulnerability. Since it is very difficult for the couple coming from outside Kathmandu to manage frequent travel to Kathmandu for treatment, a few couples chose to rent a room in the vicinity of the clinic. Sometimes the arrangement for treatment also meant that the men had to leave behind their wives alone in Kathmandu so that their wives could carry on with the treatment while the men could continue to take care of their work in their hometown. Nevertheless, it is not easy for the couples to manage living separately. The living condition in the rented room might not be as satisfactory and comfortable as living in their own home. Hence, the women have to make many different levels of adjustments to live in the new environment. The duration of the women's stay in the rented room was determined by the treatment outcome; so, there is always an uncertainty of how long the couples would live separately and that adds to the anxiety that already exists from their struggle with childlessness. Men and women in the clinic also shared these kinds of anxieties to each other while they were waiting to see the doctor. One day, I overheard a man expressing his frustration with the others in the waiting room:

> *"We have a three-storeyed house in Biratnagar and I rent out two floors. Here my wife is living in a single room with a small stove at one corner for cooking food. What is more*

[70] I discuss about this below.

annoying is that I have to leave behind my wife alone here."

At one level, the man's remark could only be a plain indication of his frustration and an expression of his helplessness arising from having to live separately from his wife. However, if studied closely, this statement bespeaks volumes about a man's anxiety stemming from patriarchal norms of masculinity, viz., control and male dominance. In his study of Hindu upper-middle-class upper caste men in Banaras, India, Derné (1994) found that the patriarchal gender ideology of restricting women's movement outside of home and confining them to the private sphere of home results into the gender power imbalance whereby women are subordinate to the men in their family. Like in *Manusmriti*[71]—the text that reflects the ideologies of classical Hindu patriarchy, which mandates that women should never be independent and are to be controlled by their father before marriage, by husband after marriage, and by son if the husband dies, Derné's male interlocutors also expressed similar views of their gender role in controlling their wives and sisters (Derné 1994: 208). These men did not allow their wives to venture out in public alone; the women, however, could do so only after seeking their husbands' permission. In most cases, even the women who were allowed to go out by their husbands had to be chaperoned by the male member of the family, usually the husband's younger brother (Derné 1994: 210). The men expected their wives to maintain certain decorum, such as being shy, docile, and modest, while they were in public spaces (Derné 1994: 208). These mandates on the women, as the men argued, were on place in order to protect the honor (*izzat* or *ijjat*) of the husband and his family. Derné found that the men he interviewed were "convinced that the family honor depends on the propriety of women's actions," and told him that "a wife's contacts—however innocent—with men outside the home threaten the family's reputation" (1994: 209). Thus, it is not surprising to see the men taking a protective role by controlling their wives' behaviors.

Maycock et al. (2014) also found a similar notion of masculinity and *ijjat* among young men in two towns in Eastern Nepal. For these young men, an adult man was responsible to provide and care for the family, through which he gained

[71] Discussed in chapter 2

respect from his family and community; this meant that the man has "a degree of power or authority to make decisions for family members, especially women" (2014: 13). The responsibility of care also entailed "an element of 'management', not only of financial resources but in some instances also of members of the household," (Maycock et al. 2014: 15). One of Maycock *et al.'s* interlocutors told them that "[…] as a man, our main responsibility is managing our wife to maintain peace and harmony at home" (2014:15).

Likewise, Maycock et al.'s interlocutors also expressed their responsibility to uphold their *ijjat*, which for men accumulated "over time through achievements gaining social status," while women's *ijjat* is tied also to their families and "is closely linked to their sexuality and complying with gender norms, and can easily be lost" (2014: 30-31). Therefore, men find it as their duty to protect women, which they might do by restricting and controlling the women's "freedom and autonomy" (Maycock et al. 2014: 31), for example, by accompanying the women when they venture in public. This was one of the ways men ensured the upkeep of their *ijjat*. Maycock et al. argue that "[…] men's control of women or their exercising power over women was thus largely seen as justified. Men saw the loss of family's *ijjat* as a subversion of their ability to protect it," (2014: 31).

As a result, the men who fail to carry on their responsibility are considered a failure and will be emasculated by being called *namarda, hutihara*, or *lafanga*, argue Maycock et al.. (2014). As I described in the second chapter, these terms are used in a variety of contexts; among many definitions of *namarda*, some, in Maycock et al.'s context, are: "a married man who fails to father children," "a man who lets his wife to make decisions", or "a man who does not show courage when needed"; likewise, *hutihara* is "a man who has not been able to achieve anything in his life"; and *lafang*a means "a useless man, who roams around and does not bear any responsibility" (2014: 15).

Liechtyalso describes the importance of *ijjat* for the urban middle-class in Kathmandu, which, he argues, is tied to both moral and material economy. He translates *ijjat* as "prestige," "dignity," "respectability" or "honor" (2008: 83); it is "something that can be gained or lost, preserved or expended," (2008: 257). *Ijjat* economy is central to the making of the middle-class in Kathmandu, argues Liechty, in which "[…] honor and prestige is the central form of capital" (2008:

83-84). In this *ijjat* economy, the middle class is constructed by "both upholding the moral canons of sexual and ritual practice, *and* consuming the goods (from fashion to education) that act as recognized material markers of the middle class" (Liechty 2008: 84). The material aspect of *ijjat* economy is "[equally] important as the moral one in generating class distinctions. The wedding celebrations, home furnishings, clothing, and hundreds of other material accoutrements that are required to establish middle-class status effectively distinguish its members from those in poverty" (Liechty 2008: 84). Additionally, in the *ijjat* ecomony based on material consumption, Liechty argues, "even once-unquestioned forms of prestige, such as caste status, have to be backed up by the display of goods, as those able to adopt new consumer lifestyles threaten to subvert traditional forms of prestige altogether," (2008: 111).

Hence, on the one hand, the man's remark in the infertility clinic reflects his anxiety about the loss of control over his life and exposes his vulnerability. It also reflects the perceived threat to his masculinity because leaving his wife alone in Kathmandu not only renders her vulnerable[72], but it also makes him a man who is unable to provide security to his wife and have control over her through his direct presence in Kathmandu. As I discussed above, a man's *ijjat* in patriarchy is reckoned by his (in)ability to control his wife, hence living separately from his wife potentially brings threat to his *ijjat* as well. It is, therefore, a shame for him to be in such a situation.

On the other hand, the remark is also indicative of the anxiety the man feels from failing to maintain his middle-class status in Kathmandu. He contrasts his social status as a homeowner in Biratnagar who enjoys income from rent to the fallen status of a room renter in Kathmandu whose wife has to accommodate in a small space for both cooking and living. This is in sharp contrast to the *ijjat* economy among the middle-class that Liechty describes where "personal and corporate (usually family) prestige (*ijjat*) is increasingly tied to the acquisition and display of consumer goods," (2008: 114). In the small room in Kathmandu, which is a temporary abode for the duration of treatment, the man and his wife probably cannot display as many consumer goods that would bring them social

[72] Discussing about the limited access to public spaces in Kathmandu for young middle class women, Liechty also argues, "a woman's honor (*ijjat*) is always at risk" in public spaces (2008: 234).

prestige. In addition to that, since it is common among the childless couples to keep their treatment secret from their family and neighbors, it is highly likely that the man and his wife would keep a low profile in Kathmandu and not display their middle-class exuberance that they would do in Biratnagar. Hence, seemingly small changes like renting a room for treatment in a town elsewhere from their home also significantly affects multiple aspects of the childless men's lives since they have to rearrange their life around their treatment and renegotiate what it means to be a man.

3.9 Conclusion

In this chapter, I have argued that although childlessness is ubiquitous and highly visible in Nepal, it is difficult to find childless men to share their experience of childlessness. The reason for this could be due to the normative patriarchal gender ideals that mandates men to be strong and in control of their life. Discussing about their failure to father a child would mean revealing their vulnerability and loss of control and exposing their emasculation. Physical factors such as road conditions, travel, and arrangement for accommodation during treatment added to the suffering of childless men traveling from outside Kathmandu for treatment. Regardless of whether the men had easy access to the treatment or had to travel long distances for treatment, childlessness is a debilitating condition that threatens men's overall wellbeing and questions their masculinity by rendering them vulnerable in many aspects of their lives. It is a stigmatizing condition as well that exposes men to many vulnerable situations like emotional exploitation by healers, financial pressure, ridicule, and social scrutiny. Factors like the overzealous neighbors and the perceived sense of being under constant social scrutiny makes the childless couples modify their behaviors and tackle stigma strategically. Such vulnerability and inability to have control over his finances and overall life situations due to childlessness is a weakness, or *kamjori*, of a man, which when coupled with the inability to actualize the normative ideals of biological fatherhood prevalent in Nepal, only compounds his suffering. Thereby, the childless men's pursuit of treatment by traveling long distances, even in bad road conditions, and enduring all kinds of suffering that

come with their pursuit is their strategy to overcome their *kamjori*—both biological and social—and restore their masculinity.

Chapter 4: Semen, Male Infertility, *Kamjori* and Masculinity

4.1 Introduction

Reproduction and childlessness used to be a private affair of a couple in the past, but today it has gradually become a biomedical issue that needs constant medical monitoring (Rothman 1986; Davis-Floyd 1992; Martin 1987; Lock 2001; Rapp 2001). Women's bodies become the primary target of such monitoring (Franklin 1997; Becker 2000; Thompson 2005; Bell 2010). According to Greil (1991), medicalization of reproduction began after the advent of fertility drugs in the US in the 1950s, which gained further traction after the development of the assisted reproductive technologies (ART) in the recent decades (Greil and McQuillan 2010: 137). Successful application of two technologies of reproduction, Artificial insemination by husband (AIH) and Artificial insemination by donor (AID), was reported in the nineteenth century. Ever since, reproductive technologies have evolved into arrays of other sophisticated services available today, such as in-vitro fertilization (IVF), intra-cytoplasmic sperm injection (ICSI), gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT). All these reproductive technologies have proliferated in such a high speed across cultures that Knecht et al. have labeled them a "global form", which according to Aihwa Ong and Stephen Collier, are characterized by a "[…] specific capacity of decontextualization and recontextualization" (Knecht et al. 2012: 16-17). Not just developed rich nations but also developing countries like Nepal have participated in this global phenomenon that purports to be alleviating human suffering caused by childlessness.

Medicalization of childlessness is further illustrated in its biomedical definition by the Practice Committee of the American Society for Reproductive Medicine, which is a prominent group in the United States for reproductive medicine. The group defines infertility as a "disease" that is marked by the inability to "achieve a successful pregnancy after 12 months or more of regular unprotected intercourse"[73] (Greil and McQuillan 2010: 138). For the women over

[73] Greil and McQuillan (2010), however, raise a critical gaze at this definition and argue that intention of the couples trying to get pregnant should also be included while defining infertility. According to the authors, there are multiple

the age of 35, the time window is 6 months (Greil and McQuillan 2010). Although earlier the World Health Organization (WHO) had defined infertility using the two-years mark (Greil and McQuillan 2010: 152), after 2009, it has also adopted the 12 months period in its standard definition of infertility. The WHO also defines infertility as a "disease of the reproductive system"[74] (Zegers-Hochschild et al. 2009: 2686). Infertility is a significant medical problem as 15 percent of the reproductive aged couples worldwide are affected by it (Inhorn 2012: 54; Inhorn and Birenbaum-Carmeli 2008:179; Vayena et al. 2002); this rate is 30% for South Asia (Mascarenhas, *et al. 2*012). According to Borght and Wyns, more than 186 million people are affected by infertility worldwide (2018: 3); while more than half of the cases are male factor related, men alone are responsible for about 20-30 percent of infertility cases (Vander Borght and Wyns 2018: 2; Kumar and Singh 2015: 191). Since male infertility is one of the most difficult forms of infertility to treat and affects millions of men worldwide, Inhorn and Birenbaum-Carmeli (2010) have termed male infertility as a "chronic reproductive health condition," which, according to Inhorn, cannot be "cured" but only be "solved" by ART like intracytoplasmic sperm injection, or ICSI (2012: 54). Hence, it is evident that by defining childlessness strictly in terms of bodily dysfunction/failure, biomedical narrative has created further stigmatization of the men and women who are not able to reproduce. This adds to the suffering of the men and women.

Majority of the work on the reproductive technology and treatment of childlessness focus on the suffering of women and biomedical gaze on their body. However, I found that men also suffer in the infertility clinics in a different way than the women. Their suffering is linked with masculinity. The failure to uphold the patriarchal normative ideal of a man as a breadwinner who has control and command over his and his wife's (sexual) life marks a man as the one with *kamjori*, or weakness, an attribute that is emasculating for a man. In this chapter, I will explore at least three different ways *kamjori* is enacted in the infertility

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factors that determine a couple's intention to conceive (or not to conceive) and hence the way women perceive about their actions to seek medical help and in/fertility condition does not get reflected in the standard definition of infertility.

[74] https://www.who.int/reproductivehealth/topics/infertility/multiple-definitions/en/ [Accessed 2/2/2019].

clinics and argue that the patriarchal ideal of manhood—that of a strong and powerful breadwinner who has command over his life—is undone in the space of the infertility clinics where men face deep humiliation, vulnerability, and threat to their masculinity at various points during the treatment. Additionally, in the clinic's laboratory, *kamjori* is enacted through the semen analysis report where the lower number of sperm count denotes the potential inability of a man to father a child. In a larger context, this indicates the failure, or *kamjori*, of a man to uphold lineal masculinity.

4.2 Infertility clinics

The descriptions I will present in this chapter are based on the study of two infertility clinics: a) Kathmandu Infertility Clinic in Kathmandu, and b) Bharatpur Fertility Center in Chitwan, a district that is almost 150 kilometers away from Kathmandu. Although the findings in these clinics cannot be generalized to all the infertility clinics in Nepal, the choice of two clinics located in two different locales provided me with some good insights into the many similarities and idiosyncrasies in the way infertility is enacted in the infertility clinics in Nepal.

4.2.1 Kathmandu Infertility Clinic

Kathmandu Infertility Clinic was founded by Dr. Sweta and is very well renowned in Kathmandu. The clinic is regularly featured in the major media, both print and electronic, and Dr. Sweta has appeared in numerous TV programs that cover the issues of childlessness and infertility. It is through such newspaper coverages that I came to know about Dr. Sweta and her work. She was very welcoming when I approached her to discuss my project. Since she is also involved in academic teaching and research in a college in Kathmandu along with her clinical practice, she was interested in my research right away. Therefore, she easily offered me the permission to conduct my research in her clinic where I initially spent 4 months from October 2016 till February 2017. Since then, I also conducted few follow up research until 2019.

The clinic is located on the second floor of a building that has other business ventures on different floors. It has several rooms with different

functions: three waiting rooms; a consultation room; a room for IUI treatment; a room to conduct semen analysis; a small kitchenet-eating area for the staff. The three waiting rooms are always full. The regular opening hours of the clinic are 10 am till 5 pm from Sunday to Friday; but the closing time extends to 6 pm usually. The clinic is extremely busy. It is very normal for patients to arrive at 10 am and wait till 5 pm for their turn to see the doctor. This clinic is operated by 8 staff members; except for a male lab assistant, all the other staff are women: two doctors (Dr. Sweta and Dr. Reshma), two nurses, a receptionist, an assistant, and a cook. This is important to note as it had a significant impact on the experiences of men who came for the treatment. I discuss more about it in the subsequent sections below.

The walls of the clinic's waiting room are covered with the pictures of babies that were conceived after the treatment in the clinic. Some of the pictures have "Thank you Dr. Sweta" printed on them; these are the pictures given by the parents of the children to express their gratitude to the doctor. On the same walls, some certificates of merit and acknowledgements of the doctor hang on the wooden framed glasses. Some printed information on the dos and don'ts of IUI and pregnancy are also pasted on those walls. Among such papers is an interesting letter written by one of the patients of Dr. Sweta. It is a long-handwritten letter written by a man who likens the doctors to a god and calls her his saviour. He writes that he and his wife had totally lost their hope from failing to conceive a child even after visiting several doctors and pursuing many other treatments for ten years. Their condition was successfully treated by Dr. Sweta and now they have a child. While on the one hand, these pictures and the letter create a cosy environment in the clinic, on the other hand, they provide legitimacy to the treatment provided by the doctor. Many men and women referred to these pictures and letter while telling me that they trusted Dr. Sweta's treatment and that they would succeed in becoming parents.

4.2.2 Bharatpur Fertility Center

I came to know about this clinic during my visit to my hometown Narayangadh, a town about 150 kilometers southwest of Kathmandu, in April 2018. The clinic is located in Bharatpur, a small town in a distance of 1 kilometer from Narayangadh. It had opened only a month ago then. I heard about the clinic

through the advertisements on the local FM radio and the clinic's pamphlets that was distributed in the town. As it was still in its initial phase of establishment, its owners advertised widely about it in various media outlets. My dad and uncle received those pamphlets in their shops and brought them to me.

The clinic was started by a famous gynecologist Dr. Hari Gautam, a longtime resident of Bharatpur who now lives in Kathmandu and works in a renowned gynecology hospital there. The clinic opens every day of the week. On a day-to-day basis, a male gynecologist from the local hospital examines the patients. On the third Saturday of every month, the clinic management brings Dr. Shristi Shrestha, a female gynecologist from a renowned private hospital in Kathmandu that specializes in IVF and IUI treatments. She is renowned as an "test tube baby" specialist. Likewise, Dr. Gautam visits the clinic on the last Friday and Saturday of every month. Except on the days the doctors come from Kathmandu, there are very few patients in the clinic on regular days—a huge contrast to the well-established Kathmandu Infertility Center in Kathmandu.

The layout of the clinic space is also important to note as I noticed that the arrangement of the space itself influences the experience of men in the clinic. I will discuss more about it below. The clinic is divided into several rooms—reception room, out-patient department (OPD) room where the consultation takes place with the doctor, X-ray room for the ultrasound lies across the passage from the OPD room. On a wall of the reception room, there is a large rectangular board-like glass on which the name of the clinic is written, with a caption "Bringing you the joy of parenthood" underneath a sketch of a mother who is kissing a child wrapped around her arms. Right across the reception room lies a spacious waiting area. At the end of the building, adjacent to the OPD room there is a toilet. Then adjacent to the toilet, outside the main building, lies the laboratory room. At the rear side of the building premise, lies another toilet, which is completely separated from the clinic premise. Like the other clinic in Kathmandu, this clinic also has its own pharmacy.

4.3 Exclusion of Men in the Clinical Consultation

Most of the men I met in the Kathmandu Infertility Clinic revealed to me that they did not feel comfortable in the clinic, be it during the clinical

consultation or while collecting semen for analysis. They felt disempowered by the doctors' aggressive approach to treatment that did not give them any room to negotiate the treatment choice and make decisions about their treatment plans. On top of that, given that the treatment procedures are disproportionately centered around treating the woman's body, these men felt their needs were not properly addressed by the doctors. Hence, the men felt further excluded from the treatment plans that the doctors made for them and their wives. I could glean some of these issues during the observation of many clinical consultations. Below, I present one of such consultations.

As I was busy speaking to the men in the waiting area one day in December 2016, a young couple entered the clinic. They greeted Sunita, the clinic staff member who was periodically coming out of the consultation room to the waiting area to summon the patients into the consultation room, and told her that they wanted to see the doctor. It was their first visit to the clinic. Sunita entered the reception area in the corner and pulled out the roster of patients. She asked the name of the couple; the husband gave his wife's name and other personal details like age, contact number, and address that is required for the clinic's record. Sunita jotted that information on the roster and prepared a consultation booklet for the couple. The booklet is used for the consultation record keeping and it also acts as a prescription for medicines. Sunita handed the booklet to the couple and asked them to take a seat and wait for their turn to see the doctor.

Like others, this couple also sat for about an hour before they were called by Sunita into the consultation room. I talked to them while they were waiting and built a rapport. That must be the reason when I asked them if I could observe their consultation with the doctor they told me they did not mind. The doctor had already permitted me to sit beside her desk whenever I wanted and observe the consultation. I had done that many times before already. However, whenever I planned to observe the consultation, I would separately seek permission from the couples as well. If the couples did not want me to be present during the consultation, I stayed back in the waiting room.

I followed the couple into the consultation room when they were summoned from inside. The couple greeted the doctors and took seat across from the consultation desk as they handed the consultation booklet to Dr. Reshma. The

doctor then started her interrogation and noted everything in the booklet, which is a protocol that the doctors call "taking medical history of the patient." She asked them a series of questions: about their physical health, age, occupation, duration of their marriage and since when they had planned to have a child, frequency of their intercourse, other doctors they have visited, medicines they have taken in the past or are currently taking, if they have had any kind of surgeries, and if anybody in the family is childless. Those questions were common to both the husband and wife. Then there were specific questions: for the woman, if her period is regular, if she had ever become pregnant or had any miscarriages, and if dilation and curettage (simply understood as 'curette' by the women) was performed to remove the tissues from the uterus; and for the man, some lifestyle related questions like if he chews tobacco, *gutkha*[75], smokes, or drinks. Men were advised to stop smoking or drinking because, they are told, those substances lower the sperm count.

After the initial medical history taking protocol ended, the doctor started what she called *"counselling."* It was a long explanation of the overall reproductive system and the overview of clinical procedure like IUI to the couple. The counselling was over in about 5 minutes, by the end of which the couple seemed a little more informed about the medical treatment journey on which they are about to embark. Like in any other typical counselling sessions, Dr. Reshma first narrated to the couple how a child is conceived through the *"meeting"* of husband and wife, which was a covert way of referring to sexual intercourse. She explained,

> *"a child is made when the husband's sperm and wife's egg come in contact. Therefore, in this clinic, we investigate and treat both husband and wife parallelly*[76]*. This is infertility care center*[77]*, that's why we only do things that will lead up to making a child. We do not treat gynecological cases."*

[75] It is a preparation made of tobacco, beetle nuts mixed in some sweetening flavorings. It is used as mouth freshener and people usually get addicted to it.
[76] Her words
[77] I have italicized the words and phrases spoken by the doctor in English.

Demarcating the clinic's sole aim to be infertility treatment, as opposed to gynecological treatment done in regular clinics and hospitals in Kathmandu, Dr. Reshma claimed:

> *"That is why we investigate every minor and subtle thing*[78] *to completely ensure that the couple has a child."*

The doctor then briefly turned to the man and explained to him that the sperm count must be 200 million per milliliter and in this clinic, 60 million per milliliter and 60 percent motility rate is considered as a borderline. She described to him:

> *"There are various factors that cause men to be unable to have a child: such as the quality of sperm is poor; or the sperm is not enough; or because of your age the sperm might not be strong. If the sperm count is over 35 million or even if it is borderline, we will try to make it active and strong anyhow. We have a technology, which is known as intrauterine insemination. We put your* virya *in a machine and throw away all the* kamjor *ones, select the good ones and insert them into the uterus through a small pipe."*

Pointing at a small generic anatomical drawing of the female reproductive system that was kept handy on the table for consultation, she continued,

> *"It normally deposits here* [pointing on the cervix] *but we take it up there* [top of the uterus]. *Instead of slowly climbing up from the cervix, it is easier and quicker for the sperm to just travel from here* [the top of the uterus] *to the [fallopian] tube. It is called IUI and it is quicker too. The chances of getting pregnant quickly goes up this way."*

Then she asked the man to give his semen sample for analysis if he had not had sexual contact for three days.

> *"If you have less/little* virya [low sperm count]*, then we will give you medicines. The treatment for a man is done after that. A woman requires a lot more tests/treatments,"*

said Dr. Reshma to the man.

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[78] Her words

Dr. Reshma then turned to the woman and started explaining her about the treatment. She pointed at the drawing of uterus, ovary, fallopian tube and described,

> *"When you menstruate, five or six eggs will increase in size and one among them breaks away*[79] *and comes out* [of the ovary] *to the fallopian tube; we call this process ovulation period. You must have* [sexual] *contact during that time."*

Continuing her briefing, the doctor explained to the woman,

> *"During the intercourse the semen gets deposited on the mouth of the uterus/cervix, after which the sperms enter the uterus and swim to the fallopian tube and penetrate the egg. The fertilization occurs once the egg is penetrated; then the two become one, which is called embryo. The embryo travels from the fallopian tube to the uterus, which has a layer where the embryo sticks/implants. After it sticks, you stop being* nachhune[80]*, which means you are pregnant. That is a normal cycle of pregnancy."*

Dr. Reshma further clarified to the couple that,

> *"Even though there might be sexual contact there might be no contact of sperm and egg inside for some reason."*

Hence, the term contact in the doctor's counselling carried a specific meaning, that is, a contact is considered only if the sperm penetrates the egg. She further explained,

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[79] They call it as *phutne* which can be translated in various ways: break, break away, rupture being the closest to ovulation

[80] A term that translates to "being untouchable." It is used to denote menstruation. A menstruating woman is considered to be impure and polluting for the first four days of their period. Therefore, she is not allowed to enter the kitchen and also does not perform household chores during these days. She sleeps on a separate bed from her husband and is also forbidden to touch any man who has already undergone the thread ritual (*bratabandha*), the ritual which makes him an adult male. I have described this in the second chapter. She becomes pure and clean again after bathing on the fourth day and performing certain purification rituals.

> *"In case there is no meeting of the sperm and egg, one of the eggs out of the five or six that grows big is released and the rest of them shrink. Simultaneously, as the eggs shrink, a thick layer is formed in the uterus until the eggs completely shrink to size zero. This layer takes fifteen days to form and fifteen days to shrink/come off. That makes a cycle of a month, which is called the normal cycle of menstruation."*

She added that there are three important factors that determine a successful conception:

> *"Wife's egg, husband's sperm, and the* [fallopian] *tube. Out of the three,"*

She argued,

> *"The most important is the fallopian tube because it is through this tube that the sperm travels to the egg, and embryo comes to the uterus after the fertilization occurs."*

Then Dr. Reshma explained the ways she examines the egg. The quality of egg is first determined by two methods: a) drawing the blood on the second or third day of menstruation to examine five hormones; b) conducting an ultrasound through

> *"the below* [vagina], *which is called transvaginal ultrasound." "If there are some* gadbadi [problems] *in the hormones, then they are treated accordingly. The low-quality eggs will rupture and turn into 'water-like bubbles.'*[81]*"*

She explained that the transvaginal ultrasound makes possible to view what cannot be seen from the normal ultrasound, which is conducted from the surface of the stomach.

> *"The fat in the stomach obscures the vision of the uterus when the ultrasound is externally conducted on the stomach,"*

she said and added,

[81] It is a term she used to describe cyst

> *"instead, we can easily see all the organs through this* [transvaginal] *ultrasound. We show the patients the right and left ovary and examine the uterus and measure the size of the egg and uterus."*

According to her,

> *"normally, there should be four to five eggs in the ovary but if there are more than twelve or fifteen eggs then it is called polycystic ovary. In such cases, all the eggs compete to grow and none of them will be of a good quality. One among them will rupture and come out, but instead of an egg, there will only be 'water'* [cyst]*."*

The doctor continued to explain,

> *"Now what will the sperm penetrate in that case? There is nothing for the sperm to penetrate, so the remaining eggs start to shrink. The shrunk egg will come out of the uterus and the menstruation cycle begins."*

Through the ultrasound, the doctor also examines if the uterus has required layers and if there are knots and tumors in the uterus. The fallopian tube is also examined to check if the passage is clear.

> *"The tube has to be open otherwise even if the quality of egg is good and the sperm is also strong, then the sperm cannot meet the egg. This leads to the shrinking of the egg and the menstruation cycle starts again. Therefore, we need all these three things to be functioning well,"*

said the doctor. The doctor ended the counselling by prescribing the man to give his semen for analysis and set a date for the follow up visit.

It is probably obvious by now that the entire counselling is heavily focused on the explanation of the processes of female reproduction where sperm only becomes a small part of the counselling narrative. Many feminist critics have pointed out that the women's body is the object of biomedical gaze (see for example, Thompson 2002; Laborie 2000; Greil et al. 2010; Rapp 1999, 2001; Culley et al. 2013) and it can be clearly discerned in the infertility clinic as well. Most of the treatments are conducted on the women's body; probes such as transvaginal ultrasound and HSG invade the intimate spaces of women's bodies

and the hormone pills intricately regulate and control how women's body acts and experiences the world. Men do not generally have to undergo similar kind of physical probing of their body[82]. In the IUI treatment, men do not have to undergo invasive surgical procedure and are thus spared the physical suffering that the women have to bear. However, this does not mean that they are spared from any suffering at all. Instead, as I mentioned above, I noticed that men also suffered in ways that were different from the women.

Nonetheless, I found this particular infertility clinic to be unique in the sense that the doctor allowed the men to observe their own sperm while she performed semen analysis. This perhaps was the doctors' way of making men feel comfortable and included in the treatment, which also helped them to gain the men's trust in their treatment. Once the consultation was over, men were asked to go to the lab on the other side of the consultation room for semen analysis. The clinic staff, in the lab handed men a plastic cup and directed them to the semen collection room. The men collected the semen in the container and

[82] Although there exist invasive surgical procedures like TESE and MESE that are performed in men who have obstructive azoospermia, but at the time of my study these technologies had recently entered in Nepal and were available only at a select few hospitals in Kathmandu. Dr. Sweta, who has been in the field of infertility treatment and reproductive endocrinology for more than 25 years, was critical of those services offered by those few hospitals. In her opinion, although the service is offered by the hospitals, it is still in its nascent phase and those centers have not successfully treated male infertility using the TESE and MESE procedures. Hence, she argued that it was unwise for her to refer her patients to those medical centers for the treatment.

There is some truth to Dr. Sweta's argument. Although there is a surge of infertility clinics in Kathmandu in the recent years, it is a very new development. Infertility treatments like IVF and ICSI require a high level of technical and medical expertise, and a lot of investment for the expensive medical and laboratory equipment, which not many doctors or clinics can afford. Thus, most of the infertility clinics and hospitals that offer infertility treatment use IUI as a treatment solution for male infertility which is much cheaper in comparison to other treatment options. Additionally, a prominent urologist and surgeon in Kathmandu told me that since andrology is a subfield of urology, urologists in Nepal can treat the cases of male infertility that can arise due various problems in the male reproductive organs. However, invasive treatments such as surgically correcting obstructive azoospermia or varicocele have a very low success rate according to him. Therefore, he argued that the uro-surgeons do not want to take the risk of performing such treatments that jeopardize their professional reputation. The men, thus, have no other choice than to resort to IUI treatment, which is ubiquitously offered in the infertility clinics.

submitted it in the lab. After about half an hour the semen was ready to be analysed. One day, Dr. Reshma took a male patient to the lab where she had a petri-dish with his sperm under a microscope. She also asked me to follow her. I asked the man if it was okay for him and when he nodded his head, I followed after him. As she had mentioned during the counselling session, the doctor called the man to the microscope and asked him to look at his sperm. She took a pen and made a sketch on a paper and said to him,

"Look for small thin object like the one I've drawn. You'll see a tail like this and it'll be running. Look!"

She turned to me and said,

"His count is not that bad; it is on the borderline."

The man looked into the microscope. The clinic staff who was next to him asked if he saw what he was instructed to see.

"Close an eye and you'll see better with only one eye,"

she guided.. The man's face looked curious and amused as he looked under the microscope.

"That thin…"

he uttered.

"Yes, that thin…like a fish, a fish that swims in the water,"

added the clinic staff.

"It looks like a leech to me,"

said the man. The clinic staff still insisted that it looked like fish:

"Fish, that swims in the water. It's just like that. This is a bit small and the fish is bigger…that's the only difference."

She further continued,

"Your count and motility are both…"

At this point, the man interrupted:

"I have heard that there is this thing called how many percent or something like that. Can I also see that?"

Dr. Reshma did not seem to hear that. She turned to me instead and asked me to have a look as well.

"You may need to adjust the focus,"

she advised. I obliged and approached the microscope on the table. That was the first time I had ever seen sperm therefore I had no idea what I was expecting to see. What I saw under the microscope looked very much like tadpoles swimming in a pool of water.

Like me, the men generally had no idea what they were supposed to look at. However, the doctor guided them to see a moving "fish-like" structure. The men were overwhelmed to see, for the first time, what constituted the most intimate bodily fluid that came out of them. However, the men also have their own imagination at play while trying to make sense of their sperm. For the man whom I discussed above, what he saw wasn't analogous to fish but leech. This is an instance where the doctor's description and the man's imagination came into clash; however, the clash got resolved through a common understanding of both of them that what matters is not what the sperms resemble but their number and volume[83]. That is when the man inquired about the count of his sperm and the doctor told him a number. Still, it is the doctor who interpreted what the number means and suggested that it is not bad. The same number also dictated her further course of action, viz., she should prescribe him some medicines that will boost his sperm count. Hence, sperm analysis presents a teamwork of the doctor, men, and technology that co-create male in/fertility in the clinic.

Nevertheless, there lies an asymmetry in this co-creation. Despite the doctor's guidance, not all men comprehend what they are shown under the microscope. A man once pointed at this discrepancy between the doctor's effort to make the semen analysis process more participatory, and what she called in counselling sessions her practice of being "transparent," and the men's expectations and comprehension.

> *"They take us in that room and tell us, 'look at* yours' [sperm under the microscope]*,"*

he said, and added,

> *"but we don't know what we just saw/looked at. Even an educated Nepali man pays 50 rupees extra and asks*

[83] It is important to note here that when it comes to semen analysis visuality is not as important as the number. This is in contrast to the other reproductive technologies such as ultrasound, which creates different sorts of realities and possibilities of actions by making the health and sex of the fetus visible.

someone to fill a form that costs only 5 rupees, you tell me how much would an average Nepali understand [about such technical details like sperm count]*?"*

This demonstrates a gap, or a cognitive dissonance, that exists in between the medical authority, the technical knowledge they hold, and the men to whom this knowledge is disseminated. Same was true when it came to men's comprehension of the doctor's counselling during the consultation. Many men did not fully grasp what the doctors had explained inside the consultation room. When I talked to them in the waiting room, it would be apparent to me that they were not clear about the difference between IUI and IVF.

4.4 Loss of control and negotiability during the consultation

Although the doctors are sensitive to the needs of their patients most of the time, which can be sensed during the consultation and counselling sessions, sometimes they appear to be a bit pushy and aggressive while prescribing their treatment. They tell the patients that their only quest is to make babies, either using the husband's sperm or a donor's sperm. In such a solely success driven approach of treatment, the doctors sometimes seemed to overlook at the sentiments of men and did not give them any space of negotiation about their treatment choice. During the first consultation, the patients who have visited doctors elsewhere before coming to this clinic are asked to show the prescriptions and reports of tests from those doctors. Nevertheless, the doctors in this clinic seldom accept the diagnosis and reports of other clinics on the ground that they cannot trust those reports. They make the patients do battery of tests in their own laboratory so that they can have reliable reports and make better diagnosis[84]. Sometimes, the patients tell the doctors about their diagnosis at the previous

[84] The doctors claim that the labs in Nepal are not standardized and therefore there is a lot of variation on the test reports based on the different parameters used in the measurements. Patients are skeptical about the doctor's explanation as they view it as the doctors' way of conning them to spend money in the latter's laboratory. If the clinics do not have their own laboratory, the doctors send the patients to some specific third party laboratories and might not accept the reports from any other laboratories. Patients are critical about this practice as they speculate that the doctors might receive certain percentage of commission as a reward from those labs for sending them patients. I have also found that it is not completely untrue as well.

doctor's clinic and argue that they do not want to repeat the tests. The doctors at this clinic would totally dismiss that and, in an authoritarian manner, question how the patients would be so certain. When the patients refer to their previous diagnostic reports, the doctors tell the patients that they do not believe somebody else's diagnosis and will therefore only make such claims after a fresh examination in their clinic again. The patients are left with no choice than to oblige to the authority of the doctors. For instance, during a consultation a woman said,

"I was told that I've a cervical cyst."

The doctor's reaction to that was,

"Huh? How do you know? You can't see it yourself."

At this point, the woman's husband pulled out the diagnostic report from the other clinic and said,

"well, it is this…when she had UTI…"

The wife interjected him,

"when I'd UTI, the cervical cyst was seen in the x-ray."

That did not make any difference to the doctor as she only said,

"we'll investigate. I told you we check every little detail."

Although the doctor was saying that as a way of reassuring the couple, they later told me that they felt like the doctor was not interested to hear their part of the story but was only concerned to start the treatment right away without fully giving them any space to negotiate and participate in the decision making process of their treatment. I also observed similar authoritative interactions many other times as well.

4.5 Experiencing emasculation, humiliation, and vulnerability in the clinic

Usually men accompany their wives during the first few visits. They are asked to do semen analysis and those who are diagnosed as having no sperm are asked to give their consent for the use of donor sperm for IUI to be performed on their wives. After that, it is the wives who come for several follow up appointments to prepare them for the IUI. During these visits the women either come alone or are usually accompanied by other female member of the family.

As can be seen from the section on counselling above, if the semen analysis shows below the "borderline" sperm count and motility, men are given medicines to boost their sperm count. Second semen analysis is conducted after a few months. If there is a significant increase in the count by then, the husband is deemed fit to give sperm for IUI. But if the count fails to increase, the doctors discreetly push for the option of using donor sperm. Therefore, there is not much of a choice for the men, who have come thus far in their treatment and who thus are desperate for a child, to opt out of the treatment. They feel coerced by the doctors who leave them with no room for negotiation, which was especially true with the men who were diagnosed to have no viable sperm in their semen.

I observed one such case once. A couple who had been married for 5 years came to the clinic one day. They were in their late twenties. The man, Pawan, was a police officer in the Armed Police Force[85]. It was the couple's first visit to this clinic. They had been trying to have a child for 3 years. As part of the routine of the treatment, Dr. Reshma prescribed the man to collect semen for analysis. The semen analysis report showed that Pawan did not have any sperm, and hence he was diagnosed as having azoospermia, or *kamjori* in common parlance. The doctor told the couple that the only treatment choice available to them was to perform IUI using donor sperm. The wife consented easily to that while the husband was clearly reluctant. It was obvious from his facial gesture that he was humiliated to further discuss his condition with the doctor. He was shocked to hear about his inability to procreate and therefore did not speak much after that. Dr. Reshma told him that he and his wife will need to provide their thumb prints and signatures as a consent from them for the use of donor sperm to continue the treatment on his wife, which she just took for granted that the couple would consent without any reluctance. Pawan was very hesitant. He asked the doctor, in a shaky voice, to reconfirm,

"Is it impossible for me to father a child at all?"

Dr. Reshma told him bluntly,

"You cannot father a child at all."

From the expression in his face, I could gauge that he was very much in pain and confusion. Dr. Reshma pressed him further to give his consent for the use of

[85] An institution of national security that is a hybrid of army and police

donor sperm to start the treatment on his wife. He seemed very perplexed. He told the doctor that he must discuss the matter with his wife, who was sitting next to him—equally silent and perplexed, before he would consent.

At this point, the doctor started to get annoyed. She raised her voice and said,

> *"What's there to decide now? You will never be able to father a child through your own sperm."*

Then she started consoling him by saying that conceiving via donor sperm is not a matter to worry about. She compared the use of donor sperm to the use of donor blood and argued that sperm is also just a bodily substance like blood.

> *"Think of it this way: don't you easily consent to receive donor blood if you have an accident and desperately need blood to survive? This issue is also similar,"*

said the doctor.

Instead, the doctor urged Pawan to be happy that there was no problem in his wife's body. She reminded him that many women suffer from condition like polycystic ovarian syndrome (PCOS) that makes it very difficult for them to conceive.

> *"In any case,"*

Dr. Reshma told him,

> *"your wife has to get an injection so that we can start the IUI procedure from today and not lose any time."*

The injection is usually given to increase the ovum size and induce ovulation. Since the wife was in her ovulation phase, the doctor wanted to start the IUI procedure right away. Otherwise, she would have to wait until another ovulation phase in the next month; the doctor did not want to lose any time. Pawan said he needs some time to think about that carefully, to which the doctor exclaimed,

> *"What's there to think about?"*

She looked at me and, with a smirk, said,

> *"Oh, look he does not want to* [go for donor sperm]*."*

Pawan's face turned red; he was visibly ashamed and hesitant. After seeing his reaction, Dr. Reshma softened her tone and tried to console him some more:

> *"I understand. Think over it."*

Immediately, without any pause, she added,

"But she has to get the injection today and you should both come to sign the consent form tomorrow."

The couple left the consultation room quite perplexed. The doctor clearly was not happy about Pawan's denial and told the few of us in the room that he will eventually return as he had no other choice. Maybe Dr. Reshma's nonchalance toward Pawan was a result of her long experience with such cases, but I could not stop feeling bad for him.

After about 5 minutes, the wife entered the consultation room alone. She told the doctor that she does not want to take the injection and hence would not proceed further with the treatment plan. She said,

"He has refused to continue the treatment using someone else's sperm, so there is no point for me to take the injection."

She also told that her husband forbade her to take the injection and carry on with the further treatment. She started crying profusely and could not talk. Dr. Reshma tried to console her and told her that it is normal to use donor sperm if a man cannot provide his own sperm. The woman told Dr. Reshma that her husband had not expected this and therefore he is not ready for the option of using donor sperm. The doctor gave in and cancelled all the prescribed plans but asked her to at least take folic acid and come next month on the second day of her period.

"Start convincing your husband until that time,"

she told her. The woman said she will try and left the room.

The doctor then started telling those of us in the room that she was upset that the woman did not start her IUI procedure.

"The woman is not to be blamed,"

she told us and said,

"It is the husbands like him who are the cause of women's suffering."

Sunita entered the room from the reception area and told the group:

"I met the husband on my way back here. I told him clearly 'your wife wants a child very much. So if you do give your consent for the use of donor sperm she will leave you'."

This is a good example of how men are disempowered and emasculated in the infertility clinic. The doctors usually do not give them time to come to terms with

their condition; instead, the men are coerced into making choices that they might personally not prefer or endorse.

The way doctors dealt with men with azoospermia might be considered exceptional whereby the doctors also do not have any other solution than to convince the men anyhow to give their consent for the use of donor sperm. But I noticed a similar attitude of the doctor even toward other men who were not diagnosed with azoospermia. Once a man came to the clinic for consultation. He had only come to gather some basic information about the treatment procedure that day and had not come prepared for any kind of medical check-up. After asking few questions, the doctor told the man to give his semen for analysis before he left and bring his wife the next day for the check-up. When he told her that he needed some time to think about it, the doctor's response was,

> *"What's there to think about? Conduct your test first. Why do you hesitate to conduct just one test while your wife has to undergo so many tests?"*

The man became nervous as he was not expecting such remarks from the doctor. The doctor later justified her response and told me that she had to be firm with some men because they hesitate to accept that the problem might lie with them instead of their wife. Although the doctor might have good intentions behind her stern interactions with the men, the men felt threatened because of the doctor's aggressive behavior towards them and also for being at loss of control of their life situation. For most men, what they experienced in the clinic is a reversal of what they usually experience in other domains of their social life such as work space and home where they are in control of their situation and are in the decision making empowered position.

Moreover, as I mentioned above, the clinic space itself became a cause of distress for some men. There are few studies on the use of public spaces such as streets and public transport in Kathmandu (Poudel 2011; Poudel, R. 2012) which found that these public spaces are heavily men dominated and hence women felt uncomfortable being in such masculine spaces. Contrastingly, I found that there are more women in the clinic than men at any given time. This could be due to the fact that women are repeatedly called for follow up treatments while their husbands do not necessarily have to be present at those times. The few men who accompanied their wives would either silently sit beside their wives in the

waiting room, read the newspapers and magazines kept on the table or play games in their mobile phones. When I managed to break their silence, some of them would reveal that they were feeling uneasy in the waiting room. For instance, one day I met Ravi who told me that in many of his previous visits he would always leave his wife at the clinic's entrance and go to work while she went in to see the doctors. He had not entered the clinic until the day I met him. The reason behind his reluctance to enter the clinic was that the waiting area of the clinic was always filled with women, which made him feel awkward and uncomfortable.

> *"Being a minority among the women in the waiting rooms,"*

he told me,

> *"I felt like I was being exposed."*

Such accounts of men's vulnerability, feeling of humiliation, and perceived threat to masculinity was also apparent at other times in the clinic, especially during the time of semen collection for analysis. I will discuss that in the following section.

4.6 Men's complaints about the semen collection in the clinic

In the Kathmandu Infertility Clinic, men collected semen for analysis in a small room in the clinic; the room was rather a small enclosure made of thin plywood inside the room used for cleaning clinic's treatment equipment such as syringe, gloves etc. The clinic staff frequently used this cleaning area even while the men were inside the semen collection area. Hence, many men complained to me that they could hear all the activities outside while they were collecting semen inside; they told me that this made them very uncomfortable and created tremendous pressure to successfully perform, i.e., have an erection and ejaculate, within a stipulated time.

Some men shared their bitter experience of semen collection to me. Prem, whose narrative I presented in the previous chapter, was not happy that the clinic does not provide a comfortable environment for men to collect their semen. With a clear frustration in his voice, he said,

> *"They treat us like animals. How can we do it* [collect semen sample through masturbation] *when there is not*

enough privacy and the right environment? At least, keep some magazines for us. Don't they know that we need to feel in order to come to emotion?"

A few months back, two other men I met in the clinic had also complained to me about the lack of privacy and conducive environment for the semen collection in the clinic. A man had complained to me that the staff would come and bang at the door and shout *"are you done yet?"* from outside while he was collecting semen inside the semen collection room, giving him little privacy and time. Likewise, Nabin had an excruciatingly humiliating experience in the clinic's environment. He expressed that he felt ashamed when he had to pass the women in the waiting area to go to the semen collection room for semen collection. He felt their penetrating gaze on him, which made him nervous and shy. He said,

"All the women who come to the clinic are adult and have experienced sex, so they know right away why men are entering the semen collection room immediately after the consultation. It feels very awkward and shameful to walk past them. There is no privacy; it feels like I am in the middle of an open bazaar where everyone is watching me while I am collecting semen."

The situation in the Bharatpur Fertility Center was not any better either. There is no separate semen collection room in this clinic; so men are asked to collect semen in one of the two toilets there. The same toilets are also used by everyone else as well, which sometimes created some awkward moments. One day I met Bishal, a 29-year-old man from nearby town, in the clinic. He had already visited Dr. Shristi, who was coming to the clinic from Kathmandu that day, in Om Hospital in Kathmandu and had already given semen for analysis once before there. Since a few months had passed since then, he was asked to give his semen for analysis this time as well. He went to the lab, obtained a sterile container from the lab technician for the semen collection and went into the toilet that lies adjacent to the consultation room. There were a group of women and men outside the consultation room waiting for their turn to see the doctor. Some of them were talking among themselves. I met Bishal's wife there and started talking to her. At times, someone would pass by us and go to the toilet. They

would pull the handle of the toilet's door and try to open it. Within ten minutes, I noticed three men turn back after finding the toilet was occupied. If Bishal's wife noticed people going towards the toilet, she would loudly tell them that the toilet was being used.

All that time, I was thinking what must be Bishal going through inside the toilet. There he was, trying to collect his semen while being disturbed by other patients who came to use the toilet! He came out of the toilet 15 minutes later. He looked totally flustered and stressed. He had washed his face and the water was dripping from the face to his shirt. He did not speak to anyone, passed by his wife and me, and went to the pharmacy outside the clinic. He walked past me with a blank expression on his face while I continued to talk to his wife and others who were in the waiting area.

After about five minutes, his wife paused our conversation and loudly alerted a man, who was walking towards the other toilet located at the backside of the building, that the toilet was occupied. Only then I found out that Bishal was inside the other toilet. I had not noticed him going into that toilet. He came out after another 10 minutes. This time he was very happy and there was an expression of accomplishment on his face. He entered the lab and after 5 minutes, came to talk to me. He told me he was finally able to collect semen. However, it was not an easy feat, as can be discerned from what he told me:

> *"I was so distressed in the first toilet* [the one next to the consultation room] *and could not get an erection at all. I was hearing everyone talk outside. Then periodically, someone would try to open the door. How can I come into emotion*[86] *required for such an act* [of masturbation] *in that environment?"*

This reminded me of the men in the clinic in Kathmandu who had expressed similar experience while collecting semen in the clinic's semen collection room.

Bishal eventually could have an erection and the *"intense emotion"*[87] after he changed the bathroom where he was able to get some sense of privacy and security.

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[86] His word
[87] His word

> *"Going to that other bathroom was much better than here* [pointing to the bathroom adjacent to the consultation room]. *I could not hear anyone talking immediately outside the toilet and that made me feel I would not be disturbed by the people wanting to use the toilet,"*

said he. He knew that the patients would use the toilet that was adjacent to the consultation room because it was near to the waiting area and hence convenient. That is why Bishal could feel he had some privacy in the other toilet. He confided to me that although it was quite a struggle to have an erection and *emotion*[88], at the end, he was able to have *strong emotion*[89] and could fill up the container they gave him.

> *"The container was nearly full. I am very confident that this time my count will be high,"*

he boasted. He appeared animated and enthusiastic.

These examples from the two clinics give a glimpse of the distresses that men undergo in the clinic space during the semen collection process. The common anxieties expressed by the men in both the clinics was that the clinic's environment was not conducive for semen collection as there was no privacy for them, which made them feel exposed and vulnerable. This was a humiliating experience for these men who until that point had taken for granted that the intimate acts like sexual intercourse and ejaculation was a private matter, and thus, to be protected from public scrutiny. The clinic in Bharatpur has tried to partly address this by allowing men who live close to the clinic to collect semen at home and bring it to the clinic. However, it was not a feasible option for all men as they had to travel from afar and could not therefore bring the semen within thirty minutes after collection. Thirty minutes is the standard time in which semen undergoes liquefaction, hence freeing the sperms to swim to the egg. After a short while, the sperms will gradually start to die; thus, in order to obtain an accurate reading, semen analysis should be conducted immediately after the liquefaction occurs. Therefore, majority of men opted to collect semen in the clinic. Moreover, the doctor and the lab technician also encouraged the

[88] A word he used to describe arousal
[89] His word

men to collect semen in the clinic's toilet because the lab technician could examine the freshly collected semen right away and hence that would minimize any potential errors in handling and analyzing the semen.

There are few studies that focus on the way childless men elsewhere outside Nepal are dealt in a clinical setting. In the study from Canada, Guay investigates the ways masculinity is constructed in two different contexts: a) sperm banking and fertile men; and b) an andrology clinic and infertile men (2000: 43). Guay found that although sperm donors are considered to be hyper-masculine, potent, and hyper-fertile for the excess of sperm they can dispense with, they are considered to be lesser men by the sperm bank staff because of their lack of control of their own sexual activities; the sexual activities of those men are governed by the strict regimen of the sperm banks. On the contrary, the infertile men visiting the andrology clinic were self-empowered by the doctors who boosted their clients' masculinity by focusing on testicular health, capacity to produce sperm, and sexual potency rather than the condition of their infertility (Guay 2000: 190-192). Another way to self-empower such men was to "tell them that they too can produce spermatozoa, and it takes only one to become a father" (Guay 2000: 202). Hence, Guay argues that "[…] fertility, sexuality, potency, and masculinity are all conflated" in the Euro-American societies (2000: 205).

Barnes (2011) also found a similar connection between infertility and masculinity in her studies of childless men in the US. Building on the "doing gender" concept of West and Zimmerman—the concept of gender that these authors define as "something one does, and does recurrently, in interaction with others" (1987:140), Ridgeway and Correll (2004) developed "gender system" model to describe how gender constructing processes occur. Gender, according to Ridgeway and Correll, "[…] is an institutionalized system of social practices for constituting people as two significantly different categories, men and women, and organizing social relations of inequality on the basis of that difference" (2004: 511). There are three levels to the gender system: a) at a macro-level, gender involves cultural beliefs and the distribution of resources; b) at the interactional level, it involves "patterns of behaviors and organizational practices"; and c) at the individual level, selves and identities are formed (Ridgeway and Correll 2004: 511). This gender system is sustained by the hegemonic cultural beliefs about gender and the "social relational contexts." Gender beliefs, for Ridgeway

and Correll, are basically stereotypes and preconceived notions of a particular gender. Likewise, they define social relational contexts as the situations in which people interact with others and define themselves in relation to others to understand their actions and the situation they are in (Ridgeway and Correll 2004: 511). There is a constant interplay between the three levels that result in the construction and perpetuation of the hegemonic gender beliefs.

Basing her studies on the gender system model, Barnes illustrates how processes of constructing gender and disease (here male infertility) occur simultaneously and are also enmeshed with each other; i.e., disease-construction process also occurs at three levels—culture, institutions, and individuals (Barnes 2011: 21). For instance, the treatment of male infertility, and how it is constructed by the medical institutions, are informed by the gender beliefs—the stereotypical assumptions, which in turn affects how patients and doctors interact and deal with each other. Some of the prevailing gender beliefs about men and reproduction that inform how male infertility is constructed by the medical institution, and in turn how that affects the men dealing with infertility, are: "[…] men are supposed to be effective, in control, and highly motivated sexual creatures…masculinity is proven through a man's ability to impregnate a woman" (Barnes 2011: 144). These beliefs then serve as the basis for further beliefs about masculinity: "men enjoy masturbation any time, men like to hear they have large genitals, sperm counts are a measure of masculinity, and infertility must be humiliating for men" (Barnes 2011: 144). These beliefs are played out in the medical setting where, like Guay (2000), Barnes also found that the doctors use mechanical metaphors about cars and planes like fuel, engine, exhaust etc. to explain male infertility to their patients in order to empower them and prevent feelings of emasculation (2011: 139).

Like in Guay's study, I also found that virility and masculinity are conflated in Nepali context as well in the sense that the men with low sperm count labeled themselves as the ones having *kamjori*, or weakness, and therefore higher sperm count was considered desirable by the doctors and men both. However, as discussed above, the doctors in the infertility clinic did not boost their male patient's masculinity like the doctors in the andrology clinic in Canada did; instead, they undermined the men's pride, and in turn masculinity at large, through means like scolding if the men hesitated to give semen sample for

analysis or shaming the men if they refused to give their consent for the use of donor sperm. This was further aided by the failure of the clinic to cater to men's need of a separate private room for semen collection where men felt safe, comfortable, and in control of their own sexual activity.

Although my findings do not completely match with that of Barnes', the way doctors dealt with men in the infertility clinic in Kathmandu can also be understood through the gender system model. In contrasting to Barnes' findings, I found that the doctors in the infertility clinic in Kathmandu did not use masculine metaphors to empower men and boost their masculinity. Instead, as I mentioned above, they humiliated and repudiated men frequently, whereby the men felt threatened and emasculated instead. I believe what is at play here is the stereotypes and preconceived notions of men that the doctors carry and enact while dealing with men. Some of the common stereotypical gender beliefs held by doctors are: men do not accept that they might be the cause of childlessness; they are non-compliant when it comes to treatment; instead, they blame their wives for the reproductive failure and therefore will marry again for children.

In the sections below, I will describe how *kamjori* is enacted in the clinic's laboratory.

4.7 Semen analysis in the clinic

In the laboratory, masculinity is enacted in numbers and through the parameters set in the semen analysis report generated by the clinic. Since *virya* signifies virility and strength, higher the number of sperm, the stronger and virile a man is considered. At least that is the message men get in the clinic. Although the doctors tell men that only one sperm is needed for fertilization, they also prescribe medicines to increase the sperm count if the count is below a set standard; they tell the men:

"So as to increase the chance of fertilization."

Although there might be several factors that determine male childlessness, in the biomedical narrative of reproductive health, semen quality serves as a "[…] surrogate measure of male fecundity" (Cooper et al. 2010: 231). During the consultation, the doctor asked the men to give semen for analysis if they have not had sexual intercourse in the past three days. The staff in the lab handed them a

sterile container for the semen collection and directed them to the semen collection room or toilet. From the point when men collect the semen and hand it to the lab technician, men, in their flesh and blood, disappear but are enacted in their semen and its analysis; the enactment that is made possible by the technologies like microscope and counting chamber, biomedical discourse, medical expertise of the lab technicians, and the doctor's interpretation of the report.

One day, Samjhana, the lab technician in the Bharatpur Fertility Center, illustrated the procedure of semen analysis to me. She described that the semen is a phlegm-like substance that is constituted of protein and sugar beside the sperms. Those protein and sugar bind the sperms in the phlegm-like matrix. The semen undergoes liquefaction, freeing the sperms for them to be able to swim to the fallopian tube for the fertilization of the egg. As mentioned above, generally, the liquefaction process takes place within 30 to 60 minutes after the semen is collected (or deposited into the vagina/cervix during the sexual intercourse). The analysis can only be conducted after the liquefaction of semen.

Once the liquefaction is completed, a drop of the semen is drawn using a plastic dropper and put on a clean slide for the observation under a microscope.

> *"It has to be a nice round drop, otherwise the readings are affected,"*

said Samjhana. She told me *"a nice round drop"* is 20 microliters. But she told me in some labs, they consider a drop to be 50 microliters. I was dismayed about the variation in the drop size according to the labs. That could be the reason for differences in what is considered a "normal" or "average" count by different labs. I asked her,

> *"What if the drop does not contain 20 microliters and would not that affect the total count? Why not use the pipette instead to have an accurate sense of the count?"*

She told me,

> *"The pipette can also be used but I do this analysis so routinely that I can just gauge the volume from the dropper itself."*

The drop on the slide is covered by a plastic slip to fix the specimen and the slide prepared thus is put under a microscope. The area that is directly observed under

the microscope is called a field of vision. Count is performed on a few of such fields of vision and an average of those counts give the final total sperm count that is reported to the patients. The counting is done manually by the lab technicians. Since they have mastered the art of semen analysis through routine, they can just look at the fields and, after only a few seconds, can come up with a number. The number is scaled to be reported in millions per milliliter scale. Motility rate, volume, morphology, and number of dead sperms, the color of the semen, viscosity, and pH are noted.

I was a little concerned about the potential of error in the count if the analysis was conducted in a fashion Samjhana explained to me, which involved a lot of estimations (the nice round drop is 20 microliters, the number of sperms per field etc.). That would also mean that the reports from different labs would vary as the lab technicians in different labs could use their own estimation while counting. Samjhana did not deny the potential of such error but told me that the difference margin of 10-15 million per milliliter does not make much difference in the treatment outcome or doctors' diagnosis.

> *"It does not matter much whether a person has a count of 80 million or 90 million. Both are high counts. We only need to be alarmed if the counts are exceptionally lower than our set standard of what is normal* [50-160 million per milliliter]*"*

she clarified.

I thought about Bishal's excitement when he found the count of his sperm increased from 55 million per mL to 95 million per mL and the motility rate of his sperm was 75%. Not everyone might have the similar big jump in their count but an increase in 10 or 15 million per mL also is perceived differently by the men. Although their count might fall in the range set by the clinic as normal (50-160 million per mL), the men know that having a 90 million per mL and 50 million per mL is not the same. The number has a performative function where the men clearly perceive and act differently when they find their count is 90 million per mL as opposed to 80 million per mL. What could be deemed a high count, and thus not a matter of worry, by the lab technician's standards, the men would still see the difference of 10 million per mL as significantly high.

If there are some doubts about the count, for example, in cases where the count turns out to be exceptionally low, Samjhana uses another method of counting. She uses a counting chamber, like the one below, and a mathematical formula to calculate the number of sperms per milliliter that produces more or less an accurate result according to her. A counting chamber is a glass slide with pre-prepared grids on it. The sperm is drawn by a pipette and is put on a chamber grid. The grid has a certain depth to hold the sperm in the chamber. The sperm is diluted with a fluid for a better reading. A coverslip is tightly placed on the chamber to ensure that the sperm is sealed. Then the chamber is placed under a microscope for the count. Samjhana counts the sperm that are located on the four corners of a grid and uses a formula to calculate the final volume in millions per milliliter. The number of sperm count is multiplied by the depth factor of the chamber and dilution factor of the sperm; the result is then divided by the number of corners where the sperm was counted[90]. Since the dilution fluid kills the sperm, only the volume can be determined using this method. A separate analysis should be conducted to determine the motility percentage. Hence, in a clinical setting, the lab technicians generally do not prefer to use the counting chamber as they have to conduct two separate analyses for a given sample; this adds to the cost of the procedure and time of the technician.

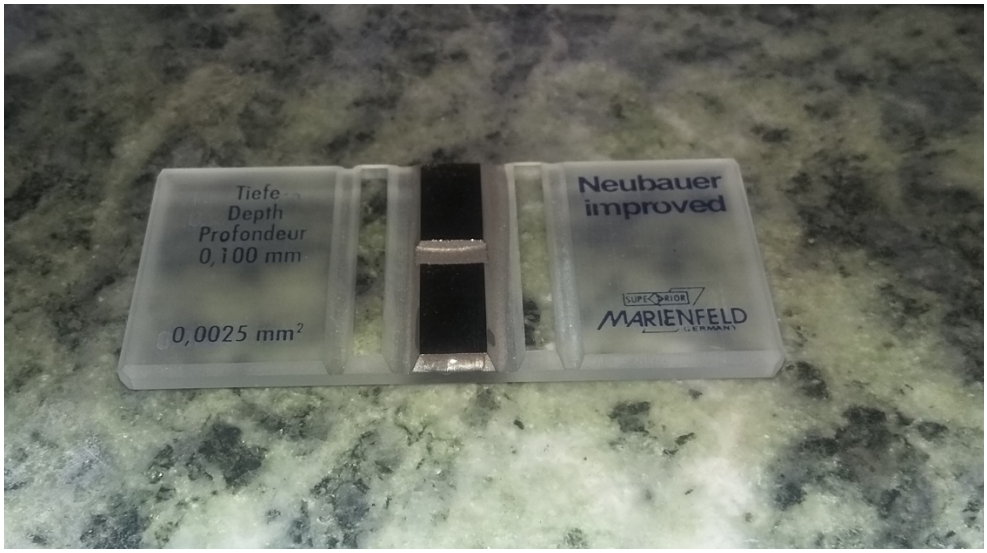


Figure 2: Counting chamber

[90]I have described how Samjhana had explained the method she uses and her understanding of the semen analysis. For technical details see *ESHRE Monographs: Manual on Basic Semen Analysis, 5-9, 2002.*

Wanting to understand the process, I asked Samjhana if I could also look under the microscope and count the sperms. She consented easily and guided me through the counting process and instructed thus:

> *"What you see is a field; count how many sperms there are in that first field. Move the slide to another corner and that is the second field; count the sperms you see there. Likewise, change the field few more times and count. The average of those counts is the final volume. While you count, also notice the movement and the morphology of the sperms; are they moving rapidly? Are they moving on a straight line? Are they sluggish? Do they have a long single tail or do they have double tails? Are their heads pointed or stunted? How many heads are there? Do they have a uniform size or are some exceptionally larger than the rest? How many are dead? Are there any pus cells in the mix? Those are the things you need to examine."*

I was overwhelmed by the number of parameters that had to be considered. I looked under the microscope and tried to count the sperms in the field. After failing to count fast enough, I gave up after a few seconds. Although I had observed the sperm under the microscope once before in Dr. Sweta's clinic in Kathmandu, I did not have an opportunity to understand the actual process of analysis. This was a thrilling moment for me; an entirely new world opened up to me, which would not have been possible without the guidance of the lab technician.

Nonetheless, I felt exhilarated as I was watching the sperms moving under the microscope. There probably were about 80 sperms in the field. There was a world of its own in the field; the crowd of sperms had their own movement patterns: some were going in a random direction; some were moving in a trajectory; some were not moving at all; some were merely vibrating sideways; some were racing straight up; some were only wagging their tails without going anywhere; some were moving so fast as if they were in a rush to reach somewhere; some had longer tail than the others; some had two heads; some had truncated tails; some did not have tails at all; some were symmetrically beautiful;

some looked confused and lost. Only one among them is needed for fertilization I realized; but still higher their volume and number the better. At least that is what the men are told in the consultation room by the doctors. However, the men with low sperm counts are not discouraged either; they are prescribed medicine and told that their count will improve and only one sperm is needed to make/father a child. Instilling such hope is also a routine part of the clinical consultation.

Here, it is important to discuss the significance of the world of sperm I saw under the microscope in relation to masculinity and the social world it inhabits. Besides being the bodily fluid and male gamete, semen and sperm have been described symbolically as a kinship generating substance (Douglas 2010; Mohr and Hoeyer 2018). Moreover, scholars have also found that their representation in the scientific works and medical textbooks in the US is informed by the gender stereotypes of male and female roles whereby sperm is considered to be active, penetrating agent as opposed to the passive egg waiting to be penetrated (Martin 1991; Metoyer and Rust 2011). Moore found that the current understanding of sperm being in competition with each other to reach and fertilize egg is faulty at best; according to her, this theory was derived from the studies on nonhuman animals but it has been extrapolated to humans (2002: 105). As described above, this image of sperm has been taken up by the scientific community as well as.

Moore further argues that there is a scientific drive to study sperm and categorize them into good and bad using masculine and feminine terms. According to her, these scientific studies,

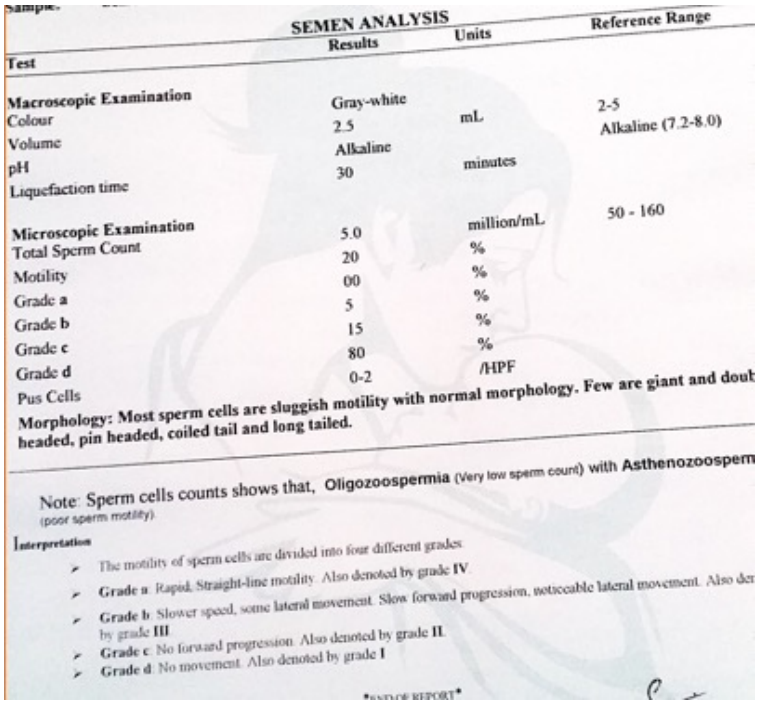
> [strive] to quantify the potent/healthful and weak/dangerous qualities of sperm. These scientific metrics, laden with unscientific qualitative subtext, assist in the social construction of sperm as "good guys" and "bad guys." That is, sperm is transformed through analogies into powerful heroes and evil villains or degraded through the use of feminized adjectives and adverbs. (2002: 92)

Thus, scientifically, sperm is measured and evaluated through their motility and morphology; this information is then used to construct "pathologies of sperm," according to Moore, who also argues that "knowing, naming, and diagnosing semen's pathological forms is produced in interaction with existing

beliefs about "pathological" men" (2002: 99). In such beliefs about men, the "lack of fertility" is assumed to be "the threat to masculinity" (Moore 2002: 99).

4.7.1 Semen analysis report

Semen quality is analyzed through parameters like semen volume, sperm morphology, sperm motility, and sperm count, latter three of which are conducted using a microscope in a laboratory. In this biomedical narrative, the defects in sperm constitute male infertility, and in the context of Nepal, it marks men as having *kamjori*. The sperm defects are grouped into four different major categories: a) oligospermia, or low sperm count; b) asthenozoospermia, or decreased sperm motility; c) teratozoospermia, or abnormality of sperm morphology; and d) azoospermia, or zero sperm in the ejaculate. Azoospermia can be of two types: i) obstructive, in which the transport of sperm is blocked; and ii) non-obstructive, a condition in which sperm is not produced at all (Inhorn 2012: 54). Below is the sample of a report:



SEMEN ANALYSIS

Test	Results	Units	Reference Range
Macroscopic Examination			
Colour	Gray-white		
Volume	2.5	mL	2-5
pH	Alkaline		Alkaline (7.2-8.0)
Liquefaction time	30	minutes	
Microscopic Examination			
Total Sperm Count	5.0	million/mL	50 - 160
Motility	20	%	
Grade a	00	%	
Grade b	5	%	
Grade c	15	%	
Grade d	80	%	
Pus Cells	0-2	/HPF	

Morphology: Most sperm cells are sluggish motility with normal morphology. Few are giant and doub headed, pin headed, coiled tail and long tailed.

Note: Sperm cells counts shows that, **Oligozoospermia** (Very low sperm count) with **Asthenozoospem** (poor sperm motility)

Interpretation

- The motility of sperm cells are divided into four different grades
- **Grade a**: Rapid, Straight-line motility. Also denoted by grade IV
- **Grade b**: Slower speed, some lateral movement. Slow forward progression, noticeable lateral movement. Also den by grade III
- **Grade c**: No forward progression. Also denoted by grade II
- **Grade d**: No movement. Also denoted by grade I

Figure 3: Semen analysis report

The final report of the semen analysis is printed on a page with all the parameters defined and is handed to the patient. As can be seen in the sample above, the analysis is divided into two parts under the headings "Macroscopic Examination" and "Microscopic Examination." Under the former, the color,

volume (in mL), pH, and liquefaction time (in minutes) is reported. The range used as "reference" is also reported on a column next to the results. The range for volume is 2-5 mL for this clinic. Likewise, alkalinity range (reported in pH value) is 7.2 to 8.0. Any deviation in the ranges is considered problematic. Longer liquefaction time (beyond 30-60 minutes) is also deemed alarming. Similarly, under the "Microscopic Examination," the total sperm count (in million per mL) and motility percentage is reported with a breakdown of different kinds of motility, which is graded in four categories. The range for the total sperm count is 50-160 million per milliliter. This contrasts with the infertility clinic in Kathmandu. Dr. Sweta's clinic considers 60 million per milliliter to be an average sperm count, below which requires medication.

Likewise, the graded categories of the motility are described in the index at the bottom of the report of this clinic: "Grade a: Rapid, Straight-line motility. Also denoted by grade IV"; "Grade b: Slower speed, some lateral movement. Slow forward progression, noticeable lateral movement. Also denoted by grade III"; "Grade c: No forward progression. Also denoted by grade II"; "Graded: No movement. Also denoted by grade I." I did not notice such breakdown of motility into various categories in the clinic in Kathmandu. In addition, the presence (or absence) of pus cells is also reported. The high level of pus cell indicates infection. The morphology of the sperms is also noted. For example, a person's sperm morphology is reported as, "most sperm cells are sluggish motility with normal morphology. Few are giant and double headed, pin headed, coiled tail [sic.] and long tailed." Then a final concluding note is inserted as, for example, "Oligozoospermia (Very low sperm count) with Asthenozoospermia (poor sperm motility)."

The patients collect the report from the lab technician who conducted the analysis. However, the lab technician does not interpret the data for them though the patients casually ask how good (or bad) their report is. Sometimes the patients do not get to consult the doctor immediately after receiving the report because the doctors might not be around; therefore, they have to wait for a few days before they see the doctor who interprets the semen analysis report for them. By then, most of the patients I met, like Bishal, read their report and formed an opinion about their health condition and themselves at large. As I discussed above, for these patients, numbers in the report spoke volumes and determined their self-

esteem and performance around other patients in the clinic. For instance, Bishal was really distressed throughout the time he was in the clinic and expressed his anxiety to other male patients but when he received his semen analysis report by the end of the day, he became super excited and went around boasting to others about his high sperm count—the number he read in his report.

However, the patients should be cautioned about the way they understand the report. It is important for them to know that the total sperm count, though it indicates volume, does not denote how many sperm among them are viable and motile. As discussed above, the motility is reported in percentage. I noticed that usually the patients, and even the doctors, only read the total motility percentage and do not carefully read the breakdown of that percentage into various grades that is reported immediately below the total percentage. A high percentage is what is preferred but if a significant portion of the motile sperms fall into grade c or d mentioned above, then the total higher percentage does not mean much. This gets lost in translation when the patients only read the total motility percentage and form an opinion about their report. Even the doctors do not fully interpret the report for the patients, who get told in simple terms that their sperm count is either good or low. In the latter case, the doctors simply tell the patients that they should take the medicine for a few months. The men are henceforth marked as having a defect, or *kamjori*, in them. Most men I met did not hesitate to share that they have a "little *kamjori*" but were clearly hesitant to reveal the sperm count[91].

Semen analysis has become a routine part of clinical test in the infertility clinics. As discussed above, it is done by testing the quality of semen. In the context of infertility clinic, semen quality means "a measurement of the ability of sperm cells to fertilize an egg cell" (Mohr and Hoeyer 2018: 14), which is done by quantifying various parameters depicted in the analysis report above. The semen quality is not only a measure of the ability of a sperm cell to fertilize an egg cell but, according to Mohr and Hoeyer, it also is connected to "our understanding of the role of men, both within reproduction and more generally as

[91] Hence unless the men (like Bishal) willingly revealed their sperm count number, I could not differentiate between the men who had no sperm count at all and those who had low sperm count, both of which are termed as *kamjori*. For the obvious ethical reasons, I did not probe men to reveal their sperm count to me unless they voluntarily shared that with me.

part of a heteronormative society" (2018: 14). Hence, for the men, the poor quality of semen is "connected to being seen—and understanding oneself—as a man of lesser quality" (Mohr and Hoeyer 2018: 14; Goldberg 2010; Birenbaum-Carmeli and Inhorn 2009).

Interestingly, Mohr and Hoeyer argue that such scientific measurement of semen quality does not involve objective measures but also subjective judgement. Therefore, it is difficult to conduct precise measurements of semen quality as the variables are not stable and differ over time and contexts like environment and lifestyle (Mohr and Hoeyer 2018: 15). Moreover, these parameters need to be interpreted for them to make sense. Even the measurements involve a lot of approximations as I have demonstrated above. Thus, Mohr and Hoeyer argue that the objective measurement of semen quality "can never fully do away with the fact that measurements embody norms, and that the semen samples which are measured are influenced by subjective circumstances such as sexual arousal" (2018: 15). Yet, such interpretations of the numbers derived from approximations have performative function as I have demonstrated in the case of Bishal. The men who are deemed to have less sperm or low sperm quality are considered to be defective, or in the patriarchal context of Nepal, the ones with *kamjori*; and their conduct around other men and women is affected accordingly.

4.8 Men's fear of sperm mixing in the lab

Once the quality and quantity of sperm was determined through semen analysis, there were few courses of action: a) the men whose sperm count was deemed higher than the "normal" were advised to have sexual intercourse with their wives on few days before, and continue until a day after, their wives' ovulation time; b) in the case of men who did not have any sperm, they were asked to proceed with IUI using donor sperm right away; c) the men whose sperm count was lower than the set standard, or "normal", were prescribed medicines and called after few months for another semen analysis. Depending on the factors like age, urgency, and desperation of the couple, the doctors did not wait until the second semen analysis and proceeded with the IUI using the men's sperm while the men were taking medicine. These men were asked to collect semen once again on the day when the IUI was performed. IUI is a procedure in

which the sperm is inserted into the uterus via syringe or catheter. IUI was performed once a month, when the ovulation occurred and the egg was available for fertilization. Since success rate of the treatment is very low[92], it was quite common for a couple to repeatedly try another round of IUI every month. The doctors advised the couples to try for at least 6 times and take a break for few months before continuing the treatment. Hence, this meant that most men underwent the harrowing experience of semen collection in the clinic after every treatment failure.

Unlike the women on whom the IUI procedures were conducted, the men were not involved in the treatment after they handed in the semen to the doctors. They did not get to see or know how their semen was handled after that point onward. They were asked to wait outside in the waiting room while the doctors conducted IUI on their wives inside one of the rooms used for the IUI procedure. Therefore, this left a lot of room for a common speculation among the men that the doctors used donor sperm or mixed the sperm to boost the success rate of their IUI treatment.

The speculations were also not totally baseless. Dr. Sweta claimed that in many cases, the donor sperm is more powerful than the semen of the husband with oligospermia.

"Success rate is better,"

she claimed and showed me her logbook that contains the record of the IUI done using husband's sperm and donor sperm. Ironically, the record of the past few months showed that the IUI using husband's semen was more successful than that done using the donor sperm. Dr. Sweta explained the discrepancy as an exception and reiterated her claim.

"The male factor infertility or combined factor infertility are better treated with donor sperm,"

said Dr. Sweta. She described combined factor infertility as the condition where the eggs are not healthy/good and the woman has irregular period and the man has oligospermia.

[92] Considered to be in between 30-40% (https://attainfertility.com/understanding-fertility/ivf-101/ivf-success-factors/)

"The preferred choice of treatment for the combined factor infertility then is IUI. The eggs are stimulated with the hormone treatment first; once the eggs are good after the treatment, they are capable of catching weak sperm too,"

claimed the doctor. She continued,

"When the IUI is done by taking the sperm into the uterus after that,"

and snapping the two fingers said,

"then miracle happens."

This was a fascinating gesture of the doctor whose performance was akin to that of a magician.

Men like thirty-seven-year-old Krishna Bahadur Khadka from Itahari, a town about 370 km east of Kathmandu, were skeptical about starting the treatment in the clinic for the same fear held by many men. Unlike some other reticent men I met, Krishna was affable and did not hesitate to talk to me when I approached him in the waiting room. We spoke for almost two hours. He was in Dubai for a long time, working as a chef in a hotel. He had to quit his job there since he could not make family while staying afar from his home. He had been married for thirteen years and it had already been seven years since he returned from Dubai. He had been to a few doctors in Kathmandu and one in Biratnagar, a town near his home. But he was not fully convinced that these medical treatments work. He had already spent a fortune on the treatment and had grown skeptical about such biomedical treatments. At the time of our meeting, he worked as a chef and manager in a hotel in Inaruwa, another town near Biratnagar.

No doctor except Dr. Sweta had prescribed medicine to Krishna. He told me,

"I have visited few other doctors before I came to Dr. Sweta. They had told me that I have sufficient sperm count. But the doctor in this clinic told me that my sperm count is low. I think this might have been caused by the nature of my work. I work in extreme heat in the kitchen with the exposure to fire and flames of oil all the time. The low sperm count could be the result of that."

I was amazed to find that Krishna had traveled such a long distance to seek medical help for his problem. He told me,

> *"I wouldn't have come if one of my close relatives hadn't insisted me many times to come to this clinic for a check-up. Otherwise, I was very hesitant to come here to be honest. I have been to many other places already; I haven't gotten a positive result from any of those places. That's why I do not expect anything fruitful will come out of here as well. Besides that, I am already tired of pursuing therapies any further. But I decided to come to the clinic anyway in order to put up with my relative's constant nagging. He was also childless for a while. His wife had blocked fallopian tubes. Therefore, he consoled me that he understands my agony very well. That is why he insisted that I should visit Dr. Sweta, be it for the last time I visit any doctor. I took a bus in Biratnagar and traveled overnight to Kathmandu."*

When I spotted him in the waiting room, he was dozing off at one corner due to extreme fatigue from travel. He was asked to come to the clinic only to give his semen so that the doctors could proceed with IUI on his wife. He could not clearly tell me when his wife was scheduled for the IUI.

Krishna was confused about the difference between IUI and IVF. I explained it to him through a handwritten drawing on my notebook, something I had learned while observing Dr. Sweta during her consultation. I told him how IUI is useful for the cases of low sperm count or zero sperm count. He had a misconception, like many other men, that a donor sperm was used for the "test-tube baby." I clarified that if the husband's sperm was good enough then it was not necessary to opt for donor sperm. He was concerned about the meticulousness of the clinicians and if they would mix his sperm or use someone else's sperm while performing IUI on his wife. I told him I don't think the clinic would do that deliberately. In case they wanted to use donor sperm, they would ask for the couple's consent, I assured him. He made it clear that he would never opt for donor sperm. He said,

"I will rather not have any children. I have five brothers, who all have a son and a daughter each. In case if I ever want a child then I will adopt my brothers' children."

I also met few other men who also expressed similar sentiment. Avisekh, an engineer from Kathmandu, had been frequenting the clinic for a few times when I met him. He was concerned about the way the staff handle semen in the clinic's lab. He saw that all the semen samples are stacked in a single rack and he was doubtful if by any chance the staff made any error while conducting IUI. He got reprimanded by the doctor when he brought up this issue with her. He expressed his anxiety to me thus:

"If somehow they use somebody else's sperm and we find that out through DNA test after the baby is born, we cannot cope with it. I will not feel that the child is mine. The clinic should ensure that such human errors aren't made. But when I tried to inquire about it with the doctor, she was really annoyed and instead yelled at me for asking such questions. I see that other patients here don't bother asking such questions, so the doctor isn't prepared to answer and be accountable to the patient's queries."

Likewise, Keshav from Urlabari in the east Nepal, whom I mentioned in the previous chapter, was also suspicious how the sperm is managed in the clinic. He told me that he had come to know there was a secret in the clinic about how they handle the sperm. He told me:

"They tell you that your sperm count has increased and show a number to us and take permission from the wife to use someone else's sperm. That way husband also feels that it is his sperm that has been used,"

When I asked him about how he found that out, he said he was just guessing as he had heard some rumor from others. However, such rumors were not totally baseless as well. Girish, whom I introduced in the previous chapter, had told me that when a few attempts of IUI treatment failed due to his low sperm count, Dr. Sweta suggested him to try IUI with his sperm mixed with donor sperm. He consented to her proposal and the doctor performed IUI with a

mixed sperm a few times. From the low voice and hesitant expression on his face, I could tell that Girish was visibly embarrassed when he revealed that to me.

These examples of the men's fear demonstrate that purity of sperm is of utmost importance for these men as it is a common perception among the men that the mixing of sperm sullies their lineage, or *vansha*, as well. The men I met unanimously explained that *vansha* is carried on by the children through the *virya* that goes onto making those children; hence, they defined *vansha* in terms of the biological connection to their children established through *virya*. Since these men felt they have a responsibility, or an obligation of some kind, to maintain and pass on the lineal masculinity that they have inherited from their father (and fore-fathers), in case the sperm is mixed, the men would fail at upholding and perpetuating their lineal masculinity. This failure is also *kamjori* of the man in its broad sense.

The link between semen, sperm and *kamjori* is found elsewhere in South Asia as well. However, in that context *kamjori* is used to signify impotency, which is also conflated with infertility. Khan et al. (2006) found similar idea of semen and semen loss existed in the men aged between 18-55 years in Bangladesh. These men defined *kamjori* as sexual weakness that occurred as a result of thinning of semen and reduced semen quantity and termed semen as "the most powerful and vital body fluid representing their sexual performance and reproductive ability" (Khan et al. 2006: 426-427). As I have discussed in the chapter 2, the word for semen, *virya* also means vigor, which according to Khan et al.., indicates that semen conserves "men's eternal force of life and survival" (2006: 427). Khan et al. discuss that the Bangladeshi men also considered semen, or birjo[93], as the source of masculine essence and hence "an 'adequate' amount of semen was described as symbolizing *birjoban purush*" where *birjoban purush* meant "a sexually 'powerful' or 'potent' man'" (2006: 430).

Contrarily, the loss of *virya* means loss of vigor or life force of men. In the study of the north Indian Hindu men, Gilmore describes that masculinity among the north Indian communities is tied to the notion of male honor, or *izzat*, that is codified in the "male virtues of courage, generosity, and defense of family" and virility (1990:175-178). But emphasis on a virility that is almost

[93] Bangladeshi word for *virya*

impossible to attain and sustain is also responsible for what Carstairs (1958) and Edwards (1983) call "virility anxiety," which is a heightened fear of impotency (Gilmore 1990: 182), unique to Indian men.

Other scholars also have discussed the uniquely culture-bound syndrome of semen loss anxiety among Indian men. Psychologists describe this syndrome as "[…] a pathological fear among south Asian men of mature women and of male reluctance towards sexual activity" (Osella and Osella 2006: 120; Kakar 1982, 1989). Hence, this category broadly denotes 'potency anxiety', 'fear of virginity', and 'ambivalence towards female sexuality' (Osella and Osella 2006: 124). Alter (1992) also discusses this anxiety with loss of semen inherent in the making of wrestlers' body in Banaras, India. For the wrestlers, semen is a life force that gives them strength to fight; likewise, it is also a source of "all energy, all knowledge, all skill" (Alter 1992: 108). Therefore, semen should be conserved in order to increase masculine strength necessary for wrestlers. In addition to practicing strict bodily discipline, the wrestlers are advised to adhere to austere practice of *brahmacharya*—"celibacy and self- control" (Alter 1992: 108).

Khan et al. (2006) also found similar sexual anxiety among the Bangladeshi men. They attributed the cause of their *kamjori* to excessive masturbation and engaging in sexual activities that was not sanctioned by the religion. Additionally, they also speculated that the *kamjori* was also caused by the deficiency of nutrients in their body. One unmarried man told the researchers that his body might be lacking vital nutrients that has caused his semen to be 'bad' and speculated that thus he might "lack an adequate number of *sukkro* (sperm)" and argued, "This can seize my power of impregnating my wife. You know that infertile men are not real men" (Khan et al. 2006: 430). As can be seen from these findings, these men are fearful that their *kamjori* will render them infertile, making them "not real men".

The relationship between sperm count and semen quality with food was also seen in my study where men like Bishal obsessively worried about the type of food they consume and its effects on his semen quality. Likewise, many other men and healers I met al.so considered the adulterated food and "chemically treated food" were responsible for the declining sperm count and semen quality among Nepali men. The doctors also held the same view. Thus, alongside prescribing medicine, Dr. Reshma recommended men to consume certain food

like pistachio, cashew, nuts to improve their sperm count and semen quality. This is similar in the case of Bangladesh where the men were recommended by the traditional healers to take diet rich in protein such as "meat, milk, eggs etc., onion, and pumpkin to increase the concentration of semen" (Khan et al. 2006: 429). There are several studies that confirm the effect of food and alcohol on the semen and sperm count. In the systematic review and meta-analysis done by Ricci et al., the authors report that everyday consumption of alcohol affected semen volume and sperm morphology whereas it did not affect concentration and motility (2017: 45).

Similarly, number of studies also have investigated the effect of diet on sperm quality. In the study of men in the US, Afeiche et al. have found that men who drank low-fat milk had higher sperm concentration and improved motility of sperm; cheese consumption, however, was related to lower sperm concentration among current or past smokers (2014: 1280). Similar result was found by Attaman et al. in their study of men in the US; they report that high consumption of saturated fats was related to low sperm concentration whereas omega-3 fatty acids, which is a polyunsaturated fatty acid, was related to improved sperm morphology (2012: 1471). Likewise, two studies, one conducted among the men in Netherlands (Oostingh et al. 2017) and the other among the men in the US (Gaskins et al. 2012), show that men who had healthy dietary intake, which consisted of fruit, vegetables, whole grains, had higher sperm motility and sperm concentration.

Interestingly, like the classic breadwinner ideal that define masculinity of men in Nepal, Khan et al. also found that masculinity in Bangladesh was determined not only by sexual potency, physical strength, or fertility, but it was also equated with monetary wealth and earning capability of a person (2006: 432). Hence, in this case as well, *kamjori* means the inability of a man to become a breadwinner and look after his family. Therefore, fertility, virility, potency, breadwinner capability and masculinity are all interlinked; the man who lacks them is marked as having a *kamjori*.

Although not the same kind, there existed similar kinds of anxiety around/over sperm in the western countries like US and UK too. The anxiety was aggravated after a 1992 study by Carlsen et al. claimed that over the period of 50 years, there was a significant drop, of more than 40 percent, in the sperm count of

men. Other reports that followed this also confirmed that the sperm count of men was declining; some studies compared sperm count of men from various regions of Europe and Asia (Jørgensen et al. 2001; Iwamoto et al. 2007). This was termed as a "big drop theory" and turned into a widespread panic in the western world (Inhorn 2012: 55). Following the work of Carlsen *et al.* (1992) male fertility was deemed to be in crisis, which was frequently reported by the newspapers in the UK. While some other reports did not confirm the decline in sperm count but these reports were ignored by the media (Gannon et al. 2004: 1170). Gannon et al. have studied such newspaper reporting to "gain insight into the relationships between fertility and masculinity as expressed in the popular media" (2004: 1170). Using Foucauldian Discourse Analysis to investigate ways English media constructed male infertility, they found that there were four primary discourses around sperm and male infertility. The newspaper reports described declining sperm count as a threat to the continuity of the entire human race and blamed pollutants and synthetic estrogens in the environment for the decline. These reporting employed stereotypical masculine language to describe sperm and male reproduction whereby "the testes were compared with car factories" and sperm was described in mechanical terms. Some newspapers used the language of conflict and war imagery to describe the decline in sperm count and expose vulnerability of manhood. All the reporting equated masculinity with quantitative measure of sperm count and thereby conflated virility, potency, and fertility (Gannon et al. 2004: 1172). Hence, Gannon et al. argue that such conflation helps one understand that "infertile men are stigmatized because they are perceived as being deficient in a defining component of masculinity" (2004: 1174).

Guay also discusses how male (in)fertility is measured through the sperm count in the US, which she argues is problematic in itself due to reasons like the non-standarizability of sperm quantity and quality across any population group; sperm quantity and quality of an individual varies even according to season (2000: 166-168). Additionally, she also describes how potency and masculinity was medicalized and normalized through the discourse of erectile dysfunction during the 1990s in the US (2000: 224-234). Likewise, another study in Canada by Thompson (2005) also reports a similar case of the conflation of masculinity and sexuality. In the IVF clinic where Thompson conducted her study, the men with low sperm counts were deemed feminine and impotent who lacked sexual

prowess (2005: 126-129). Thompson further argues that unlike in the case of women where achievement of motherhood is a necessary component of femininity and womanhood, fatherhood is not necessarily tied to manhood, which is instead closely interlinked with masculinity and sexuality (2005: 136; Barnes 2011: 16). However, as I have pointed out in the previous chapters, I found that fatherhood is an integral component of masculinity in Nepal as can be discerned from the fact that men felt responsible for the continuation of their lineage or *vansha*; thereby, virility, ability to impregnate their wife, and fathering a child are all tied in the context of Nepal. Inability or failure of a man to uphold those is deemed as his *kamjori*.

4.9 Conclusion

To conclude, in this chapter, I described the ways male infertility is enacted in two infertility clinics in Nepal during the counselling, consultation, and through semen analysis. In the setting of the biomedical clinic, sperm becomes a marker of male fertility, and masculinity at large, where technologies like microscope, measuring grid, and medical expertise of a doctor come together to set the parameters of in/fertility through the count and quality of sperm. Semen volume, sperm count, morphology and motility of sperm become the markers of a man's ability or inability to father a child, which determines his masculinity at large. In the context of Nepal where Hindu ideals of purity and pollution are hegemonic, the purity of sperm is of utmost importance. This is seen at instances when men are critical about the way sperm is handled in the clinic's laboratory. This is also reflected by the deep fear that exists among the men about the possibility of mixing or switching of the sperm inside the laboratory. These men felt a strong responsibility to guard the purity of their lineage and passing on that pure lineage through the son they beget from their own sperm. The inability to uphold the lineal masculinity, thereby, marks a man as having a defect, or *kamjori*. This chapter discussed two ways *kamjori* is enacted in an infertility clinic: a) during the interaction with the doctors and in the clinic space, the patriarchal ideal of strong and powerful man is challenged whereby men are rendered vulnerable, face deep humiliation and threat to their masculinity; and b) in the laboratory, *kamjori* is enacted through the semen analysis report where the

lower number of sperm count denotes the potential inability of a man to father a child.

Chapter 5: Therapeutic Assemblage and Healing Dynamics of Involuntary Childlessness

5.1 Introduction

In the prologue, I presented the case of Anup from my hometown in Chitwan who traversed through multitudes of healing options in an attempt to overcome his childlessness. His therapeutic quest spanned not only the geographical boundary of Nepal, but also across the other side of the political border into India as well. Likewise, the therapeutic landscape comprised not only crossing the border or traveling to multiple places well beyond his hometown, it also included crossing over multiple healing options that constitute multiple ontologies. Anup is only an example of the many childless men and women I met who make similar journeys into seemingly disparate healing options in their quest to overcome childlessness. Although the extent of therapies Anup has pursued and his patience while he underwent all those procedures relentlessly for seventeen years might be rare to find, but it is not uncommon for a Nepali childless couple to have undergone similar journey if they are childless for a long period of time. What propels these childless couples to take extreme measures in the pursuit of a child is a question worth pondering. One of the prominent factors that impel involuntarily childless couples like Anup to embark on their quest between different, sometimes competing and conflicting, therapeutic options, is the obligation and pressure the men feel to produce an heir that will continue their lineage.

Among the therapeutic options available to involuntarily childless couples, majority of my informants chose technological interventions and biomedical reproductive medicine. However, I sensed that many men and women were frustrated with these modes of treatments for they were not able to have a child even after undergoing these treatments for a long time. Some of the technological treatments regularly practiced in Nepal are IUI and IVF (HNS[94] 2012), which I have discussed in the previous chapter. The first successful IVF of Nepal was reportedly conducted at the Om Hospital by the team of Dr. Bhola

[94] Abbreviation of Himalayan News Service

Rijal in 2005 (Yogi 2005). Even though the successful use of IVF (and IUI) technology is laudable, it is not a panacea for infertility and is prone to failure. During my fieldwork in 2016, I observed that the doctors involved in the treatment, thus, resort to faith and luck for the success of the outcome of their treatment; they warn the couple undergoing treatment that "the technology [is] not foolproof and success dependent (*sic.*) upon God's grace and pure luck" (Dhakal 2009). Therefore, it is not surprising that childless couples seek multiple avenues to cope with their condition.

Shamans (*dhami-jhankris*, and *mata*—female medium/healer), astrologers, temple visits, performing religious rituals, home remedies, and herbal treatments (*jadibuti*) are a few options, among many, that childless couples like Anup pursue. These plural healing options prevalent in Asia have been studied by several scholars under the rubric of medical pluralism for a long time using the analytic categories like traditional and modern medicine, complementary and alternative medicine, the Asian systems of medicine etc. (Leslie 1976, 1980; Sujatha and Abraham 2012; Parker 1988; Penkala-Gawęcka and Rajtar 2016; Zhang 2007; Subedi 2018). Although the investigation of plural healing options using such analytic categories was a fruitful scholarly endeavor for a long time, the dynamics of healing options at contemporary times, both globally and in Asia, have rendered those terms obsolete/inapplicable (Hampshire and Owusu 2013; Thorsen 2015). Hence, in this chapter, I want to move away from the simplistic divides of traditional and modern medicine or the systemic view of healing options to acknowledge and demonstrate the complexity in the practice of these healing options I encountered in my field. Owing to the fact that childlessness encompasses multifaceted issues, which is not limited to only biological aspects, it is even more poignant to adopt this approach. Thus, I propose that the complexity of the relationships between the various seemingly disparate, and what might sometimes be considered to be incommensurable, multiple therapeutic options and their use by the childless men and women in Nepal is better comprehended as therapeutic assemblages—the concept that combines Deleuze and Guattari's idea of assemblage (1980) with the term therapeutic landscape as found in the field of health geography.

Part of this chapter explores how childlessness is enacted at various healing sites by highlighting the different ways the childless couples negotiate

between various options of healing practices they encounter in their therapeutic journey. In doing so, it broadly investigates the journey and experiences of the childless couples in Nepal who tread between various healing options available in the Nepali healthcare landscape.

5.2 Therapeutic landscapes and assemblage

The term therapeutic landscape was coined by Gesler in 1992 to describe places that have healing environments. These places include material ("natural" and "built"), "symbolic", and "social" environments (Baer and Gesler 2004; cited in Thorsen 2015: 84), which combine "to produce an atmosphere which is conducive to healing" (Gesler 1996: 96). Although initially based on the theories of structuralism and humanism, the concept of therapeutic landscape has evolved over the decades to also incorporate the relational aspects of place-making and hence contains in it the idea of fluidity and flux (Bell et al. 2018: 2-3). According to Thorsen, this relational understanding of therapeutic landscape "permits a focus on the way perception and construction of one medical treatment is undertaken in relation to other treatments as people attempt to cure illnesses," (2015: 84). Discussing how different healing options for HIV/AIDS in Thailand co-mingle with each other in a hospital, Del Casino argues that "this particular place of health is not contained as either 'modern' or 'traditional,' rather both systems operate simultaneously, albeit in a rather uneven manner," (2004: 69); therefore, he further suggests that "[w]e should consider both biomedical and other health and health-care paradigms simultaneously if we are to better understand the interrelational nature of the spaces of health and health care and the places through which such spatialized discourses and practices flow," (2004: 70). This concept has been applied to study various sites and phenomenon related to therapeutic healing in different cultures and contexts (for example, Medford 2012).

Similarly, Deleuze and Guattari's (1980) use of the term assemblage is a translation of the French word *agencement*, which according to DeLanda, "refers to the action of matching or fitting together a set of components (*agencer*), as well as to the result of such an action: an ensemble of parts that mesh together well" (2006: 1). In Deleuze and Guattari's term, an assemblage is "[…] a

multiplicity which is made up of many heterogeneous terms and which establishes liaisons, relations between them, across ages, sexes and reigns – different natures. Thus, the assemblage's only unity is that of a "co-functioning" (DeLanda 2006: 1). This means that the parts that are conjoined to form assemblages "are not uniform either in nature or origin," but exist in a relationship with each other (DeLanda 2006: 2). This is a relationship of exteriority (DeLanda 2006: 2), which according to DeLanda, "[…] is a relation established between the two groups, like the air that exists between them transmitting influences that connect them but do not constitute them," (2006: 2). Hence, an assemblage denotes flux and fluidity where two disparate components are joined in a relationship of exteriority from which emerge properties that are larger than the sum total of the components.

Taken together, the dynamic relational aspect of the therapeutic landscape is further conceptualised by the health geographers as therapeutic assemblage (Foley 2011; Medford 2012), which according to Medford, is "[…] a location where there is an emphasis upon connectedness between a person and human and non-human elements of environments, and where such elements are always in flux. The human desire and ability to gain a therapeutic benefit from that space are not necessarily the same, and are contingent" (2012: 69).

It is in this kind of relational landscape that childlessness is enacted and various healing options like biomedicine, shamanism, astrology, temple rituals, and *purana* reading are assembled in Nepal. In the previous chapter, I focused on the biomedical enactment of masculinity and childlessness through semen analysis in an infertility clinic. This chapter will focus on the enactment of childlessness in the rest of the healing sites. Such division between the healing options should not be taken as my own bias between biomedicine and its other but it is my attempt to reflect the way my informants assembled the various forms of healing options. I found that the biomedicine is a constant component of the assemblage whereas there is a variation in the way the vast array of non-biomedical healing options are assembled by the men I met. In other words, not everyone uses all the options I describe below while everyone I met had pursued biomedical treatment for their childlessness.

5.3 Enactment of childlessness in the Temples and Pilgrimages

One of the common therapeutic options employed by childless couples I met was the visit to the temple to engage in the religious activities, perform ritual worships, and go on pilgrimages to temples renowned for curing childlessness. The specific rituals the couples perform differ according to which temple they visit and when. I term this option therapeutic and not merely a religious activity because of the purpose and motivation of the visit and the practice in the temple that is performed for therapeutic end, i.e. to overcome childlessness. A large number of studies have found a positive link between religious activities and wellbeing/health (Albaugh 2003; Cotton et al. 2006, to name a few). Likewise, there are many studies on the religious places and pilgrimage sites (Livingstone, Keane, and Boal1998; Collins-Kreiner 1999; Warf and Vincent 2007), some of which have explicitly focused on the therapeutic function of such religious activities and the sites themselves (for example, Gesler 1992, 1993; 1996, 2003; Dobbs 1997; Conradson 2005, 2017; Williams 2010). These studies include the healing temples in India that are renowned for treating mental illnesses (Ranganathan 2014). Similarly, Whittaker also reports about the variety of temple shrines and religious spaces in Thailand that form a "sacred geography of fertility" where childless couples go to "[…] beg for babies" (2012: 3); according to her, "these shrines have particular gendered significance for women in their pursuit of children," (2012: 3).

Like Whittaker (2012), I found that there are numerous temples throughout Nepal that are specifically known as the pilgrimage and healing sites for childlessness. These are mostly temples of the god Shiva, one of the three most important gods in Hinduism. I came across two such temples during my fieldwork: Santaneshwor Mahadev temple in Jharuwarasi, Lalitpur (a city adjacent to Kathmandu), and Ishaneshwor Mahadev temple in Karaputar, Lamjung (another district that is about 120 kilometers to the west of Kathmandu). I came to know about both temples through some patients in the infertility clinic where I conducted my research; those patients themselves had visited these temples. Although the two temples were spatially separated by over a hundred kilometers, they were connected by a common mythological origin, which I will explain below.

In this section, I will explore the ways in which the two aspects of therapeutic landscape—A) material (natural and built) and B) symbolic and social environments, combine to create/produce healing atmosphere of these temples. However, it should also be mentioned that there are overlaps between the two categories and hence they cannot be neatly demarcated.

A) Material environment of the Shiva temples

Like the specific material environments such as water bodies and mountains that are well reputed to have healing effects, the two Shiva temples I visited are also renowned among the childless couples for their role in healing childlessness. The Santaneshwor Mahadev temple in Jharuwarasi of Lalitpur district of Kathmandu valley is located on the top of a hill that overlooks the valley. Although the temple lies only about 10 kilometers from the city center of Lalitpur and is easily accessible by a concrete black-topped road, one can sense some remoteness as one passes through a vast open rice fields on the way—a huge contrast to the crowded concrete buildings that make up the cityscape. Once one reaches the temple on the top after climbing about 250 cemented concrete steps from the road, the sight of the green hills surrounding the valley and the tall snowy mountains that form the backdrop of those hills at a distance provides much needed respite from the stress that accumulates every day from the heavy traffic and air pollution of the city.

The temple, made of bricks and wooden carved panels that are typical to any other temples in Nepal, occupies a good area. There are numerous bells around the four entrances of the temple and the temple premise has a few metal benches for the visitors to rest. These are votive objects donated by the well-wishers of the temple. At different places around the temple, there are numerous Shivalinga—the phallic symbol of Shiva—made of stone. Four doors of the temple open from the four different directions into the center of the temple where the main shrine is located. Unlike many other Shiva temples where the main shrine is a Shivalinga, the main shrine in this temple is a big rock with no particular shape instead. This was similar to the shrine in Karaputar Mahadev temple which also does not have a regular Shivalinga as its shrine but instead has a big rock.

On any regular day the Santaneshwor temple is quiet as only a few visitors come to worship; thereby, on such days one can sense certain calm and stillness

in the temple premise. Contrastingly, on the ending day of Swasthani vrata, the space is filled with a lively crowd, mostly composed of women who come to worship Shiva, sing and dance to the bhajans (religious devotional songs), listen to the Bhagavat Purana that is recited by a priest at the temple premise, and eat the rice pudding that the priest, who is also a tantric healer, prepares especially for women who are seeking a child. Beside the melodious ritual songs that fill the environment, many material objects such as ritual implements like red and yellow powders (*abir* and *kesari* respectively), incense, water, money, and fruits that are offered to the shrine make up the integral material environment of this therapeutic landscape.

In contrast to Santaneshwor Mahadev temple, Ishaneshwor Mahadev in Karaputar, which lies about 120 kilometers west of Kathmandu (it took me 9 hours of bus travel to reach there), is located on a plain that is surrounded by hills. It lies about 30 kilometers from the highway that leads to Pokhara and is also easily accessible on public vehicles that run in an interval of an hour until 2 pm every day. However, during the festival of Shivaratri when there is a big *mela* the buses run frequently until late evening. Many visitors also travel in their own vehicles on that day. Two rivers, Midim and Madi, run along the two sides of Karaputar, which adds to the serene character of the landscape. Few concrete houses make up the market area that is slowly growing. Otherwise, the houses are seen spread on the hills surrounding the market. Just about 100 meters away from the market square lies vast paddy fields that extend to the river banks. The temple is situated adjacent to the paddy fields. Once a year, during the Shivaratri festival when Karaputar hosts a big *mela*, the paddy fields are cleared to create space for the various activities like installing market stalls and a stage for the recitation of Bhagavat purana. The organizers of the mela, who are the local inhabitants, estimated that 20-25 thousand people visit Karaputar during that one day. The recitation of the Bhagavat purana, which starts 10 days prior to the main Shivaratri event and ends on the day after Shivaratri, serves as a fundraising event where many attendees donate money for the development of the temple. The organizing committee has an elaborate plan to develop the temple into a full-fledged pilgrim site by acquiring the land around the temple and constructing many buildings that house pilgrims and other visitors. Therefore, the scale of

flow of goods and people is much larger in Karaputar than in Santaneshwor Mahadev temple.

The temple shrine itself has an interesting origin story that the locals narrated to me. In the crowd, I met 44 years old Shree Pokharel. He was an inhabitant of Karaputar and had now shifted to Kathmandu to work as a tour guide. According to him:

> *"Our family is the original settlers of Karapurtar. One of the ancestors got the land in reward from the king of Dullu, today's Dailekh, for bringing/smuggling guns from Kashi*[95]*. The land used to be covered by a large water body long ago, which later turned into a cultivable land and was used for cultivation by the inhabitants of the Karapu village in the nearby hill. It was during that time when one of our forefathers was tilling the land using two oxen and a plough. Suddenly, the oxen and the man collapsed on the ground and died. The villagers came to know about the incident and went to the site for investigation. They spotted a blood stain on the ground. When they dug the area, they found a stone/shivalinga that was bleeding. They established a shrine on the premise where the stone was found. Later, in the 1600s, the king of Lamjung, who did not have a child, came to perform the ritual of holding a* diyo *and standing overnight (*"thado[96] batti*") on this shrine and was blessed with a son Rudra Shah*[97]*. He was so delighted that he constructed a temple there and established the shrine in it. The temple with the stone roof was totally damaged during the 2015 earthquake after*

[95] India

[96] *Thada* and *thado* are used interchangeably as the previous is the plural form and the latter is the singular form of the same word.

[97] The thada batti ritual is not unique to Karapurtar only. When I shared the experience of my visit to my friends, one of them told me about thada batti ritual being held during Shivaratri in Pokhara. Similarly, one of the patients in the Kathmandu Infertility Clinic had also told me that there was one in Syangja too. Interestingly, the same ritual is practiced in Uttarakhand with a similar name, khada deep. https://www.youtube.com/watch?v=Rgpm7hnQi2

> *which the Department of Archaeology of Nepal's Government has started reconstruction work. It is still under construction."*

The temple was under construction when I first visited in 2017, and in my subsequent visit in 2018, the construction had been completed[98]. The main shrine, like that in Santaneshwor Mahadev temple, is only a stone without any specific shape or form as a statue has.

Apart from the narratives of how the statue itself was discovered, both the temples share a mythical story of origin as well. The locals claim that the Santaneshwor Mahadev shrine and the Ishaneshwor Mahadev shrine of Karaputar are *the Shakti Pitha,* or the power spots, the origin of which is narrated in the *Swasthani Vratakatha*. Swasthani vrata katha is a text associated with the worship of goddess Swasthani, which started in the sixteenth century as a local practice with the focus on local mythologies among the Newars of Kathmandu. However, it gradually evolved over the centuries to incorporate the pan-Hindu puranaic tradition. Today, the major chunk of the text revolves around the story of Shiva and his consort Parvati, the supreme duo of Hindu patheon, and the text itself is considered to be a part of the purana *Skanda Purana* or *Linga Purana* (Iltis 1985; Birkenholtz 2010, Birkenholtz 2013). According to the *Swasthani Vratakatha*:

> Parvati, in her previous life, was born as Sati and was the eldest daughter of the king Daksha Prajapati. Daksha Prajapati married his 330 million daughters to all the gods while Sati married Shiva despite her father's utter disapproval. Therefore, when Daksha Prajapati conducted an elaborate yajna (fire offering ritual) once, he invited all his daughters and their husbands but deliberately boycotted Shiva and Sati. Deeply offended by her father's ill treatment, Sati went to attend the function despite Shiva's insistence to forgo the insult. Sati confronted her father,

[98] The news of its completion was published in a major national daily newspaper. This also indicates the popularity and visibility this temple has gained in recent years. See, https://thehimalayantimes.com/nepal/ishaneshwar-mahadev-temple-reconstructed-in-lamjung

who further insulted Shiva and his bohemian lifestyle in front of the guests. She could not bear the insult of her father and hence jumped into the fire of the yajna and left the body.

When Shiva found that Sati had left to attend her father's yajna, he went to Daksha Prajapati's place and saw his wife's lifeless body in the fire. Since it was the supreme goddess's body, the fire also could not consume it. Daksha Prajapati continue to hurl abuses at Shiva and disgraced him in front of all the invited gods and goddesses. This, together with the sight of his wife's body, enraged Shiva who started creating havoc in the function. He waged war against Daksha Prajapati and his army at the end of which he beheaded Daksha Prajapati and destroyed his army. Still enraged and grief-stricken, Shiva pulled his wife's body out from the fire and carried it on his shoulder and started roaming the entire universe like a madman.

After many eons of wandering, Shiva's grief still did not subside. The body of Sati also did not rot and remained intact. Since the order of the universe was disrupted due to Shiva stopping his duty of destruction, the gods pleaded Vishnu to bring Shiva to his senses and restore order in the universe. Vishnu obliged and threw his disc onto Sati's body, which then started the process of its decay. The body parts started falling off at different places of the universe as Shiva continued to roam. Power spots in the form of Shiva-Shakti were generated wherever Sati's body parts fell[99].

The locals of Karaputar claim that Karaputar is one of such power places where Sati's right thigh fell. Santaneshwor Mahadev temple in Lalitpur is another such power spot which originated after Sati's upper lip fell there[100].

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[99]My summary and translation from Nepali

[100] This narrative about the origin of power spots is widespread across South Asia (Polit 2006)

I found that the actual spot and the geography of the place where Sati's organs fell is verified through the description found in *Skanda Purana* and *Swasthani Vratakatha*. The inhabitants of Karaputar shared the same narrative as a proof of the place's origin story. According to them, the *Skanda Purana* describes that Sati's right thigh fell on the plains of Tarakeshwor hill, which lies in between two rivulets (*khola*). I later checked *Swasthani Vratakatha* text to verify the name and found mention of the two spots—Tarakeshwor and Santaneshwor—and their corresponding body part association. Ramachandra, the chief of the organizing committee of the Shivaratri event, narrates:

> *"Karaputar matches the description as it lies on the plains of the hill and is surrounded by Madi and Midim khola* [rivulets]. *So, we have taken this as a historical proof that Sati's right thigh fell on the spot where the Shiva statue was discovered,"*

The Shiva temple was first known as Tarakeshwor Mahadev, which literally translates to 'the lord who resided in Parvati's eyes,'" and added,

> *"Since Shiva's abode Kailash lies in the direction called Ishan, one of the ordinal directions, the temple is also known as Ishaneshwor Mahadev— 'the lord of the Ishan.' These days it is also known as Santaneshwor Mahadev— 'the lord of the children.'"*

This is an example of how authenticity of the temples and the rituals that occur in them is created through such interweaving of mythical and symbolic stories together with the physical environment of the place.

B) Symbolic and social environments

Likewise, the symbolic environment of these two temples comprises broadly of the embodied performance of the ritual worship, or *puja*, of the lord Shiva, though the exact details differ in the two sites. In the Santaneshwor Mahadev temple, two different *puja* are performed in the temple by the people seeking children: a) a three hour long *Rudri puja*; and b) distribution of ritually prepared rice pudding (*kheer* or *paayas*) on the ending day of the Swasthani *vrata*. The *Rudri puja* is a special three-hour long ritual worship (*puja*) of Shiva that is performed on the auspicious day fixed by the priest according to the lunar calendar. A couple performs the *puja* under the instruction of the priest inside the

temple. In the three *puja* I observed, the main priest was assisted by another priest to recite the Sanskrit mantra that formed the text of *Rudri*. Occasionally, the recitation was punctuated by the sounds of the hand bell rung by the priest. The *puja* started in the temple where the couple and the priests sat by the main shrine. The priests prepared the *puja* area with rice, ghee, *belpatra*[101] along with many other ritual objects and periodically instructed the couple to perform certain tasks such as making offerings of water or worshipping the shrine etc. There was a ten minutes break in between. The *puja* usually started by 9:30 am and lasted until 12:30 to 1 pm.

In order to understand the second practice in the Santaneshwor temple, it is important to shed light on the Swasthani *vrata*. In the mid-January till mid-February[102] both married and unmarried women from Brahmin, Chhetri and Newar communities fast and worship goddess in the form of Swasthani. The ritual begins from a full moon night of January to the full moon night of February. One of the integral part of the ritual is the recitation of *Swasthani Vratakatha* in the evening at homes (with family members) for the entire month. The origin of this month-long ritual lies in the story of goddess Parvati who maintained austere fasting ritual for a month with an aspiration to receive the god Shiva as her husband. Married women perform the fasting for the sake of their husbands' longevity and good health while the unmarried women fast, like Parvati did, with an aspiration to obtain a desirable, good, and powerful husband like Shiva. The last day is marked by a special puja, both at homes and Shiva temples, to end the fasting and conclude the month-long ritual. The text contains many stories where the women were granted their wishes of prosperity and happiness after performing the rituals prescribed to them by the goddess Swasthani. Likewise, it is also frequently mentioned in the text that the childless women will be granted a child if the ritual worship of Swasthani is fulfilled (Iltis 1985: 648). The ritual to be performed is described repeatedly in the narratives.

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[101] Leaves of plant that is specially used for Shiva worship. According to Hindu mythology, bel is Shiva's favorite fruit and its leaves are also holy. Both the leaves and fruits have medicinal properties as well. See https://www.artofliving.org/mahashivratri/bilva-patra,

[102] Since the dates are determined by lunar calendar, the actual dates fluctuate every year. In 2018, it fell in the month of January alone.

Apart from the mythical, symbolic and ritual aspects that grant these temples their therapeutic characters, Santaneshwor temple earns its reputation as a therapeutic site also due to the practice of rice pudding distribution ceremony on the ending day of Swasthani *vrata*. During this particular day, a priest from a nearby town comes to the Santaneshwor temple and prepares a special "medicine" made of rice pudding (*paayas; kheer*), and distributes that to the couples seeking children. He is 80 years old and has been healing patients for 49 years now. He specializes in tantric methods of healing childlessness and is a fourth generation healer in his family. His grandfather had successfully treated the queen of his time in Nepal for her childlessness and hence his family managed to earn good reputation from that as well. He wears many hats: he is a tantric healer, an astrologer, *Purana* reciter, and a priest. When I inquired about the relationship of *paayas* with the cure of childlessness, the priest said,

> *"You must be familiar with the story from* [the epic] *Ramayana. Rishi* ["sage"] *Vashistha gave the three childless queens of Dasharath—Kaushalya, Kaikayi, and Sumitra—to eat rice pudding made from the rice that was offered in the* yajna *fire. I use the same method and chant the same mantra to prepare the* paayas ["rice pudding"]*."*

Here it is important to elaborate the reference of the epic given by the priest[103]. This epic is quite popular across South Asia and was translated into Nepali by Bhanubhakta Acharya in 1877 AD (Acharya 2007: 11). This translated version became equally popular among the people all over the country. The first canto of the epic, "Balkanda", describes the birth of the four princes of Ayodhya:

> In Ayodhya, there was a brave king named Dasharath. He had grown old but did not have any son. Full of agony, he went to ask his teacher, Sage Vashistha, what he could do: "O all-knowing Sage, please tell me how I could have a son." Vashishtha was wise and he knew what one has to do and so he told the king: "O King, you will surely have a

[103] I described in Chapter 1 about the researcher's positionality and a blind spot of a "native" searcher; it is here that I realized that as an "insider" in the field, I oversaw and assumed many such common references to the epics and religious tropes.

> son soon. You will have to perform a *yajna,* the fire sacrifice. Please invite the Sage Rishyashringa, the husband of Shanta to join me. Two of us will perform the *yajna* for you and you will have four brave sons. All your worries will go away." Listening to Vashistha's advice, the king was very happy and invited Rishyashringa. Both of the Sages performed the fire sacrifice with *homa*.[104] Agni, the God of Fire, emerged from the sacred ritual fire, and on his hand, he was carrying a plate of rice pudding. Handing over the pudding, the God of Fire said to the king that he will have sons. The God disappeared in the fire again. The King was happy and bowed down to the Sages. Then he divided the rice pudding into two equal shares and gave them to his two queens, Kaushalya and Kaikayi. Before they had eaten it, the third queen Sumitra arrived there and asked to Kaushalya and Kaikayi where her share was. Both queens took out some of the portions of the rice pudding and gave it to Sumitra. Then all three queens had the pudding. Soon after, all three were pregnant, carrying in the womb the light of the divinities. People were happy to know about it. Lord Ram was born to the first queen, Kaushalya. All the suffering of the mother went away when she saw in her son the image of the God Vishnu (Acharya 2007: 9-10)[105]. … From Kaikayi, Bharat was born. Sumitra gave birth to two sons—the twins. The elder among them was called Lakshman and the younger one was Shatrughna (Acharya 2007: 11)[106].

I rode my scooter from home, reached there in about 40 minutes and attended this ceremony in Lalitpur in 2017. It was conducted with fanfare with a

[104] A ritual sacrifice done by pouring ghee and grains to fire while reciting the mantras.
[105] Canto 1, Stanzas 50-56
[106] Canto 1, Stanza 62

large crowd in attendance that comprised mostly of women. A lot of things were going on simultaneously—mostly the ending rituals of the Swasthani *vrata*, which culminated in the distribution of the *paayas*. A stage was setup where the priest was delivering a public recitation of the Bhagavat Purana that had started ten days ago. His reading would be periodically punctuated by lively religious songs (*bhajans*) sung by a group of singers who occupied a corner on the stage. During those times, the women stood up and danced to the songs. Throughout the day, the priest sat on the stage with his retinue of assistants who were helped him in the recitation of the *purana*. At one point, two of his assistants brought a huge vessel filled with *paayas* in front of the priest. The priest then prepared the pudding for distribution. The women seeking children were instructed the previous day to bring a handful of sesame seeds with them on this day. The sesame was collected from the women by the priest who then poured the sesame and some water offered to the main temple shrine into the pudding and started stirring it with a stick. According to the priest, the sesame seed was born out of Shiva's sweat and is mixed in with the rice pudding to ensure that a 'good/desired' child (*satputra*) is born.

The priest chanted some mantras and periodically read from his notebook all along. Time and again, he twisted his body and fell into an unconscious-like state for short periods. The entire ritual lasted for about 15 minutes after which he proceeded to distribute the pudding. The women then lined up in a single file. As they approached the priest, to each woman he first asked,

"Do you have child?"

If the answer was negative or if the woman told him she is seeking a second child, the priest would take a handful of the pudding, roll it in his hand and carefully put it into her mouth directly without letting her touch the *paayas*.

"This way the 'medicine'[107] will remain strong and not lose its power,"

he explained. Otherwise, for those women who were there only to receive the blessings of the Swasthani *vrata* in the form of *prasad*, the priest offered the *paayas i*n their hands. Later when the organizers of the event announced that anyone could take the *prasad*, the men also joined the line and so did I . It is

[107] "*Aushadhi*", as it was called by the priest, translates to medicine

interesting to note that the same substance served dual purpose depending on the intention and ways of its consumption: a) *prasad;* and b) medicine to overcome childlessness.

5.3.1 Ishaneshwor Mahadev, Shivaratri and *Thada Batti* Ceremony

As I mentioned above, there is a big fare, or *mela,* once a year during the Shivaratri festival in Karaputar in Lamjung. I attended the festival in two subsequent years: 2018 and 2019. The mela spreads across a large paddy field that surrounds the Ishaneshwor Mahadev temple. Many events were held concurrently on the site since the morning of the Shivaratri: food, and fruits were sold in the many market stalls that are spread across the field; many stalls were setup that sell milk for the offering; temple visitors queued on lines to offer milk to the Shiva shrine in the temple[108]. The visitors danced and sang *bhajan* in and around the temple; a priest recited Bhagavat Purana from the stage setup at one end of the field while his audience grouped together beside the stage; the recitation was interrupted periodically by the many announcements of monetary donation made to the temple by the visitors. Amidst those announcements, the organizing committee would also call upon the stage the couples who conceived and had children after performing the *thada batti* ritual. Those couples were visiting the mela with their children as part of the ritual of "showing" their child to the god and express gratitude for granting them the child.

Numerous couples visited the temple to "show" their child to the shrine throughout the day in both the years that I visited the temple. I managed to talk to a few of them. Some of them were childless for many years when they came to participate in the *thada batti* ritual. This practice of display of the children on the stage confirmed and added to the legitimacy and efficacy of the *thada batti* ritual. Likewise, at one corner near the temple, a stall was setup where the couples who wish to participate in the *thada batti* ritual buy their ticket. As the evening approached, the people gathered around the spots designated for the ritual and start preparing**.**

[108] The locals of the town knew that the temple premise would get very crowded in the morning because of the visitors from outside the town, so they woke up in the early hours of dawn to offer water to the shrine so that they could be free to resume their household chores.

Three types of different oil lamp rituals are performed on the evening of Shivaratri. One is known as *thada batti*, loosely translated as upright lamp. The name is derived after the practice of holding an oil lamp (*diyo*) while standing all night, which is known as *thada batti baalne* ("the action of lighting the *thada batti*") in a local parlance. This is performed by the couples who are yearning for a son. The other type of lamp is called *Purush*[109] *batti*, which loosely translates to man-light. Married women light this lamp and guard it during the entire night. When I asked the significance of this with Ramchandra, he told me that the word Purush had double meaning:

> *"Purush is a male/masculine energy as defined by Samkhya school of Hindu philosophy. Women worship this masculine energy by lighting the lamp and offering it to Shiva. Other meaning is more straight forward: the lamp is lighted for the sake of the husband's longevity and prosperity."*

The third type of lamp lighted is called *lakh batti* or one-hundred-thousand lamps that is lighted for the sake of fulfilment of various aspirations made by the individuals who light them. Out of these three rituals, *thada batti* is of concern to my study as it is conducted to overcome childlessness. Out of these three rituals, only the participants of the *thada batti* rituals are charged Rs. 500 to secure their standing spot in the designated area. Seven hundred tickets were sold in 2018, which increased to 830 in 2019. This points to the growing popularity of the practice. The groups performing other two rituals do not have to pay any fee and are free to conduct rituals anywhere in the field. However, they congregate together under tents in large groups across the field and hence the entire field is lit up with the oil lamps throughout the night. I was amused by the interesting social environment that resulted from the interactions (both directly and indirectly) between visitors from different walks of life, local inhabitants of the place and the different events that were simultaneously taking place in that space.

[109] In a colloquial Nepali language *purush* means male or man

5.3.2 *Thada Batti* Ceremony/Ritual

Several stalls were set up at one corner of the field for the people participating in the *thada batti* ritual. These stalls for *thada batti* had rows of bamboo railings that served two purposes: they acted as a support for the person's back while standing; they also created some order in what would otherwise be an unmanageable crowd. The railings were marked with a specific number assigned to each ticket holder; the couples standing with the lamp are allowed to stand only in the number assigned to them.

On the temple wall, there were instructions printed on flex banners for the visitors who came to light the *thada batti* and *purush batti*. There were 12 points of instructions for the *thada batti*: a) the couple participating in this ritual should be free of death and birth pollution in their immediate family[110] on that day; b) interested person can light the lamp either individually or as a couple; c) the person lighting the lamp should purify themselves by taking shower in the morning and only eat fruits on that day; d) they should offer milk and *belpatra* leaves to Shiva like everyone else; e) they should secure their standing spot by buying a ticket sold at the stall of Temple Area Development Committee—the organizers of the event; they should arrange for a lamp and a vessel to keep the lamp in; the vessel should not be made of brass to avoid the heat of the lighted lamp; f) Then the cotton wick to be lit on the lamp is prepared. The instruction describes a specific way to prepare the wick: a woman measures her husband's height with the wick and makes 11 rounds, to get a thick and long wick at the end. According to Ramchandra,

> *"the number 11 is significant as it signifies 11 Rudra, or the forms of Shiva."*

This resultant wick is folded into the lamp. Although there were clear instructions displayed on the flex board, I noticed that many people were confused about the size and length of the wicks. They were not consistent as to how many rounds of wick they should make; g) the lamp should be lighted in pure mustard oil; h) after the sunset, the couples should stand on the spot where the lamp would be lighted

[110] *jutho maa nabhayekaa suddha*; I have described about the pollution in the context of death in the second chapter; here I want to also add that not only death but also birth is considered to be polluting. This pollution is applicable to the new mother and is called *sutak*. See Bennett (1993) 52-54 for further details.

and make a cow-donation, *godaan*, right before lighting the lamp. Since donation of a real cow is not practical, the cow-donation is ritually conducted by substituting the cow with money and *dubo/durva* grass. The couples put some money and cow (symbolically made of *durva* grass) on a leaf-bowl (*dunaa*) for the *godaan*; i) the priest will read out the mantra for *godaan* over the loudspeaker and come to the individual's spot to collect the godaan and *dakshina* (monetary offering); j) Then the time to light the lamp will be announced over the microphone; k) The couples should ensure that the lamp is lit throughout the night by periodically adding oil to the lamp; l) The lamp should be handed over to the priest at 3:30 am by standing on the queue; it should not be handed over to anyone else.

Once the couples purchased the ticket to reserve their standing spots, they started preparing their wicks. The couples had to bring their own lamp and oil. The lit lamp was put in a bigger clay pot to avoid the heat and also to prevent the lamp from being extinguished by wind or rain, The pot was sold in the temple premise. The couples made a sling around their neck and put the clay pot on the sling and held the pot with their hands around the pot. Everybody was ready at their spots by 5 pm.

I approached many participants for an interview. However, there were few constraints for a full-fledged interview in that setting. The men and their wives were busy in the preparation of their ritual and thereby had no time to spare for a long interview. I, therefore, approached them when they were taking short breaks (for toilet or rest). Similarly, as everyone, including myself, was exhausted from staying up all night for the ceremony, nobody had any strength to discuss about the ritual and ceremony the next day. Moreover, everyone was in a rush to get back to their home; so it was not conducive to conduct any substantive interviews other than what I could do in that moment. Nevertheless, from those short conversations, I could manage to get a glimpse of the range of demographic background s of the men who visit these sites and also briefly was able to inquire about their quest for a child. Manish Bhattarai and his wife were one among the 700 couples in 2018 that lighted the *thada batti*. Thirty-three-year-old Manish is a businessman in Dulegaunda, a small town *en route* to Pokhara. After he finished his Bachelor's studies, he worked as a branch manager of a reputed bank in his hometown for 4 years. He then completed Master in Business

Administration (MBA) from Pokhara University after quitting the job. His wife also has a MA in English. He has a four-year-old daughter who was born after he and his wife lit the *thada batti* in this temple a few years ago. In 2018, the couple was lighting the lamp to have/conceive a son. Likewise, in 2019, I met 35-year-old Shankar Dhital from Kushma in Parvat. He is a branch manager of a reputed bank there. He has been married for 8 years and does not have a child yet.

As I spoke to a few men in their standing spots, an announcement was made by the priest over the loudspeakers at around 5:15 pm. He informed that the *thada batti* ceremony will begin after he chants the mantra evoking lord Shiva (*sankalpa garne*) and prays for the success of the *thada batti* ritual (i.e., prays for the child on behalf of the couples). Everyone lit their lamps and stood in their spots; after the sunset at 5:30, the priest chanted Sanskrit mantras for about 2 minutes. The entire area was overcrowded with the people standing with their lamps. I could overhear some couples complaining that they did not have enough room to move about and felt very congested in the tiny spot allotted to them. There were many onlookers walking by the side and curiously observing the *thada batti* crowd.

After about half an hour, I saw two women in the *thada batti* crowd faint due to fatigue and hunger. Others helped them to recover and they were taken out of their station. Their partners stood with the lamp instead until the women were able to resume standing. At the other corner across the *thada batti* stalls were the stalls for the ones lighting *purush batti*. This group comprised exclusively of women as the lamp is lighted for the husband's long life and prosperity. As the night progressed and the people standing with *thada batti* were tired and looked morose, the women in the *purush batti* section kept themselves awake by singing *bhajans*[111]. At 3:30 am, the priest announced that the *thada batti* could be deposited into the *agnikunda* "fire pond/pit", which was located in front of the temple. Only after the couples holding the *thada batti* deposited the fire could the *purush batti* group deposit their lamps. People formed a queue and proceeded toward the *agnikunda*.

However, soon the crowd was unmanageable and chaotic. Although the couples were supposed to hand the lamp to the priest so that he would deposit it

[111] Religious songs

into the *agnikunda*, people started depositing the lamps at every nooks and corners of the temple instead of taking them to the *agnikunda*. The entire temple area was lit up by those lamps. At one point I felt as if the fire would break out uncontrollably and cause heavy damages. The process of depositing the fire continued until after 5 am. The couples who deposited the fire in the *agnikunda* made monetary offerings along with the *puja* material/*belpatra* to the Shiva in the temple and went to fetch water from the nearby river. The water offering to the Shiva marked the end of the night long *thada batti* ritual. I left the site after witnessing the water offering by a few couples and managed to get three hours of sleep. When I came back to the site at 10 am, the entire area looked like some deserted battlefield. The used clay pots were lying everywhere on the ground. The traces of the lamps and their soot brought a ghostly feeling. The ground was littered with papers and plastics that people had left behind.

I found that the *thada batti* ritual is not unique to Karaputar only. When I shared the experience of my visit to my friends and people I met in the infertility clinic, they told me that a similar ritual is held in Pokhara and Syangja during Shivaratri. Interestingly, the same ritual is practiced in Uttarakhand in India with a similar name, *khad deeva*[112]. There are many stories in the purana of the gods, especially Shiva, Brahma, and Vishnu, who grant their devotees a boon or fulfill their devotee's wishes after he or she performs hard and austere penance for a long time to appease the gods. The practice like *thada batti* ritual could be an emulation of such penance described in the purana. Ramchandra explained to me that

> *"The purity of thoughts generated by praying to Shiva, only eating sattvic[113] food like fruits and milk during the entire day, together with fasting and austere penance by standing all night long create the required changes in the body of men and women for successful conception.*"

Hence, according to him,

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[112] https://www.youtube.com/watch?v=Rgpm7hnQi2Y; https://www.youtube.com/watch?v=i4OOB9AZ_fw

[113] *Sattvic, tamasic*, and *rajasik* are three principles or gunas described in Samkhya system of Indian philosophy and has been incorporated into Ayurveda as well. It denotes the three different qualities, among which sattvic denotes purity, light, energy etc.

> *"The sexual intercourse that the men and women engage in after performing* thada batti *ritual is more efficacious in a sense that it will result into a successful conception due to the desired changes in the body. Those positive thoughts and sattvic food cause the release of the right hormones in the body that are required for conception to occur."*

This is an interesting way of understanding the function of a ritual, which also points out to the biomedicalization of body and understanding of reproduction. Ramchandra was among many others I met during my research who explained the ritual practices in similar biomedical terms. I will elaborate on this later but before getting to that point, I will move on to another practice in the next section.

5.4 *Purana* recitation as a means to overcome childlessness

Similar to the temple ritual that functions as a therapeutic means to overcome childlessness, I found that recitation of Purana is another means by which childlessness can be overcome. A few men I talked to told me about having conducted a ritual of reciting and performing *Ganesh Purana* and *Haribansha Purana* as a remedy for their childlessness. Purana are the Hindu texts that contain mythical narratives of gods, goddesses, kings, genealogies of various dynasties, geographical descriptions, pilgrimages etc. in which local histories are intertwined with mythical history. There are 18 major *Puranas* (*Mahapuranas*) and eighteen sub-purana (*upapurana*). Which Purana fall into each category vary. Likewise, there are many puranas specific to some particular places as well (Birkenholtz 2010: 27). Usually, it is a very common practice all over Nepal to have public recitations of the Purana for mostly religious reasons of earning merits. Sometime such recitation event is conducted as a way of fundraising for temple construction. Generally known as *Purana lagaaune*, it is a practice of hosting the event in which a priest is summoned to recite and explain a particular purana. A lot of devotional singing (*bhajan*) and dancing also are part of the event. A popular purana used for the purpose is the Shrimadbhagavat Purana (or simply known as *Bhagavat purana*) that is conducted for 7 days. It is a public event where anyone interested to take part can join. However, such

recitations could also be performed in a much smaller scale, with only a single family or their close kin attending, conducting, or hosting the event.

Although the recitations of these two particular *puranas* are performed in order to have a male child, the childless couples I met who had considered to perform the recitation of these Purana did not care much about the gender of the child. However, people desire a male child if they already have a daughter. One of my maternal uncles, who has been living in Belgium for more than 20 years, fathered a male child a few years ago after performing Ganesh Purana *puja* in Nepal. I talked to my aunt about my research and she told me about her thus:

> *"After your first cousin was born, your uncle and I tried to have a second child. This time it was difficult for us even though we tried for a long while. We tried a few cycles of IVF in Belgium but that was not successful. They told us that I had some complications in my uterus after I gave birth to your first cousin; so, I had undergone a surgery to fix that problem. That did not help. I could not conceive even after the surgery. Therefore, I wanted to try* Ganesh Purana puja*. I had heard about a couple could have a child after conducting the Purana ritual. We came to Nepal and performed* Ganesh Purana puja *for 5 days. I could have a son one and a half years later. People say it was only a coincidence that I could conceive at that exact time, but I believe it was because of the puja."*

There are many such stories of success that float around.

Nonetheless, the two men I met in my hometown Narayangadh did not succeed in having a child after they performed Ganesh Purana. However, one of them told me about his grandfather who could father a (male) child after performing the *Haribansha Purana* in his village of Parbat. Interestingly, one of the leading Nepali actors Haribansha Acharya has revealed in his autobiography that he was named after the eponymous Purana because he was conceived after his parents conducted *Haribansha Purana* after having a few daughters (Acharya 2013). Likewise, when I met Shiva, whom I mentioned in the chapter on adoption, in the infertility clinic in Bharatpur, had also performed a-10-day long *Haribansha Purana* recitation in his home.

"I would have joined if I knew about it earlier,"

I expressed my interest to observe the ceremony had he told me; to which he *replied*,

> *"It was a private family affair. I decided to make it a small ceremony only by inviting close family members. In order for the ritual to be efficacious a strict purity has to be maintained. For example, the attendees should not have been going through birth or death pollution during that time; menstruating women are also forbidden to attend for the same reason. Thus, I was very selective about whom to invite as I cannot be certain if anyone outside my close kin have maintained the purity requirement."*

According to Shiva, he

> *"fasted all day long and only ate sattvic foods like fruits in the evening."*

He further continued,

> *"Although I am a priest myself and conduct such recitation and rituals for others, I cannot do that for myself. Therefore, I invited other priests to conduct the rituals for me. My wife and I participated in the recitation with a strong motivation of devotion and sincerely prayed to the god to grant us a child. Now let's see if our wish will be fulfilled."*

Since I could not find the actual performance of either of these *Purana* during my field research, I decided to explore the texts of *Ganesh Purana* and *Haribansha Purana* to find out if there were any particular rituals or methods described in them to address infertility. The texts I found were about 2000 pages each with Sanskrit and Nepali translation both side by side on a same page. Like any other *purana*, most of both the *Purana* contains the narratives of various incidences pertaining to some mythic kings, sages, and gods. The last section of *Haribansha Purana* contains the instructions for the *puja*, the ways to do them, rituals to be conducted, mantras to be chanted etc. by the couple wishing to have a child (Sharma 2015 [2072]: 1744-1760).

Contrarily, *Ganesh Purana* does not have a separate section like that of *Haribansha Puranaa* but intermittently mentions that a childless person will have a male-child after listening/hearing to the *Ganesh Purana* and has an instruction for general worship of Ganesh (Dhakal 2009 [2066 BS]:1097; 1151-53). Ganesh, the son of Parvati , is worshipped for the removal of obstacles from one's path, accomplishment of tasks etc. Therefore, it could be that Ganesh is worshipped to remove the obstacles of infertility so that the quest for a child is accomplished. The general instructions on how to conduct *Ganesh Purana* is given in detail. The Purana also mentions that even a person who already has a child and wants to have a second child, will have a male child if she recites or hears/listens the *Ganesh Purana*. Likewise, women who miscarry will also stop miscarrying and will have a child, claims the *Purana*. It narrates a story of a king who was childless even after conducting Haribansha Purana but was able to father a male child after hearing/conducting *Ganesh Purana*. His 30-year-old sister was also childless despite having a regular menstruation cycle; she also conducted *Ganesh Purana* and conceived a child [Dhakal 2009 [2066 BS]: 1098]. I am also aware that because these are performative rituals, reading the text alone to interpret it does not make much sense as the priests would interpret and conduct many things that may not have been written on the text.

5.5 Spirit causation of childlessness and *Dhami* in Chitwan

Spirit or shamanistic medium healing is one of the most ubiquitous forms of healing options in Nepal, and hence it forms a part of the therapeutic assemblage of treatments for childlessness. This form of healing has been studied in Nepal for a long time now (for example, Fisher 1989; Hitchcock and Jones 1976; Hitchcock 1967; Oppitz 1981 Desjarlais 1989). From my discussions with the patients who came to the infertility clinic in Kathmandu from different parts of Nepal, I found that different categories of spirits interact with humans and cause illnesses. The types of illnesses caused by the spirits are diagnosed and treated by the specialists who are known by different names: *jhakri*, *dhami*, *dhami-jhakri, janne* (Subedi 2018: 50). Scholars have found that the specific understanding of these terms vary according to the study sites. In eastern Nepal where Tamang and Broom conducted their study, *dhami* was defined as "a person who has learnt

spiritual healing supernaturally" whereas *jhakri* is "a person who is trained in the skill of healing (i.e. without direct supernatural guidance)" (2010: 331). *Dhami-jhakri* then is a healer who has been trained by another healer and also possesses supernatural powers (Tamang and Broom 2010: 331). Likewise, *jhakri* in central Nepal refers to "practitioners who deal with the spirits or the souls of the dead, whether the practitioner goes into trance or not: thus not all those identified as *jhakris* go into trance or heal," (Fisher 1989: 6). However, the healers who do not go into trance but deal with spirits are also termed as *jhakri* (Fisher 1989). Similarly, there is another category of healers, in eastern Nepal (Pigg 1995) and Kathmandu (Gellner N. S.) called *phukne manchhe*. They "blow, sweep (*jharphuk garne*), and shoo away the various ghosts, spirits, and shades that frequently cling to people and make them sick (Pigg 1995: 24). According to Gellner, the "[…] brushing [or sweeping] is believed to remove evil influences and the blowing to impart protective mantras," (N. S. : 31). Nevertheless, a *dhami-jhakri* can also conduct *jharphuk* ritual, hence the boundaries between these categories of healers are fluid and they are called by either of these names.

Almost every man and woman I met in the infertility clinic had also visited one or many *dhami-jhakri*. Some, like Anup, had visited multiple *dhami-jhakris* in different places across the country. A *dhami* in Parsa, a village 20 kilometers east from my hometown Narayangadh, where Anup also resided, was one among the few *dhami* Anup pursued. Although he had stopped taking the *dhami's* treatment for about 2 years when I met him, Anup narrated his journey to the *dhami* and treatment experience there. In order to understand Anup's experiences and explanation of the treatment his wife underwent at the *dhami's* place, I traced the *dhami* and visited him frequently during June and July in 2018 and a few times in 2019. I managed to observe many sessions of healing during those times and was able to gather some insights into his methods of treatment. Although not everyone who visited the *dhami* during my study came for the treatment of childlessness, the descriptions below are generic treatment modalities offered by the *dhami* which also applies to the clients seeking treatment for childlessness. Thus, although these descriptions might not directly come from the observation of treatments for childlessness, I describe them mainly for two purpose: a) Anup's wife also went through few of the treatment procedures I describe below, the experience of which Anup and his wife

recounted to me; and b) to demonstrate that the *dhami's* method is ontologically different than biomedicine and temple rituals I described above. For the lack of better word, I term the men and women who visit the *dhami* as clients.

When I inquired about the reasons for infertility and the ways the *dhami* treats infertility cases, the 56-year-old *dhami* Bharat Rijal first told me that either husband or wife can be infertile.

> *"Nothing can be done if the husband does not have enough seed. In the case of the wife, she could have problem if the spirit-beings attack and capture her womb. I remove such obstacles and clear the womb,"*

he explained to me. I was curious to know how he would determine if the husband has enough or no sperm. He told me that is determined by the doctors in the lab and he does not have any methods otherwise to conduct such tests. Anup also confirmed that the *dhami* treated his wife extensively. He did the *phukne* ritual, the bird ritual, water treatment and fire treatment on her. Most of the sessions were conducted at the *dhami's* place; a few sessions were also conducted at Anup's home. I will describe these rituals below but here I want to note that these rituals were conducted on women's bodies, sparing men from the gaze of healers. It also could be an indication that only the woman's body is assumed to be faulty and the man's body is taken for granted to be invincible.

The men and women who visit the *dhami* take the uncooked rice from their home, which the *dhami* spreads on a plate and counts a few grains with his index finger while he chants the mantra and makes his predictions/diagnosis. He uses the uncooked rice to "see" the problems that his clients are facing. This is called *aahat herne*. The diagnosis mostly involves telling the clients about the causes behind their ailments. The clients come to him with somatic symptoms, like dizziness, pain on the leg and back, lethargy, headache, insomnia etc. The people I met had already resorted to biomedicine before coming to the *dhami* but their symptoms had not gone away. That is why they had come to the *dhami*; "to give it a try," they would tell me.

The *dhami*, through both rice grain observation and pulse reading, attributes the cause of the ailments to some *vayu*[114]. According to Bharat Rijal, *vayu* is a collective term used for the beings of various categories—*boksi*, *kichkanni*, *dankini*, *bhoot*, *pret*, *masaan*, *pichaas*, *bir*, *murkhutta, duluwa, daayan, laagu, lagaan* etc. He elaborated that further more:

> *"A woman who dies untimely/prematurely turns into a* kichkanni*, which has a chest and a head but lacks the back.* Murkhutta*, on the other hand, forms after a man dies untimely; it does not have a head but rest of the body is intact.*
>
> *There are 64 different types of* yogini*, 52 different* bir*, 5 different* devi*, 3* devta*, and 84000* masaan*. These beings reside in various places, like the branches of the tree, bottom of the tree, water, bank of the water, cremation ground, air, soil, etc. and attack specific body parts of the people; for instance,* dankini *and* pichaas *attack on the left side of the body and* devta *attack on the right side."*

Once attacked by these beings, a person starts to show the somatic symptoms like the ones described above. Childlessness, hence, could manifest through the disguise of such somatic symptoms as well.

Although most of the illnesses occur after the spirit-beings attack the human bodies, some beings don't attack the human bodies but scare people by making sounds in their homes. The fright induced by such sounds could result into illnesses in the humans. For example, in one of my visits, a couple had come to see the *dhami* because the wife felt lethargic and her head was heavy and foggy. The *dhami* read her pulse and asked,

> *"do you hear any tapping sound in the house?"*

She confirmed,

> *"yes, sometimes I hear loud sounds coming from the roof of my house."*

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[114]See, Fisher 1989 for elaborate description of different categories of spirits found in Central Nepal. I found many overlaps in the nomenclature of these spirits in my study site as well.

Bharat told her:

> *"That is a* lauri[115] bir. *It is a* bir *that walks with a stick*[116]. *The sound you hear is him tapping the roof as he walks around. This is also why you have not been able to save your earnings even though you earn a lot."*

The husband was also diagnosed with some attack by a *boksi* after the *dhami* read his pulse. This particular *boksi* happened to be a close relative of the man and a senior member who commands his respect.

> *"Do not call or come in contact with your family for two years. If you cannot do that, then do it for at least eighteen months. Your problem will be solved only then. Didn't I already tell you once before also not to contact your family? You didn't take my advice seriously and contacted them a few months ago. Immediately after that, your wife was attacked by that* boksi *and showed symptoms of headache and foggy head,"* .

alerted Bharat. There seemed to be a pattern whereby the wife would be "sick" if her husband was dealing with his family. This shows that unlike the biomedical explanation of disease that is based on the germ theory, the *dhami's* explanation of disease, which could manifest in somatic symptoms, and the illness causation almost always includes social causes and interpersonal relationship issues.

Likewise, in the *dhami's* explanation of illness causation, some of the illnesses might also result from the moral failings of a person. For instance, I met a man at the *dhami's* who had come for the treatment of his headache. He told the *dhami*,

> *"My head feels heavy most of the time. I feel sleepy all day. I have gone to many doctors and none of their medicine has worked."*

The *dhami* took the man's right wrist and read the pulse. He then asked the man to bring a white pigeon. The *dhami* then responds:

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[115] Stick

> *"You loved a woman and promised her that you'd marry her but broke your promise. So, the woman cursed you for causing her pain and flew a pigeon[117]. That is why you have a headache,"*

As a treatment for the man's headache, he would perform some ritual to take away the curse of the woman.

The most frequent and common treatment the *dhami* performs is a *phukne* ritual, which is literally an act of taking ashes on the hands and tapping the different body parts, such as head, temple, shoulders, hands, legs, as the *dhami* blows air on the client while he chants the mantra. I noticed that he also does this ritual over the phone as well. He asked the clients to put the phone on the body part that needs healing and he chanted the mantra and blew air over the phone. The *phukne* ritual is enough for most of the ailments. For the ailments that involve strong spirit-beings, the client is called for further consultation that involves other treatment modalities of removing the spirit-beings from the body. The client is instructed to bring a list of implements needed for the act. These items include range of things like different colored threads, coins, flowers, food, fruits, leaves, chicken, pigeon, dough, millet flour, stick etc. What particular item is needed is determined by the type of spirit-being that has attacked the person. Sometimes the spirit-being possesses the client and instructs the *dhami* to offer specific items and the ways to offer them. Although the items are broadly similar, each spirit-being calls for specific food item or color. For instance, *boksi* requires white color thread and *duluwa* requires yellow. These rituals for exorcising the spirit-beings are conducted in the late evening and one session might last for two to three hours.

The *dhami* puts all the required items on a large leaf plate in a specific order and starts the treatment. The client sits opposite to the *dhami* with the leaf plate in between them. The *dhami* lights the incense and starts the rituals. The

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[117] To make the vow or curse more effective, various means are used; in some cases animals such as goat, and birds like hen, rooster, pigeon are sacrificed by killing them and offering them to the spirits that caused harm; while in some cases the animals are released or (in the case of birds) flown away. In this particular example, the woman had cursed the man as she released a pigeon; so, the curse would go away by offering a pigeon to whatever spirit had caused that ailment to the man.

client is required to bring either a black hen, a red cock, a pair of pigeon, or all of them. After performing the *phukne* ritual, he asks the client to hold the bird he or she has brought. The bird is first worshipped with incense, *abir* (red powder), and items like glass bangle, *bindi*[118] etc. are offered to the bird. Once the bird worship is over, the *dhami* holds the bird by its wings and slides the bird from the client's head to feet many times while he chants the mantra. This body scan is done to transfer the spirit-being onto the bird. In the process, some birds die in the *dhami's* hand, which signifies the successful transfer of the spirit-being. In cases where the bird doesn't die, the *dhami* asks the clients to keep the bird and look after it for a month or two. If the clients recover in these two months, the bird is sacrificed after performing some rituals. In some cases, the bird is taken to the nearby riverside and is set free with an assumption that it will cross the river and take away the spirit-being with itself. Usually the pair of pigeon is set free. At other times, the bird is sacrificed by the riverside and, after performing some rituals, is buried together with all the ritual materials used in the treatment session.

The *dhami* also performs two other treatment rituals to remove the spirit-being from his client's body: a) boiling water treatment; and b) fire treatment. In the former, he dips a bundle of the plant called *Simali*[119] in a boiling water and hits on the client's head and body multiple times with the bundle while chanting the mantra. The entire process lasts until the entire water is used up, which takes about 5 minutes. The water is boiled towards the end of the bird ritual described above. In the fire treatment, the client is asked to bring roasted millet flour and he or she is wrapped with a bedsheet that covers the entire body from head to toe. The *dhami* holds a fire in front of the client and throws a handful of millet flour into the fire, the force of which propels the fire to the client's body. The client looks like he or she is on fire. Simultaneously, the *dhami's* helper cleans the fire from the client's body with a broom. This also lasts until the bowlful of millet is used up. The *dhami* asks the clients to change into a new pair of clothes and conducts another *phukne* ritual. He then tears a small portion of the clothes that

[118] A (usually round) sticker worn by women in the middle of the forehead between the eyebrows.
[119] It is a medicinal herb known by many names in different language across Asia. It is known by the name Simali.

the client came wearing so that the spirit-being cannot latch onto that. The treatment ends with yet another *phukne* ritual, after which the *dhami* either calls the client for further consultation or declares the treatment to have concluded. As I mentioned in the prologue, Anup and his wife attended many sessions of these treatments but when these did not yield any desirable outcome, they stopped pursuing the *dhami's* treatment.

5.6 *Jyotishi* (astrologer) and the *chinaa* analysis

Visiting a *jyotishi*, or an astrologer, was the most common feature of the therapeutic assemblage of the childless men and women I met during my study. People in Nepal pursue astrologers for various reasons, mostly to understand and derive meanings of the life events or to deter impending obstacles in their life course. As it will be clear from the descriptions below, astrology gives ontologically different explanations of childlessness that differs from that given by biomedicine or shamanism. However, they can all intermingle in a sense that a shaman may also employ astrological methods to make his diagnosis or as I illustrate below, a biomedical doctor might coordinate with an astrologer to increase the efficacy of his treatment.

Many women (and few men) with whom I spoke to in the infertility clinic in Kathmandu had told me that they had visited an astrologer to check if they would have a child or not, which the astrologer would determine by reading their birth chart (*chinaa*). Interestingly, majority of the women I met there had been to one particular astrologer in Pashupatinath temple area in Kathmandu, Dr. Uddhav Upadhyaya; therefore, I went to meet him as well. I setup an appointment through his secretary, who could only offer me a 30-minute time slot after a week as she told me that Dr. Upadhyaya was occupied since the morning until late evening. I finally met Dr. Upadhyaya in his office one late evening in 2017. The office is located on the first floor of a two-storeyed white building by a busy street near the main gate of the Pashupatinath temple—the most important Shiva temple in the country. I was quite surprised to see a handful of motorbikes outside the building at that odd hour of 9 pm. A narrow stairway lead to the entrance of the astrologer's office. The reception room has a cabinet in which

there are a lot of implements—mostly *vaastu*[120] related geometric shapes that are supposed to bring auspiciousness in one's life, various sizes and shape of crystals for healing and bringing auspicious results into one's life. When I arrived there at 9 pm, there were still seven people in the waiting area. Two staff members behind the counter were occupied with attending to the two clients who were buying a ring and some implement prescribed to them by the astrologer for their financial prosperity.

The two staff members were priests who conduct necessary *puja*s to remove (astrological) obstacles from their clients' lives, were visibly unhappy to see me at that odd hour. One of them asked me to purchase a fifteen Rupees (around 30 cents) ticket and clearly instructed me to not ask many questions and make my consultation time very short:

> *"We've been here since 6 in the morning, so we've to go home soon,"*

they said that in a resentful tone before shoving me through a door that led to the astrologer's consultation room. The astrologer was in his consultation session with three people in the room already, so one of the priests asked me to pass through the room to a verandah outside the room and wait. It was a full moon night two days before, so the moon was still big and bright. The soothing moonlight that befell on the trees and temples around the Pashupatinath temple and the silence on the street created a serene mood that evening. A woman and her son were waiting on the verandah for their turn. The woman told me that I was able to get my turn quickly that day; sometimes she has returned home at 11 at night from there. The astrologer must be quite famous for him to be occupied with his work till 11 pm, I thought to myself. The notice displaying the codes of conduct hung at the reception wall made sense to me only then: clients are asked to take only 10 minutes for consultation.

After waiting for about an hour and a half, I was able to see astrologer Dr. Uddhav Upadhyaya. This was not any different than the infertility clinics and their long waiting hours. Attired in white *kameej* and pants, tall statured Dr. Uddhav sat on a comfortable leather chair by his desk. He holds a doctorate in

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[120] The science of ancient Hindu architecture and space design. See https://www.hindustantimes.com/astrology/vastu/10-vastu-tips-for-positivity-prosperity-and-pleasure-101633156171782.html

vaastu from Benaras Hindu University (BHU) in India. As I walked in, he was ending his consultation with the previous client. The client was sitting on a stool next to Dr. Upadhyaya and the latter held a *rudraksha mala* (rosary beeds) on his hand and put it on the man's head while he quietly chanted some *mantra*. Then he circled the same hand a few times around the man's body, put the rosary away and took some rice grains in his hand and circled the hand around the client's upper body. When I inquired to him later about his healing practice, he gave a humble answer,

> *"Oh, I don't know much about healing. I only perform some simple rituals, mostly through mantra chanting, and it seems to work."*

I found this interesting as usually I have found that the astrologers do not offer such ritual healing services. This is an instance that shows the fluidity and intermingling of these different therapeutic modes.

5.6.1 *Chinaa herne* or reading the birth chart

The ritual was over soon and Dr. Upadhyaya sent the man away and started talking to me. He seemed very enthusiastic to talk to me as he spoke continuously for about 30 minutes while explaining to me in details about the *jyotish*, or the Vedic astrological system, which defines astrological positions of different stars and signs, influences of planetary movements, and their effect on an individual's ability or inability to bear a child. He illustrated his explanation using a sample of a digital astrological birth chart on his laptop. Traditionally, a birth chart is a scroll of paper that can extend up to about three to four feet and contains detailed information about the time of birth of the person, and alignments of the constellations, planets, moon signs and various stars during the time of birth. The birth chart serves as a blueprint of a person as the information contained in it reveal the person's proclivities and life courses. The information is diagrammatically represented towards the bottom of the birth chart. Although a complex interplay of various factors is considered while reading and interpreting the chart, the diagram of *lagna kundali* is used to determine whether or not a person will have a child. Therefore, alongside the sample of the actual birth chart in figure 1, I have also included a figurative representation of the *lagna kundali*

below it to explain the important features of a birth chart in the subsequent section.

There are various components in the diagram that must be carefully considered during the analysis of the chart. What I describe here is only a brief summary of the vast epistemic system, which goes by the name *jyotish*, or which is loosely known as Vedic astrology (Sutton 1999: 1). The prominent components that are present in the chart are: a) *graha* (planet); b) *rashi* (zodiac sign); and c) *bhaav* (house).

According to the Vedic astrology, there are 9 *graha*: i) *Surya* (Sun); ii) *Chandra* (Moon); iii) *Budha* (Mercury); iv) *Brihaspati* (Jupiter); v) *Shukra* (Venus); vi) *Mangal* (Mars); vii) *Shani* (Saturn); viii) *Rahu* (Northern lunar node); and ix) *Ketu* (Southern lunar node). These *grahas* have different qualities; some are feminine, some are masculine, and some are neutral. These qualities also determine the affect these *graha* have on the overall outcome in an individual's life.

Likewise, the 12 *rashi* are 12 segments of 30 degree each in the elliptic of the sky; they are: 1) *Mesh* (Aries); 2) *Brish* (Taurus); 3) *Mithun* (Gemini); 4) *Karkat* (Cancer); 5) *Sinha* (Leo); 6) *Kanya* (Virgo); 7) *Tula* (Libra); 8) *Vrishchik* (Scorpio); 9) *Dhanu* (Sagittarius); 10) *Makar* (Capricorn); 11) *Kumbha* (Aquarius); 12) *Meen* (Pisces). Even though the Vedic astrology is based on the moon sign, as opposed to the Sun sign that is used in the western astrology, the twelve zodiac signs correspond to each other. The order of the *rashi* is fixed and hence they are represented in the birth chart by their corresponding number alone (see the figure below).

Bhaav, or the house, is also a twelve division of the chart and is calculated anticlockwise starting from the twelve o'clock position. Each *bhaav* is associated with the unique areas of an individual's life. For example, the fifth house is associated with the children, intellect, and education while the fourth house is related primarily to the relationship of the individual with his or her mother. Each *bhaav* has a *rashi* in it, which is distributed according to the order set by the *rashi* that was rising in the eastern horizon during the time of a person's birth. This *rashi* is called the '*lagna*,' which means the first moment of the person's contact with the world, and hence is placed in the first *bhaav*. This *lagna rashi* determines the overall map of the chart. For instance, if the *Karkat rashi* (Cancer)

was rising in the eastern horizon at the time of a person's birth, then the person's *lagna rashi* is *Karkat* (number 4), which is placed on the first *bhaav*. Rest of the *rashi*, starting from the fifth (*Sinha*), are progressively filled in the *bhaav* from the anticlockwise direction. The *lagna rashi* also gives the information about the overall life course of a person.

Each *rashi* has a *graha* as its lord that exerts influence on the *graha*. Since there are 9 *graha* and 12 *rashi*, some *graha* have lordship of more than one *rashi*. The lord of the *bhaav* is the same as the lord of the *rashi* that is present in a *bhaav*. For example, the lord of *Mesh* is *Mangal* and if the *Mangal* is located in the 4th *bhaav*, the lord of the 4th house is also *Mangal*. However, sometimes a *rashi* and its lord *graha* might not be in the same *bhaav*. In such cases, depending on which house/*bhaav* the lord *graha* is situated, it might still have (or no) influence over the *rashi* of which it is lord. Instead, the *graha* influences the rashi in the *bhaav* where it is residing. Additionally, some *bhaav* contain more than one *graha* while the other *bhaav* do not have any *graha* in them. In these situations, the two *graha* in the same *bhaav* interact with each other to produce a cumulative effect. The interaction could either bring positive or negative result, depending on how the two *graha* relate to each other. For example, *Kumbha* and *Karkat* are enemies; so, if they are housed in the same *bhaav*, they would produce unfavorable effects.

Moreover, depending on the *graha*, each *graha* can exert their effects on the other *graha* and *rashi* located in more than one *bhaav*—the phenomenon called the *dristhi* or aspect. *Mangal* has *drishti* in three *bhaav*: 4th, 7th and 8th, which means that Mangal influences and interacts with the *rashi* and *graha* in the bhaaiv that are located on the 4th, 7th, and 8th positions from where the Mangal is situated. On top of this interaction between the planets, zodiac signs, and houses during the time of one's birth, the current situation of the planetary motions (*dasha*) and the constellations (*nakshatra*), should also be considered for the accurate analysis and to make predictions about various aspects of an individual's life (Sutton 1999). Below is a figurative representation of a part of a *china* and its actual part.

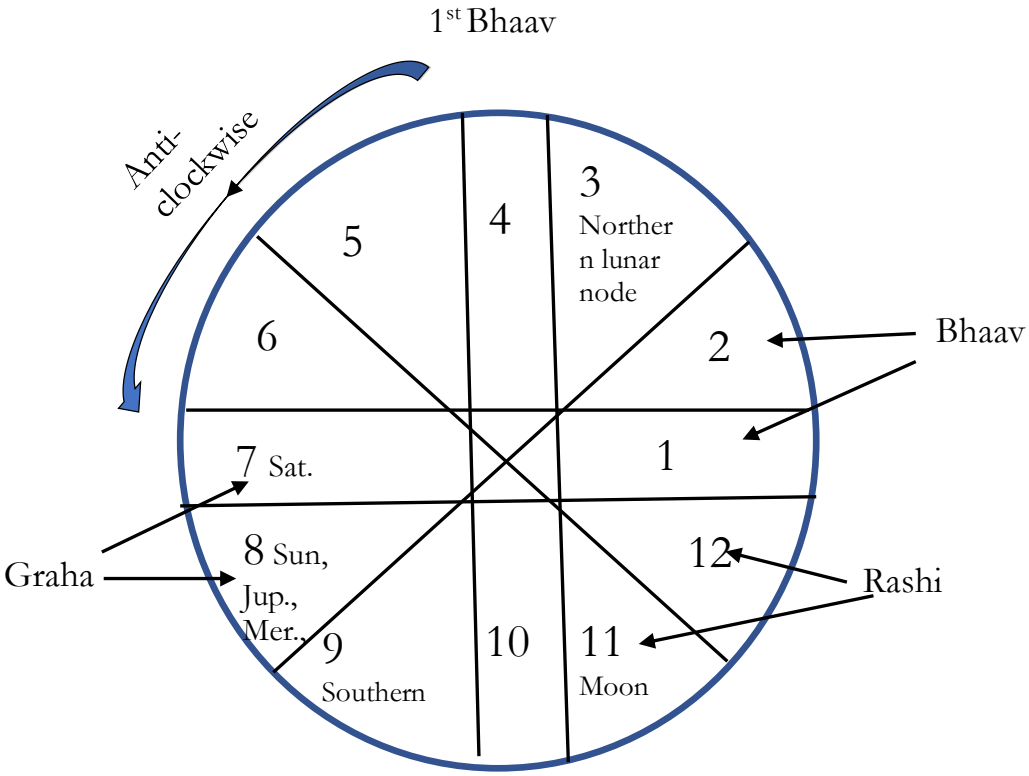

Figure 4 : Part of a *chinaa* used in the investigation; most important for determining the cause of childlessness is the chart on the upper left corner, called *lagna kundali*

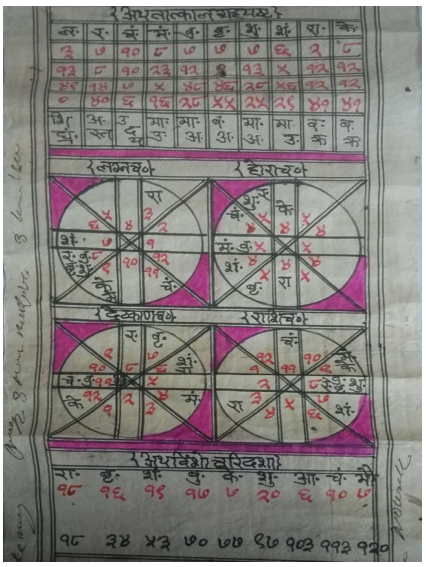

Figure 5. *Chinaa*

5.6.2 Diagnosing infertility through *chinaa*

According to Dr. Upadhyaya, whether a person is infertile or not depends on the time of the person's birth and the methods through which he or she was

conceived. As described above, once the person is born, a *chinaa* serves as a blueprint to his or her life. There are primarily two reasons why a person might be childless according to astrology. If the *graha Rahu* has occupied the fifth house in the birth chart, then depending on its interaction with other *graha* and *rashi*, it will not allow the full-term conception; hence, the person will miscarry. Another reason for childlessness is also because of the *Kalsarpa y*og in the person's birth chart. *Karsarpa yog* occurs if the 7 *graha* are housed in between the same side of the axis formed by *Rahu* and *Ketu* on the birth chart[121]. The effects of *Kalsarpa yog* can be mitigated through some ritual worships.

Additionally, Dr. Upadhyaya explained that both the partners' birth chart should be analyzed simultaneously and compared together to determine if the couple will have a child or not. If the husband and wife's *rashi* are enemy, for example like *Karkat* and *Kumba*, then they will not have any children. However, even if a partner's *rashi* precludes him or her from having a child, the *rashi* of his or her partner can override that effect and the cumulative effect can result into the couple's ability to have a child.

Another factor that is responsible for the childlessness, according to Dr. Upadhyaya,

> *"is the mismatch of the "blood group." This can be determined by checking the* naadi *of the person."*

There are 3 different types of naadi: *aadi* (first), *madhya* (middle), and *antar* (end). These signify three different personality types and play a significant role during the matchmaking process before the marriage. If the *naadi* of a man and a woman match, then the marriage should be avoided because the couple will face severe problems like lack of love and desire for each other and also infertility as well[122]".

Nevertheless, astrologers like Dr. Upadhyaya have remedies for such complications arising from the *rashi* and *naadi*. In general, the remedies involve performing certain rituals to appease the troublesome *rashi* to mitigate their harmful effects. But there are some specific rituals and remedies that Dr. Upadhyaya recommends which remove the obstacles specific to infertility. These

[121] https://www.astrospeak.com/slides/types-of-kaal-sarpa-yog
[122] https://www.astrospeak.com/slides/nadi-dosh-everything-you-need-to-know

remedies include: i) reciting Santangopal mantra, which is an incantation of the lord Krishna; ii) drinking the water from the ritually established pot, known as *Vishwa ghadaa*, on the seven-days purana recitation ceremony (*Saptaha*); iii) eating *prasad*—the remains of the offering made to the gods—of the *yagya* (fire ritual) conducted in the purana recitation ceremony,

"just like what the queens of Dashrath in Ramayana did,"

said Dr. Upadhyaya; this is the same reference that the priest who distributed *paayas* in Santaneshwor Mahadev temple during the ending of Swasthani vrata; iv) reciting the child-granting mantra from the Veda and the *Bhagavat Purana*; v) performing *Chandi*[123] *puja* to remove obstacles; vii) finding the *graha* that are causing obstacles and performing *puja* to appease those *graha* and remove the obstacles; viii) performing *Laghu Rudri*[124] *puja* in Santaneshwor Mahadev temple in Lalitpur; ix) performing *Harivansha Purana*. Some of the puja, like Chandi and that involves pacifying *graha*, might take anywhere between 5 to 10 hours to finish. Dr. Upadhyaya has a team of priests who perform the necessary *puja* to remove such obstacles. Beside the rituals, Dr. Upadhyaya also has made an arrangement with a healer from Bhaktapur, another city that is adjacent to Kathmandu, who prepares an ayurvedic medicine for the treatment of infertility. He prescribes the medicine prepared by the healer to his clients.

However, Dr. Uddhav is also aware that some of his clients might not be able to bear a child even after resorting to all these remedies. He says,

> *"We can only do so much; if the person is born with a fate of infertility, he or she will not be able to have a child no matter how much he or she tries. We can only remove the obstacles created by the* graha*. If the person's birth chart shows that the person cannot have a child, I tell that to them directly. They might have a lingering hope otherwise,"*

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[123] Chandi is a ferocious and wrathful form of the goddess Shakti. https://www.britannica.com/topic/Chandi.

[124] Rudra is a ferocious Vedic god who later evolved into the god Shiva. Rudri puja is a ritual based on the worship of Rudra. The shorter version of the text and ritual is performed in this temple, hence *laghu Rudri*. https://www.britannica.com/topic/Rudra

He then told me that both biomedicine and *jyotish* are similar in a sense that they do not have any "inherent truth" in them. By this he meant to say that neither of the treatments is failsafe and are based on trial and error.

> *"We also say let's try this and see how it goes; doctors also say the same,"*

he said and continued,

> *"in the treatment like test-tube baby, the doctors are also shooting arrows in the dark; sometimes the arrow hits the target and sometimes it misses the target. Apparently, ours* [astrology] *also appears like we're shooting an arrow in the dark but there is a vast science involved in our practice as well."*

This was a clever juxtaposition of biomedical and astrological approaches. Interestingly, Dr. Uddhav has a good arrangement with Dr. Bhola Rijal at the Om Hospital who sends him patients to determine the auspicious day to start their IVF treatment. In return, Dr. Uddhav refers his clients to Dr. Bhola Rijal. Dr. Uddhav told me that it is necessary to use both his and biomedical approaches to tackle the problem of infertility. I find this arrangement between Dr. Rijal and Dr. Uddhav, the nexus of science and religion, fascinating.

5.7 Herbal healers

Another common treatment method that forms the therapeutic assemblage complex to treat childlessness is that of herbal healing. In Nepal, medicinal plants are commonly known as *jadibuti* and the treatment with herbs is interchangeably called as Ayurveda as well; whereby, the herbal healers are called *baidya*, (or *vaidya*) (Cameron 2009a). According to Cameron, "Ayurveda has uniquely evolved in Nepal from the ancient and dynamic theory of *tridosa* (three humors of *vata, pitta* and *kapha*) found at the core of South Asian Ayurvedic medicine to produce a variety of related forms of practice," (2009a: 236). The use of medicinal herbs at home for the treatment of common ailments is also commonplace in Nepal. There is a long tradition of Ayurvedic practice in Nepal, which was mostly based on the family tradition.

However, after the 1950s' modernization drive of the Nepali state, Ayurveda has been institutionalized and professionalized and modeled after its biomedical counterpart. The institutional training of Ayurveda is standardized through a set curriculum, examination, and certification (Cameron 2009a; 2009b). Contrary to this mode of practice of Ayurveda, the lineage-based *baidya* are trained informally in their homes under the tutelage of their practitioner family members, most often father or uncle. While some may also learn independently through other means; for example, a medium healer might acquire his or her knowledge of medicinal plants through dreams. There is a wide range of variety in the way the informally trained healers operate; some may not practice as full-time professionals and may be engaged in another wage earning job; while others may be priests who offer *jadibuti* as part of the other ritual healings they offer; likewise, some spirit-medium healers might also prescribe *jadibuti* to their clients.

During the course of my study, I met two herbal healers, both male, who specialize on the treatment of childlessness. They both use herbal combinations as their primary mode of treatment. I asked them about the herbs they use, but they dodged my inquiry by saying it is some *jadibuti*. When I insisted more, they said it is a family secret that they cannot divulge. They told me that they inherited the knowledge from their fathers and swore the oath of secrecy to their *"guru"* (teacher; in this case, their fathers).

Deepak Napit, one of the two healers, is a barber by profession in Bhaktapur, a city that lies adjacent to Kathmandu. I found out about him through Soniya whom I met at the infertility clinic in Kathmandu. When her previous biomedical treatment did not succeed, she had taken Deepak's medicine and was able to conceive. However, she miscarried after a few months. She stopped taking Deepak's medicine and had decided to revert to biomedicine. I observed that switching between therapies and healers is very common among childless men and women.

I traced Deepak's hair salon in Bhaktapur and visited him a couple of times. He was extremely busy every time I met him in his shop. On my third visit, he could spare about an hour to talk to me and told me about his healing practice. He attends to his clients and offers his healing service in his home before he comes to the shop in the afternoon.

G: How did you learn this?

D: I learned it from my father when I was a child.

G: What kind of healing did he do?

D: He used herbs to treat. He used to take me to assist him when he went to bring medicinal plants from the forest and other places. He showed me how to recognize the medicinal plants from other kinds of plants.

G: What herbs do you use?

D: I cannot tell you that.

G: Why?

D: I have made a promise to my father that I will not tell it to anybody.

G: Oh. Can you then tell me how do you know what herbs to prescribe?

D: Yeah, I check a person's pulse and determine what is the problem. Once I find the problem I prescribe the medicine.

The other healer is a 63-year-old Ram Prasad in Lalitpur, also a city adjacent to Kathmandu, who did different odd jobs before he retired. He has been offering his treatment for forty years now. I met him at his residence in Lalitpur. I found out about him through a friend, Sabin, whose cousin had a child after taking medicine prepared by Ram Prasad. According to Ram Prasad,

"It is easier to treat women who are young, 25-35 year old. But it is difficult to treat women who are older than 45."

Pulling out a *paatro* (astrological lunar calendar) from his pocket, he continued,

"First I find out if the nakshatra[125] of the husband and wife match. In some cases, the husband and wife do not have

[125] The astrological constellations according to Vedic astrology. Almost all wedding matches are arranged by the family or their kin. It involves matching the horoscopes and other parameters such as birth-chart and astrological charts. This chart is referred to frequently for other purposes such as to determine the reasons behind childlessness *et. cetera*. See https://www.ganeshaspeaks.com/astrology/nakshatras-constellations/ for some explanation of these concepts and their usage.

any physical problems but still they cannot conceive. In those cases, we should check if their nakshatra match or if there is a mismatch in each other's nakshatra. Since whether a couple can have a child depends also on their luck[126]*. I cannot give any guarantee to the couple if the they can bear a child.*

Ram Prasad doesn't mix any biomedical treatment and only prescribes *jadibuti* treatment. His grandfather and father also treated childlessness using the same herbal formula and he trained under them. He uses 6-7 different herbal plants to make his medicine, the identity of which he did not reveal. He has sworn secrecy of the *mantra* to his gurus, in his case his father and grandfather, and therefore cannot disclose the identity of the plants or his medicine making process. He fetches the herbs from the forest by himself, unaccompanied by anyone so as to maintain the secrecy of the identity of the plants. Nevertheless, he gave a general overview about the process of medicine preparation. He said,

*"Once the herbs are plucked and brought home, they have to be dried under the shade. One must be careful not to expose them to direct sunlight; direct sunlight diminishes the potency of the plants. Once the herbs dry, they are grinded into powder. Then the powder is mixed in honey and clarified butter (*ghee*). The medicine becomes ready only after I chant some mantras from the Vedas on it. That makes the medicine potent. Otherwise, the medicine is weak and doesn't work effectively."*

It is important to mention that a similar ritual for increasing the potency of medicine exists in the practice of Tibetan medicine as well: the *medrup* ritual is conducted during the preparation of Tibetan medicine to activate the healing property of the herbs used in the medicine and make the medicine potent (Cameron 2009a).

Pulse reading is the only method Ram Prasad uses to make a diagnosis. He explained that there are nine different kinds of pulse; imbalance in only a single pulse is enough to make one ill. It took Ram Prasad nine months to master

[126] *Bhagya*

the technique of pulse reading. According to him, childlessness is also caused by imbalance in the pulse. He added, "The imbalance might also be caused by spirit-beings like *bhoot*, *pret*, and *dakini* but belief in such beings has diminished these days, not just in Nepal but in foreign countries as well." Curious about his explanation, I asked him if these spirit-beings even exist in the first place. He narrated an incident from the past when he encountered a *bhoot* riding a white horse while he was traveling to another village. When I seemed surprised, his daughter-in-law who was present in the room, also added that she has seen one herself too. Since people have built houses in what used to be cremation grounds in yesteryears, such beings are very much present and haunt those houses today as well she said.

Although many people have shown interest in learning these healing methods from him, Ram Prasad does not plan to pass on his knowledge to anyone except to his own children.

> *"This is a knowledge that originated from the Vedas. There are many aspects that I can [am allowed to] teach and many that I should not teach [and maintain secrecy]. The knowledge will lose its strength if I teach it to others so easily. But I should only teach one person and I have determined that will be my own children,"*

he said. Ironically, none of his 4 sons and a daughter is interested in inheriting this healing knowledge from him. Nonetheless, he plans to write everything down and pass it on to his children regardless of their interest. Ram Prasad boasts to have successfully treated a couple who had not conceived for 25 years. He also gave me examples of three other couples whom he treated successfully; all of them had a long history of childlessness. One among them was my friend Sabin's cousin.

When asked about the treatment procedure, Ram Prasad told me that he calls the women on the fourth day of their period and gives them his medicine.

> *"The women must take shower and be pure and come without eating anything; only then if they take the medicine I have prepared, they will surely be able to conceive.*

Though the first dose of medicine works for many women, some women have to take two or three doses,"

he said. Ram Prasad does not proceed beyond the third dose and, in such cases, tells the women they cannot conceive. Whether the child will stay full term in the mother's womb or if it will be miscarried can also be determined by checking a particular plant from which the medicine is made. If while digging the plant out from the soil, its roots come out intact then the miscarriage is ruled out. However, he also determines if a woman can conceive or not before starting the treatment by checking both the husband and wife's *nakshatra* in the astrological calendar; according to him, a couple cannot bear a child if their *nakshatra* are "enemies". Other than that, the reason behind a couple's inability to bear a child is also due to the mismatch of their *blood*, according to him.

"The husband's and wife's blood also should mix properly, otherwise the baby does not form,"

he said, and added,

"Apart from that, if the woman's menstrual blood is not clear and is instead clumpy then also the baby doesn't form."

Ram Prasad's treatment is also gendered in the sense that women form the primary target of the treatment.

"Do you only give the medicine to the wife?"

I asked.

"Yeah. It's not necessary to give medicine to the man. Only if his nakshatra shows some defect, which happens sometimes, do I perform some phukne *ritual on him,"*

he told me. He only offers his treatments on Sunday and Tuesday because those were the days that his gurus deemed auspicious.

Deepak and Ram Prasad's cases demonstrate that the boundary between the treatment procedures are fluid and constitute an assemblage of various ontologically different healing modalities. Both of them make use of the knowledge of medicinal plants they learned from their fathers and grandfathers. They also mix astrological charts and pulse reading to determine the match (or mismatch) of the *nakshatra* and whether the body of their clients has been attacked by the spirits. Unlike the biomedical doctors who explain childlessness

strictly in terms of bodily failure and infertility, instead these healers' explanation of illness causation combines physical aspects like the condition of menstrual blood and the idea of "blood" matching as well as mantra chanting and spirit-beings.

Similar to these two healers, I also met another healer, Baldev Acharya, in the Pashupatinath temple area of Kathmandu who uses Hindu tantra, Ayurveda, and astrology to treat myriads of illnesses and disease categories, infertility/childlessness being one of them. I saw his advertisement in the marketplace, so I contacted him and setup an appointment. He received me at the entrance of his home and took me to his consultation room on the second floor. The room had a small shrine of Shiva at one corner beside his seat. There were three cushions on the floor for the visitors to sit. On the walls were hung the pictures of Shiva and other gods. One wall had drawings from astrological charts on some papers, which he used to explain how planets were arranged in the astrological houses of one's personal astrological chart. Just like the other astrologers, he also explained that depending on the location of certain planets, which he explained to me in detail, in a specific house of the birth chart, one either is capable (or incapable) of bearing a child.

Baldev loves to talk, so he spoke incessantly throughout the interview, and gave me many insights into his work. According to him,

> *one can find out if a man can bear a child or not by putting the semen on a glass of cold water so as to find out if the sperms are dead or alive. If the semen floats then the sperms are dead because there is "no childbearing substance," or dhatu in it; if it sinks, then the sperms are alive and therefore heavy due to the presence of the "childbearing substance." But one needs to be careful about the temperature of the water as it should match that of the semen lest the test fails.*

Then Baldev handed me a handwritten notebook in which he had scribbled different methods of treatments for various ailments. He told me,

> *"I compiled these from extensive readings of various sources,"*

In one of the pages, he had written many methods used to successfully have children. In brief, these methods include: a) eating certain parts of plants, roots, leaves, or seeds with milk or by mixing them with clarified butter (ghee); b) some treatment involves tying a root of some specific plant to one's body during the time when certain stars—*nakshatra*—have arisen, which is determined by the lunar calendar.

One of the remedies is that a woman should grind flowers and leaves of Shivalinga plant[127], a climber which derives its name from the resemblance of its seed to Shivalinga[128], and mix the powder with the milk from a one-year old cow. Then she should consume two spoons of the concoction thus prepared for ten days after she menstruates. The woman should recite a Sanskrit mantra "*Om namo bhagawate Basudevaye Devaki suta Govinda Basudeva jagatpate dehime tanaya Krishna twaamaha sharan gata*" 108 times daily for those ten days. After that she should prepare a yantra[129] by writing on a birch leaf with *ashwagandha*[130], white sandal, *kesar*[131], *kasturi*[132], *gorochan*[133], camphor, and wear it around the neck.

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[127] Scientifically known as Bryonia laciniosa, the seeds of this plant has been known to boost sexual function and fertility in Ayurveda (Chauhan and Dixit 2010). https://www.nature.com/articles/ijir200962

[128]Shivalinga is a representation of the lord Shiva's erect phallus on a flat circular base, which represents the vulva of his consort Parvati. According to the myth in Linga Purana and Swasthani vrata katha, Shiva was roaming in the world like a madman after his wife Sati died. He had lost his senses while grieving for his wife's death. At one place, he was spotted by the wives of the Seven Sages, who were immediately lured by his charisma and followed him. The Sages, upon seeing this, cursed the Shiva who to them was just another mad yogi in the street. The curse of the sages led to the falling of the Shiva's phallus, which created a big damage of apocalyptic scale. Only then did the sages realize their mistake and went to Brahma for help. Brahma told them that the Shiva's phallus can only be pacified by Parvati's yoni—vulva. The sages then managed to get Parvati to help them, after which the Shiva's linga stopped creating havoc and the order of the universe was restored (Iltis 1985: 232-235).

[129] Mystical geometrical drawings used in tantric practices

[130] Ayurvedic herb used for the treatment of many health conditions, infertility being one of them. It is used as a tonic to boost the sexual health of both men and women. https://chopra.com/articles/what-is-ashwagandha

[131] Saffron

[132] Musk

[133] Stone or bezoar that forms in the cattle.
http://www.sacreda.com/gorochun.html

Unlike in the case of Deepak and Ram Prasad both of whom I met through personal reference, I do not know anyone who had visited Baldev for the treat of childlessness. Therefore, the information he gave me needs to be further triangulated and investigated to verify if such methods are actually used for the treatment or exist only in theory. Nonetheless, the information provides a glimpse at various ways childlessness is understood and tackled by the healers. This also gives a hint of how various medicinal plants, mantra, astrology, and ritual implements are assembled together to create remedy for childlessness.

Before closing this section on the different healing modalities of childlessness and moving onto explore the dynamics of how they interact with each other in the field, I want to reflect on the issue of secrecy about the identity of herbs and treatment procedures among the healers. Deepak and Ram Prasad are only two examples of many healers who keep their treatment methods a secret. As discussed above, they are bound by oaths of secrecy given to their teachers. Baldev is an exception who revealed his treatment methods to me, and also the herbs and substances he uses to treat childlessness. In my second visit to him on 21 May 2017, Baldev asked me what had I managed to find about the treatment procedures of childlessness since I last visited him. I told him that I managed to visit a few healers in the due time but could not gather much details about their treatment methods. He responded,

> *"Nobody will reveal you any details about the treatment methods. Even I should not have given you much information but I did because I wanted to help you. Otherwise, it's our duty to keep these information a secret,"*

I was curious to know why the healers keep their knowledge secret, to which he gave four basic reasons: i) the power of the mantra is lost and the treatment loses its efficacy if it is revealed easily; ii) to preserve their trade secret as someone might learn their trade and pose a threat to their livelihood; iii) fear of being ridiculed for practicing seemingly "illogical" and "bizzare" treatment methods; iv) there is no economic benefit, or other non-monetary gains like social recognition, for the healers to share their knowledge.

The last point above is worth pondering as Baldev explicitly posed a rhetorical question to me:

"Why should I waste my time talking to you and share my knowledge when I don't gain anything from it in return?"

It was clear to me that he was expecting some kind of reciprocal exchange from me. In my previous visit, he had given me a few copies of his business card and asked me to distribute them to people I know. I had cursorily told him I would see what I could do about it because as my position as a researcher, I did not feel comfortable advertising or persuading the childless couples I met to visit any particular place or healer. However, after meeting him, I had once briefly told the men and women in the infertility clinic about him. In this visit, Baldev was not happy that no one had come to him for the infertility treatment in these two months since I had visited him; by which he inferred that I had not advertised about his service. Pointing to some 20 rupees and 50 rupees notes on his table, he added,

"I don't have any fixed consultation charge. But why would I talk for 30 minutes with people who only give me 20 or 50 rupees? How would I be motivated to talk at all for that much money? Instead, if the same person pays me 250-300 rupees, I will be motivated to talk for at least an hour."

I could sense that he was hinting to me about the amount of time he was spending on talking to me. In my previous visit, I had put 100 rupees bill on his table before leaving; he had spoken to me for about 2 hours then. Now after spending about an hour and a half talking to him, I kept 300 rupees on his table and left. Incidents like this sometimes posed ethical dilemma and methodological challenge in the field.

5.8 Dynamics of the interaction between different healing options

In the remainder of the chapter, I will explore the dynamics of the interaction between the different healing options in the therapeutic landscape. As I mentioned in the beginning of this chapter, therapeutic journey between various disparate healing options is a norm, rather than an exception, among the childless couples. However, I found that not everybody readily accepts the mingling of epistemically different therapies. Even the ones who do, there is always some

element of skepticism and initial reluctance. Many men like Bikash Neupane from Banepa near Kathmandu whom I met at Dr. Sweta's infertility clinic told me that they don't believe in healing practices such as that of *dhami-jhakris* as

> *"those practices lack any 'logic'* [like biomedicine]*".*

However, they told me that they have been to a few such healers. The reason behind their visit to those healers, they confessed, was not because they believed in the healers but because of the pressure they feel from their family and relatives. Bikash said,

> *"I half-heartedly pursued them,"*

However, he added that he is also not an absolute non-believer. But he told me that he only wants to follow the biomedical treatment for a while. He is tired of going to many places.

> *"The cause [of childlessness] could be something else but every other person tells us to visit this place or that place. That creates unnecessarily pressure in me,"*

he told me, and continued,

> *"I don't want to pursue treatments of* dekhaune*,* heraune *(soothsayers,* dhami jhakri*,* jyotishis*) anymore because it feels like I'm straying aimlessly in desperation and have no control over my life."*

I asked him if he does not feel the same desperation, tediousness, and loss of control while visiting the clinic as there too he is asked to do multiple treatments and visit repeatedly without any certainty of the treatment success. He answered,

> *"I don't feel that here. In my opinion, those kinds of other treatments are empty like air, with no firm logical basis. Just done because someone says do so and so, which is not easy to explain with any logic,"*

Likewise, few other men like Prabesh who, when I told them about Santaneshwor Mahadev and *jyotishis* that people visit, made comments like,

> *"There is no use going after such superstitions (*rudhibadi*). There is nothing else besides science. Going to temple is a matter of faith (*aastha*) but nothing is going to happen there. It's just a practice that has been going on since ages."*

Others also echoed the same sentiment as they claimed that

> *"People go to* janne *because it is a custom."*

At other time, a woman who was pursuing her treatment in the infertility clinic remarked:

> *"People have studied so much these days. Science has taken us so far ahead, how does the logic that eating raw meat cures infertility make any sense?" she asked in a skeptical tone and added, "The cure depends on how much the medicine works on our hormones. For some, the medicine works right away and they can conceive within two months; for others, the medicine might take longer to act."*

Similarly, I also overheard a group of women talking in the waiting room of the clinic once when a woman told others that she is doubtful about the healers and gave an example from her personal experience. A healer (*baba*) had predicted that she would have a son but his prediction failed to materialize as she gave birth to a daughter. When she confronted the healer, he rationalized the failure by giving some explanations. She provided this example as a proof that the healers are not to be trusted.

Moreover, like Anup's experience at the clinic in Delhi that left him humiliated even till the day he recounted it to me, many men are subject to such perceived ill treatments at the hands of treatment providers, be it a medical doctor, *dhami-jhakri*, or an herbal healer. These men might not fully approve of such encounters, yet they are coerced into submitting to the authority of the treatment providers. Sometimes they are also not convinced that the treatments work, like what Anup concluded after the treatments at multiple *dhami* failed. Other times, they are skeptical about the *dhami* because they do not see any rational basis in the *dhami's* treatment. Like Bikash, Girish is another example of that. Girish was born and raised in Parbat but lived in Bardiya and Nepalgunj, towns in the west and migrated to Gaindakot, a town near Narayangadh, later. He was only 21 and his wife 18 at the time of their marriage; thus, they waited for a few years to plan for a child. But when they decided to have a child and failed after trying for a few months, he sought medical help in Bardiya, where he lived

then, and found that his sperm count was low. Therefore, he told me, he did not find any reason to go to other healers like *dhami-jhakri*.

However, Girish went to a *jharphuk* healer in Nepalgunj. He was apprehensive of the *jharphuk* because the healer would only treat his wife and give her some liquid medicine to drink while he was not given anything. The diagnosis was also made for his wife—some *laagu-lagaan* (a category of spirit-beings) had latched on to his wife's womb that caused irregular menstruation and heavy bleeding during menstruation. The healing practice performed on the wife was to remove that *laagu-lagaan* and open/clear the womb. He told me, that except for a few times,

> *"Which is normal, she hasn't had heavy bleeding during menstruation. Her period is also not too irregular. But the* jharphuk *healer does not check me. He doesn't even know what the actual problem is; he doesn't conduct any test to find that out. I know it is my* kamjori*."*

Girish added,

> *"He has a set script of treatment and diagnosis that he uses on everyone. Besides that, these healers only treat women because usually it is the women who have the problem; so, if the husband is treated, then the wife will feel that the treatment was incomplete.*

Nevertheless, Girish continued the treatment with the *jharphuk* healer for three months without any concrete result. His cousin has been to a *dhami*—Tharu *guruwa*—in Tandi where the treatment involves consuming blood of a chicken or a goat. Girish did not pursue such treatment because he does not believe in such *rudhibadi* (superstition/backward thinking). He attributes his skepticism of the *dhami's* treatment to his educated family background where even his father had completed Bachelor—a great feat during his time—and was a teacher.

Even if the *dhami-jhakri* or herbal healer's treatment succeeded, the men and women remained ambivalent about the efficacy of those healers' treatments. 40-year-old Dinesh Pokharel from Chabhil in Kathmandu is one of them. He had been childless for 8 years. He sought biomedical treatment with a prominent gynecologist and infertility expert in Kathmandu. His sperm analysis showed low sperm count and therefore he was given medicine for fifteen days, after which the

count improved. His wife underwent four unsuccessful IUIs and also opted for IVF twice. When the IVF also failed, the doctor consoled them by saying,

> *"I have done everything I can; I have offered the best treatment there is. Now it is up to the god to grant you a child."*

Upset and dejected, Dinesh lost hope, but tried to make peace with the entire ordeal. He continued to narrate his story:

> *"I decided to wait for some time to see if it happens by itself without going to a hospital. If that would not work I decided to bring a child from a hospital* [i.e. adopt]."

Meanwhile, a friend told Dinesh about Bankali *mata* near Dinesh's home in Pashupatinath area who treats childlessness. Dinesh was reluctant to go the *mata* at first, as in his words,

> *"Even the most prominent infertility expert had already given up hope and the top of the line treatments had also failed, how could I believe such healer could do anything else to treat our condition?"*

Nonetheless, he visited the healer. The *mata* gave his wife some "small white pills" to consume and his wife conceived by the fourth visit and gave birth to a female child. When I asked him about his initial reluctance to visit the *mata* and his opinion of her and her treatment, he laughed and answered,

> *"I don't know how to make sense of it. I can only understand it by thinking that it was the right time and my wife's body was ready to conceive. Had we not undergone biomedical treatments, I doubt only such small white pills of the* mata *alone would work. But I also know that the biomedical treatments alone also had failed. So it is the combination of all those factors that enabled my wife to conceive."*

Similarly, Prem has also pursued many *dhami-jhankris* in the past. He personally does not believe in them he told me and would not go to them but he gave in to the pressure from his spouse and the family to visit such places. I told

him I have met some people who have had child after going to a *dhami* while the biomedicine failed them. He said,

> *"it could be so because something was missing in the biomedical treatment, which the* dhami's *method complimented. Or it could be that the biomedicine took so long to act and it so happened that the biomedicine worked while the person was seeking the* dhami's *service. In such case, the* dhami *gets all the credit."*

This was the logic many others expressed repeatedly whenever I told them about Dinesh's treatment success story. Prem at least speculated a possibility that the biomedicine and *dhami's* treatment were complementary; but some did not see that possibility at all. For instance, a woman from Biratnagar I met in the infertility clinic reasoned:

> *"This is how it works. People go to such places after the treatment in all other places doesn't work. But doctor's medicines continue to work inside their body even long after they have stopped taking those medicines. They don't know that internal wounds of their body have healed due to the medicine; when they go to such healer's place, it seems like the healer has done something. But the doctor's medicines work when they reach the healer's place and therefore they've the child. Instead, people say they were able to have the child after coming to the healer's place."*

Prem definitely did not want to continue to talk on this subject of *dhami* and other therapies as I could see that he was telling me all this in haste and his face cringed when he spoke about the visits. It seemed to me that he wanted to disown that experience by explaining he would not have gone to the *dhami* but went nonetheless in order to soothe his family and, in his own words,

> *"To follow the ways of the society."*

This is not to paint the picture that everyone I met disapproved of the *dhami-jhakri* and other healers. I want to point at the ambivalence that lies in the discourse of these treatment modalities. Contrasting to the ones who downrightly

called *dhami-jhakri* and other healers as fraud and the practice as mere superstitious beliefs, there were many who also told me they believed in these practices and also vouched for their efficacy. A man told me that he had been to a *janne* in Sinamangal in Kathmandu. He argued that such healers are popular because people recommend others once they succeed in having a child after getting the healer's treatment, just like in the case of medical doctors too.

> *"Why'd people believe if it didn't work?"*

he asked. Likewise, Birendra Acharya from Jagatpur in Chitwan opined that

> *"Not just due to superstition, we follow such practices thinking that it worked for others so it might also work for us. We also follow such practices because of hearsay. because others have told us it works."*

At another time, I found a group of women discussing about the treatments they have pursued when I walked into the waiting room of the clinic. One woman was telling others present in the room that she believes in the healers like *dhami-jhakri* because her own mother-in-law, who was childless for 22 years, could conceive after going to such healer; she had not taken any biomedical treatment in the meanwhile.

Similarly, there was a consensus among some that the healers like *dhami-jhakri* and their treatments should not be blatantly labeled as *andhabishwas*, "superstition," and these men challenged the authority of modern science as well. A man argued that,

> "*Everyone says science these days, anything except facts is called superstition (*andhabiswas*) but that's wrong. There were people even before the modern science started. People call themselves modern and only believe in science, but how long has science been around? 200-300 years?"*

A few others also echoed the same reasoning. According to them, *dhami-jhakri* and visiting temples are part of Nepali culture and therefore participating in such activities makes them who they are. They did not reject *dhami-jhakri* and temple visits as superstitious practices but saw them as complementing the biomedical treatment. For instance, Dambar, who has a child, told me that he had visited a temple to pray to the god and also visited a healer. He said both of those have a role in overcoming his childlessness. He argued,

"When I can't have a child, I'll say let's go to the temple and do puja, Santaneshwor is there. I know going to the temple is not going to make me a father, I am satisfied here in the medical clinic than going there. I can go to all the gods and goddesses to check what they do in those places but I cannot just go there solely for the treatment purpose. Medicine has a part in the treatment. It is because of the medicine that I could become a father but going to a healer and temple made my mind satisfied and mind is responsible for producing hormones. Going to the temple and healers will definitely do something to the hormones as well. I can vouch with 100% certainty that it is not due to visiting temples and healers solely that one conceives/fathers a child. Taking biomedicine for a long time definitely changes hormones; then it so happens that the person is able to conceive while visiting the temples and healers."

In his opinion, one should visit such places if doing that gives them satisfaction. But he also argued that only focusing on such healing practices is not enough, and added,

"Yet medicine alone also is not enough as well."

Dambar further described that the people in the village who do not have any access to the medical treatment resort to practices like *dhami-jhakri* only.

"But educated people try many things,"

he said.

"But why do you think even some educated people call these things andhabishwas *then?"*

I asked Dambar. His answer was,

"No that's not true. We have labeled those practices incorrectly. Whatever cultural things we have are tied to religion. We have grown with our culture so we participate in such things. We cannot fully emulate what the Europeans do in the pursuit of being modern and discard

our cultural practices but we follow these practices because they are part of our own culture and sanskar.*"*

Therefore, men like Dambar considered visiting temples, *dhami-jhakris*, and biomedical doctors as complementary practices, albeit, as we saw above, these practices exist in an uneven relationship to each other in the therapeutic landscape.

Moreover, people's skeptical attitudes were not limited to *dhami-jhakri* only but some were skeptical about herbal healers as well. After learning about Ram Prasad's herbal treatment methods through his cousin, my friend Sabin was surprised that it even works. He visited Ram Prasad to find out more about the treatment. Ram Prasad narrated his discussion with Sabin to me. He remembered Sabin telling him,

"Don't you have to tell the couples to go to a hospital instead of coming to you? Even in this age, people seek such treatment…"

Ram Prasad scoffed while reminiscing his encounter with Sabin:

"People don't believe in our medicine these days. They put one tablet of biomedicine in their mouth and are cured by the time they swallow it. Our medicines don't work that way, so people have become skeptical."

He then continued,

"All the people who come to me do so after having been to multiple hospitals; they are tired of the unsuccessful biomedical treatments. My ayurvedic medicine has worked as those couples are able to have a child after taking my medicine,"

and asked me,

"You tell me, now should I tell them to go to the hospital instead?"

Ram Prasad, however, was humble about his claim of treatment success and added,

"The Ayurvedic medicine is also not failsafe; it works for some and does not work for others. I should not be questioning or objecting the rigorous research done by

specialists and scientists [to produce biomedicine], but the same is true about the hospital's medicine too; it works for some and doesn't work for others! Does any single treatment method work for all? It doesn't."

This was similar to what Dr. Upadhyaya had told me about astrology and biomedicine; i.e., both operate in trial and error. Therefore, Ram Prasad argued that we ought to consider both biomedicine and Ayurvedic methods alike:

"We need hospitals too; I trust in hospital (biomedicine) even though I work as an ayurvedic healer. I am also alive because of the hospital's medicine I take for my chest problems."

Another healer, Bandevi mata, who treats the spirit causation of childlessness, also argued similarly. She boasted to have successfully treated childless women who had failed to overcome their childlessness even after spending fortunes in the "test-tube baby" treatments. She claimed that she could cure cases that the biomedical doctors could not. However, she argued that one should go to the doctor as well. She also visits the doctor and takes biomedicines for her heart problems. She said,

"One should pursue biomedical treatments for the ailments that are treatable by biomedicine; likewise, people should come to me for the ailments that are treatable by addressing the spirit,"

She was very clear about the limitations of each treatment approach; she opines,

"you can't just go to one and avoid the other,"

Likewise, since most of the patients who come to Ram Prasad, or any other herbalists, most likely take biomedicine simultaneously, I asked him if his *ayurvedic* product and biomedicine could be taken in tandem. He repeatedly told me that *ayurvedic* medicine is totally safe and does not do any harm when taken together with biomedicine. Many of these healers proposed that an illness has a multifaceted aspect and hence it requires combination of treatment approaches. According to Ram Prasad and Baldev, there are three different approaches that is used to tackle an illness according to the Hindu worldview: *yantra, mantra*, and *tantra*. *Yantra* is a material aspect of treatments such as taking medicines, visiting doctors; mantra denotes ritual aspects such as recitation of *Harivansha Purana*

and *Ganesh Purana* etc.; and tantra denotes spiritual treatments, making vows and visiting temples etc. It is only in combination of these three approaches can an illness be tackled effectively. Hence, it is not surprising that these healers did not find the use of biomedicine in tandem to their treatments problematic, as for them, these two treatments were dealing with different aspects of childlessness.

5.9 Biomedical authority's cynicism and irony of her beliefs

Although healers like Ram Prasad and Bandevi mata argued that childless couples should take recourse to both biomedicine and their treatment as childlessness has multiple causation, some biomedical doctors did not necessarily subscribe to the same view. I told Dr. Sweta about Dinesh Pokharel's success story and Baldev's tantric treatment methods. With a smirk, she told me to be careful about such treatment claims. According to her, these days so called Ayurvedic healers crush the (biomedical) pills and prescribe the powder as the Ayurvedic medicine. She said,

> *"That could be either Clomiphene Citrate or folic acid, if the man said they were given small white pills. Mata doesn't manufacture anything. Use your logic. Can those healers do that? Who is regulating them? They need to be put behind bars, giving such medicines without identifying them! What nonsense!"*

Similarly, she also dismissed Baldev's method of using water to determine if the sperm is dead or alive. She said there is no logic in that without even considering the possibility that Baldev's method might be based on different epistemology/ontology than that of biomedicine.

However, Dr. Sweta confessed that some *tantrics* do have "real" power to predict the causes, and prescribe cures for various ailments. She has been to one during some difficult times in her life. The tantric rightly found out the cause of her problem and also provided the right remedy. She claims,

> *"Though I cannot understand their ways, some good tantrics have their own logic that works,"*

Nevertheless, except for homeopathy, which

> *"has a logical basis to how it works,"*

she seems to be cynical about the other healing therapies. This too is an instance of ambivalence that people have regarding various healing therapies. As a biomedical authority, Dr. Sweta sees it as her responsibility to deter her patients from taking recourse to other healers lest those therapies do more harm than good. Yet she is also aware that some healers provide efficacious treatments and like everyone else, she herself has taken help of those healers.

5.10 Agency of the patients

I usually traversed between the consultation room and the waiting room throughout the day in Dr. Sweta's infertility clinic. The patients had to wait for hours before they were called for the consultation. I used to strike up conversations with the patients during their waiting hour. They were also eager to know about my research findings. When I narrated the story of the Bankali *mata* and the doctor's response about the white pills, one of them shouted,

> *"If the doctor is so sure that the white pills are folic acid or the allopathic medicine, why doesn't she give that medicine herself so that people like us would conceive easily without having to suffer for so long?"*

Then immediately, they asked me for the Bankali *mata*'s contact number and expressed their interest to visit the *mata* right after their doctor's consultation was over. Then they started revealing about their own visits to other healers besides biomedical clinic or other treatments they were taking, which they sometimes pursued simultaneously.

Urmila started showing her ultrasound report to another patient and they discussed the size of the egg and multiple cysts in their ovaries. Then she said to others,

> "*I found in the internet that gooseberry reduces the size of the cyst and therefore I have been consuming a lot of gooseberries."*

She suggested the other two women present there to take gooseberry and drink a lot of water.

> *"From my own experience, one has to eat a lot of gooseberry before coming for the IUI treatment so that the*

result will be better. My egg hadn't popped out[134] *when I came here yesterday* [as confirmed by an ultrasound]. *I, therefore, went back to my home and ate a lot of gooseberries and drank plenty of water,"*

she told the others. That day her egg had ovulated properly, which is a must for the IUI procedure.

Besides gooseberry, Urmila also found what she called, "ayurvedic ways" to take care of cysts through searching the internet.

"I found that aalas[135][flaxseed/linseed], *and white of the egg cure the cyst. I have been eating two eggs every morning since then," she said.*

Likewise, she also ate avocado after finding about its health benefits in the internet.

"Avocado doesn't taste good, but what to do, I eat it for the sake of my own health,"

she sighed.

After telling other women about the various "ayurvedic ways" and food she takes to deal with her ovarian cysts, she warned,

"But one should also not stop taking medicine as well."

She also shared that she keeps a chart of what she eats and what medicines/treatments she has started on her mobile phone as a note. Mobile gives her reminder ring when it is time for her to take medicines.

"One shouldn't take any tension[136] [stress] *during these times,"*

said she. This was one common suggestion everyone repeatedly gave each other in the waiting room. Urmila also revealed that she's been simultaneously visiting an Ayurvedic doctor and taking his medicines as well. When I asked if she's told that to Dr. Sweta, she smiled and said,

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[134] *Futeko thiyena*; this is a word commonly used for ovulation. In colloquial use, it means rupture, break, pop out

[135] http://www.thegundruk.com/spices-herbs-flavoring-ingredients-used-nepali-cuisine/ [Accessed on 25 August 2019].

[136] Her word

"How can I tell such thing to her? She'll be furious and will scold me for not trusting her and mixing therapies."

These vignettes provide rich ethnographic insights into the interplay of various dynamics in the healing path of childless couples in Nepal. They illustrate the ways childless couples seek multiple therapies, the couples' agency while they negotiate between healers and medical practitioners, and at a macro level, the ways various healing therapies co-exist and form a therapeutic assemblage. However, as can be seen from some of the cases above, the assemblage of multiple healing therapies does not form an even playing ground as there seems to be a clear asymmetrical relationship between the healing therapies found in Nepal. For instance, although the childless couples I met might contest the biomedical authority or pursue other therapies simultaneously, they cannot completely abandon the biomedical treatment for other kinds of healing therapies; or even if they do so, that only happens after a lengthy period of engagement with biomedicine, by when they have totally lost hope. Likewise, they cannot fully disclose to the biomedical authority that they are simultaneously pursuing other forms of healing as well for the fear of being reprimanded or ridiculed. The same might not be the case while they pursue non-biomedical therapies (such as *dhami-jhankri*, *mata,* and *jyotishi*), which they seek with an air of skepticism. The healers like *dhami* and *mata* are clear that their treatment might only work for some and that people should also take biomedicine to tackle their childlessness. Some doctors, however, even if they pursue healers like *tantrics* and *dhami-jhakri* for their own personal problems, warn their patients against going to those healers for the treatment of childlessness.

In her studies of *dhami-jhakris* in a village in eastern Nepal during the late 1980s, Stacey Pigg (1996) observed a similar attitude toward *dhami-jhakris*, which she argues is the result of the development discourse that started after 1950s in Nepal. Nepal opened its border to the outside world only during the Panchayat regime in 1950s and became a member of the WHO in 1953. Panchayat era also saw a massive state structuring guided by the ideology of *bikas*, or development and, as Malagodi describes, "the pursuit of 'modernity' explicitly became the State's raison d'être" (2013: 34). This was modernization driven by the non-governmental organization (NGO) led development model and was supported by foreign aid (Gurung 2006: 203-204). One of the ways

Panchayat sought "the pursuit of modernity" was through adopting biomedical model of healthcare (Dixit 1999). One of the aims of development was to introduce "modern medicine", which is placed to displace the existing healing modalities eventually: "'Modern medicine' thus has to combat healers like shamans" (Pigg 1996: 162). Although the Nepali state has come a long way since the Panchayati days, the current healthcare model is still a legacy of the Panchayat era's modernization drive. Today, the Nepali government has tried to address the issue of childlessness by recommending IVF, along with artificial insemination using sperm from the husband or donor, and surrogacy as a treatment option for sub-fertility and infertility in its health policies (MoHP 2014).

The media alongside heavily promotes biomedicine; for example, the articles published in the national daily newspapers on IVF and infertility have a standard narrative: couples who have failed to conceive naturally, and hence are facing social stigma and psychological stress of childlessness, resort to modern technology that miraculously cures them of their ills. But, like anywhere else in South Asia and beyond (Leslie 1976, 1980) there are many other healing practices available in Nepal (like Ayurveda, Tibetan medicine, ritual and faith healings) that involuntarily childless couples might choose to pursue beside biomedicine. This, however, is not reported adequately and favorably by the media and also is absent from the public discourse. For instance, in a recent Nepali movie *Kabaddi Kabaddi*[137], a childless woman character consults a *dhami* in her village who asks her to come alone for the treatment and bring some rice pudding with her. She obliges. The *dhami* puts something in the pudding and makes her eat it, which makes her drowsy and puts her to sleep. The audience then are implicitly made to understand that the *dhami* establishes a sexual contact with the woman, who becomes pregnant with his child. Later, she confesses to her husband about the *dhami*'s deed, which she was aware of while lying semi-conscious after consuming the pudding, and the couple leaves the village for Kathmandu in order to avoid the stigma and village gossip.

[137] https://www.youtube.com/watch?v=p951u0L9gVA [Accessed 31 March 2017].

Such representation of a *dhami* and his method of infertility treatment in a contemporary Nepali cinema is not very far off from what I found in my study as well. The men I spoke to in the infertility clinic almost always mockingly brought this issue of *dhami*'s "method" when we spoke about *dhami-jhankri*. Some even made reference to the same movie. Dr. Sweta also narrated a story of one of her female patients who came to her in tears proclaiming that she narrowly escaped being sexually assaulted by a *dhami* as a part of his treatment procedure. Veracity of such anecdotes are extremely difficult to establish due to the sensitive and secretive nature of the issue. Below I present this as an example of how such anecdotal evidences are propagated to discredit *dhami-jhankri* not just in the popular media but also in the infertility clinics and society at large.

However, Baldev recounted a time a few years ago when he was approached by a man who said he was childless due to his own condition of azoospermia. Therefore, he had come to Baldev to arrange for a solution to his problem. When Baldev told him that he did not have any treatment for azoospermia, the man proposed that he would send his wife to Baldev on a stipulated day and requested Baldev to "bless" her, which was a covert way of telling him to establish sexual intercourse with her. According to Baldev, he thought for a while and obliged to help on altruistic ground:

> *"I consented to the proposal of the man because if I can help someone and bring happiness in their life even by taking such means, what is the problem?"*

reasoned Baldev. However, Baldev said that the man returned to him after a few days and told him that the wife mockingly refused such proposal by the husband on the ground that the healer was not handsome enough. Although this situation ended comically, and might also be a fabricated story by Baldev, which I do not have any way to verify, it is a telling example of the possibility of the different means people take to overcome childlessness and also such examples bolster people's perception of *dhami-jhakri's* "methods."

Similar representation of *dhami-jhakri* and their "method" abound in the Nepali literary fiction too. Maya Thakuri's short story *War* is one example of that, which captures the narrative similar to what Baldev recounted to me. It is a story written from the wife's perspective whose husband has azoospermia. "[H]e was not ready to be called a *namarda*, less than a man, by his parents, relatives

and friends," writes the story's narrator. Despite her reluctance and refusal, the man coerces his wife to visit a healer, Swami Maharaj, after making an arrangement similar to that of the man who approached Baldev. The husband tries to persuade her by saying, "many childless couples got offspring because Swami Maharaj had blessed them…All you need is his blessing and you will be blessed with offspring of your own," (Thakuri 2016: 55). She gives in and visits the healer with her husband two times and refuses to go there the third time. Instead, she writes a letter to him recounting her experience in the healer's room and leaves him. She writes that the healer sent the husband away and conducted a ritual worship of her body with flowers and rice grain mixed in red powder (*aksheta*); he then offered her to drink some kind of juice, which she refused to drink. She leaves the healer's place as her husband tries to convince her to stick to the arrangement he had made with the healer. In the letter she reminds him that "[i]n your mind, you are suffering from the fear of being called a "*napunsak*" and "*namarda*"….[t]o prove your masculinity to society and to fulfill your desire, you were suggesting that I sleep with the sadhu," (Thakuri 2016: 52; 57). The wife disapproves of her husband and leaves him.

Although the short story might be a fictional account and that not all women in real life are equally empowered as the protagonist of the story and can exercise their agency like she did, this and Baldev's narratives illustrate that the gossip about *dhami-jhakri* and their "method" that circulates in the infertility clinic is not completely baseless. Just like the legitimization of using donor sperm in the infertility clinic, the *dhami-jhakri's* "method" must have been an approach that was legitimized as a religious/ritual solution to childlessness when the biomedical reproductive technologies were not available or for those who did not have access to such technologies. In contrast to the image of the *dhami-jhakri* and their "method", the IVF technology's entry into Nepal received a considerable positive attention by the Nepali media (e.g. Yogi 2005; Dhakal 2009; Dhamala 2014; Maharjan 2012). Such public perception created by the media and the state promote biomedical ideology, which may also add to the stigma of the "traditional" healing options, might be some of the factors shaping my informants' treatment choices and health-seeking behavior.

Some of these dynamics I witnessed in the field was seen by Stacey Pigg in her study as well. Pigg argues that the development discourse prevalent in

Nepal operated by creating a divide between a modern cosmopolitan rational Nepali subject that stood in opposition to credulous believers whose belief in local healing practices like shamanism was seen as a sign of backwardness and shamans as "illegitimate, irrational, and ineffective," (1996: 181, 187). Thereby, there were informants who told her they do not have belief (*bishwas*) in *dhamis* and such practices are *andhabishwas* (superstition). However, she found that such a neat divide did not exist in the village where villagers used their agency to question, negotiate, and reinterpret the *dhami-jhakris'* treatment to arrive at a solution that works for them (1996: 182). Similarly, she describes that the word *bishwas*, or belief, in Nepali means trust and also implies judgement, whereas, *andhabishwas* is a blind belief, which is sans judgement. Pigg argues, "[…] to be a believer, then, is to be a conscious agent, a thoughtful acting subject—very much like the rational knower in the discourse of modernity," (1996: 190). Therefore, for the villagers, *bishwas* in *dhami* means their "ability to discriminate between shamans who are credible and those that are not," and those who have this ability "can never be credulous. They are able to simultaneously assert that they are not the credulous villagers of cosmopolitan representations and still consult shamans for cures," (Pigg 1996: 190). Pigg, thereby, claims these villagers to be "modern believers," a term she coins to denote "people who believe in shamans skeptically," (1996: 191).

Not just the villagers in eastern Nepal, but the members of the urban middle-class that Liechty describes in his study (2003), and who also comprise men, women, healers, and biomedical doctors in my study, can be termed as the modern believers. For instance, on the one hand, the biomedical authority speaks from her power position granted to her by the powerful institutes of modern medicine and medical knowledge to blatantly dismiss the Bankali *mata*'s treatment method. She does not give a space for a possibility that the *mata*'s white pills could be some genuine (herbal) medicine in its own right while she also labels *mata*'s healing knowledge as fraudulent practice. Ironically, on the other hand, she believes in the tantric method of healing and can vouch for its efficacy through her own experience. The women in waiting room who question *dhami-jhankris*' methods while at the same time resort to their services also form the same pool of modern believers.

Additionally, as my vignettes have illustrated, despite the hegemony of biomedicine, Nepali childless couples seek multiple healing modalities either simultaneously or sequentially if one modality fails or is deemed ineffective. To these desperate couples, who are ready to try anything that would better their condition, factors like stigma, hopelessness, and desperation are also the driving forces behind their journey between epistemologically disparate healing options available to them. What aids this journey of the childless couple from biomedicine to other forms of healing is also the poor success rate of the biomedical technologies as well. When the medical authorities themselves resort to faith and rely upon miracles, as the success rate of their best technologies is only 30% (Inhorn and Birenbaum-Carmeli 2008), the patients are left with little choice.

Nevertheless, such journey and encounters, as seen above, are not seamless: at times, the childless couples juggle multiple authorities and knowledges—for example, biomedical, Ayurvedic, various kinds of information found in the internet—about childlessness all at once; sometimes, these authorities compete and also contest each other, as in the case of biomedical authority dismissing the *tantric's* logic behind the sperm analysis using water. Likewise, the patients are not mere onlookers as they also tacitly exercise their agency through multiple avenues like resorting to lay knowledge about what type of food increases the size of their egg, pursuing herbal treatment simultaneously without disclosing that to the biomedical doctor, using internet media platform to inform themselves about the do's and don'ts of infertility treatments, visiting *dhami-jhankris* and *matas*, questioning and doubting biomedical treatments when each cycle of IUI fails etc. In such encounters, there is a "dance of agency" (Pickering 2008), "between competing but asymmetrical forms of embodied authority made up of humans and nonhumans; ideas in the form of fragments of information through books, print and people; and in "modern times," …: Google.com!" (Naraindas 2014:141).

One important question that arises at this point is that despite the asymmetrical relationship between the healing options, hegemony of biomedical discourse, and the ambivalence and skepticism that people have about treatments like *dhami-jhakri* and temple visits, why are these treatments still very popular among people and how do people make sense of the seemingly disparate

diagnoses and treatments they are offered at these various places? The explanations of spirit causation given by *dhami-jhakri*, or astrological misalignment of planets and *nakshatra* determined through a birth-chart, or eating medicine that has its root in the religio-mythical narratives, or simply asking for child to the gods through the performance of penance are all ontologically different practices. To understand this, I borrow Taee's concept of "patient-multiple" to argue that such different practices and explanations of illness causation of childlessness are possible because [Nepali] patients "have multiple "healths" that require different curative approaches" (Taee 2017: 55). For Taee, "when a sick person places themselves in relation to a curative practice, they become a patient," and "a sick person is framed by the practices they engage and becomes a patient within the set of relations established and sustained between practice and patient (2017: 14). Using the idea of enactment as presented in Mol's *the body multiple* (2002), Taee describes the patient-multiple as "[…] a multi-subjectivity person who has different healths and bodies that are engaged in a diverse arrays of practices" (Taee 2017: 64). The childless men and women in Nepal are also trying to make sense of their condition through these diverse range of practices available to them as they themselves have multiple subjectivities constituted by the enactment of different healths and bodies. Traversing between the multiple therapeutic assemblages, hence, is possible because of this multi-subjectivity of the childless men and women and the "practices that enact them", which as Taee describes, "offer an agentive meaningfulness to experiences of suffering and healing" (2017: 65). Although the treatments might not succeed, the childless patients exercise their agency to choose for themselves "[…] which practices to use, which health a disease will inhabit, or which body to engage," (Taee 2017: 65). Thus, it is this exercise of agency and meaningful choice-making that bond and create "cohesive persons amongst a multiplicity of subjectivities," (Taee 2017: 65).

5.11 Conclusion

To conclude, my ethnographic inquiry has shown that childless couples in Nepal take recourse to multiple healing therapies in order to allay the intense pressure they face to bear a child. Biomedicine, herbal healers, astrologers, and

shamans are some of the therapeutic choices that my informants pursued. As seen in the vignettes I presented, there exists an asymmetrical relationship between the plural choices of healing options available in the Nepali therapeutic landscape where biomedicine has a hegemony over other epistemes of healing. However, the dance of agency between the competing therapies and patients, nevertheless, blurs dichotomies like 'tradition' and 'modernity,' 'global' and 'local' as these phenomena cease to exist in simple oppositional relationships. Instead, the multiple therapies exist relationally as a therapeutic assemblage and are assembled by the people as per their need and choice to create an experience of healing that is meaningful to them.

Chapter 6: Adoption, *Vansha*, and Lineal Masculinity

6.1 Introduction

In the previous chapters, I have discussed that fatherhood is an integral part of normative adult masculinity in Nepal. I also presented the findings that the reason men desire to father children is due to the felt need to continue their lineage and pass on the property, which I conceptualized as lineal masculinity (King and Stone 2010). Given these imperatives, in this chapter I probe whether adoption provides a viable alternative to overcome childlessness and actualize fatherhood in Nepal. To achieve that goal, this chapter explores the interactions between adoption, reproductive technologies, and lineal masculinity. On the one hand, I will explore how adoption creates contradictions in the concept of lineal masculinity and how they are resolved by men and women by redefining lineal masculinity. On the other hand, I will also discuss how reproductive technologies redefine both the ideas and practices of adoption, re-emphasizing ideas of lineal masculinity. Reproductive technologies seem to present an almost magical solution to having a biological child, or a semblance of that, and re-emphasize the traditional concept of lineal masculinity than socio-legal continuity that adoption offers. Contrary to the reproductive technologies, since adoption does not provide an opportunity to create the biological connection with the offspring, it is not seen as a feasible option by the childless men to form families.

Adoption is doubly stigmatized as it exposes men's failure to perform lineal masculinity and the dubious origin of the children available for adoption makes them undesirable while their loyalty to the adopted family is also questioned. For this reason, adoption is conducted in secrecy and modelled after biological reproduction. I will argue that due to the imperative to uphold lineal masculinity and have biogenetic connection with their offspring, men prefer not to adopt unrelated children but rather take recourse to the assisted reproductive technologies and many other healing options described in the previous chapter to father a child; however, even those who do not succeed to father a child and do adopt unrelated children, reformulate the idea of lineal masculinity and find ways to mitigate the social stigma attached to adoption by mimicking biological reproduction. Except for one couple who had already adopted a male child when

I met them, rest of the men and women on whom this chapter is based had been undergoing treatment for their childlessness in the two infertility clinics I visited. Therefore, most of what I present is based on the opinions of those men and women on adoption rather than the actual experience of adoption; nevertheless, their opinions reflect their attitude toward adoption and the underlying cultural beliefs that create such attitudes.

6.2 Lineal masculinity defined by *Virya*, *Purusattva*, *Purushartha* and *Vansha*

The general consensus among men that *vansha* is a form of biogenetic flow of masculinity through a male child and the imperative to enact lineal masculinity affects their view of adoption and decision about adopting unrelated children. In this section I present how two childless men conceptualise *vansha* and how that affects their decision to not adopt an unrelated child. In March 2019, I met 38-year-old Bishnu Adhikari from Bharatpur, Chitwan. He owns a provisional store in his hometown. I met him through a friend who is related to him. He was born in Assam in India and moved to Nepal when he was 9 years old. He was married 8 years ago and his wife was able to conceive five times but all of them endedin miscarriages. He had visited Dr. Sweta's infertility clinic in Kathmandu and had also visited many other healers at different parts of the country. He also performed *thada batti* ritual in the temple of Santaneshwor Mahadev in Lamjung on Shivaratri of 2019.

I visited his shop one afternoon and found him there with his wife. I had already spoken to him over the phone after my friend told him about my research. Just as I had entered the shop and taken a seat, a man stopped by. He seemed to be familiar to the couple as the three discussed something related to their common business. Then the man started a conversation on childlessness using cryptic and indirect language, which took me a while to understand. The Adhikari couple also participated intently. The three were discussing about someone called Parvati. The man told Bishnu,

> *"I will talk to her and persuade her to agree for that. I will remind her that she will get a good sum of money."*

Later, after the man left, Bishnu clarified that they were discussing about "buying the womb" of Parvati. I came to know that they were planning to persuade Parvati to become a surrogate mother of Bishnu's child. He also revealed that it would be through a consensual intercourse to which his wife also has already agreed.

"I need a child anyhow, by whatever means it may be,"

he said and grinned. The wife, who was listening to our conversation from outside the shop, nodded in agreement. Bishnu was willing to pay up to 5-6 lakhs rupees to the surrogate woman, which is a lot more than what a man would pay in both formal and informal adoption. I will elaborate about the cost and procedure of adoption below.

"We will also get what we need and that money will also help the woman in her livelihood; it's a win-win situation for both of us,"

argued Bishnu and added,

"a few men I know have already made similar surrogacy arrangements in Kathmandu."

This is how he came to know about the possibility of surrogacy.

Bishnu's family and neighbors have asked him to remarry but he does not want to because he says,

"That is unfair for my wife."

When I asked him why is he willing to take extreme measures like the kind of surrogacy arrangement he was exploring, his response was,

"You know one has to continue the vansha*, therefore I need one son at least."*

He does not want to adopt a male child instead because he opined,

"That child would not completely be mine and therefore he would not carry on my vansha*. Only the child who is made from my blood and* virya *is my* vansha*."*

This made sense why he was willing to have a child through surrogacy as the *virya* used for conception would still be his. Another reason he gave for not wanting to adopt a child was that although it might solve the problem of parenthood, adoption is not the same as having a biological child. He said,

"You need both water and food to survive. They are necessary for your sustenance but you cannot substitute one for the other,"

to argue that although an adopted child might also serve similar purpose as a biological child in the sense that a man can claim to have become a father, it would not be the same as having his own biological child. Additionally, according to him, the desire for a biological child cannot be substituted by the adopted child. Although the discussion of the practice of surrogacy, to which Bishnu was planning to take recourse, is beyond the scope of this chapter, his example demonstrates the measures that men are willing to undertake in order to actualize/enact their lineal masculinity by fathering a biological child by any means possible.

Likewise, Shiva also elaborated the concept of *vansha* as described in the Hindu scriptures and reiterated the need for one's biological child for the continuation of one's *vansha*. Shiva is one of the childless men I came across in my hometown during a visit to an infertility clinic there. He is a priest by profession and has a MA degree in Sanskrit from Banaras in India. He is in his mid-thirties and has been married for 10 years. He described *vansha* using two additional terms: *purusattva* and *purushartha*. According to him,

"Whatever a man does in his lifetime, either they be good deeds or bad, he is not remembered by anyone else after his death. However, his deeds are carried on by his sons and grandsons till the posterity through memory. That is what I mean by purusattva *and* purushartha*. I am enjoying the* purusattva *of my grandfather and father today. Likewise, my* purusattva *is enjoyed by my children,"*

And continued,

"We have not achieved any kind of purusattva*, which we will succeed to achieve by begetting children."*

In his description, *purusattva* or *purushartha* is

"The cumulative tangible and intangible assets of a person that is earned through meritorious acts in his lifetime. Those assets, which also includes the man's fame and family prestige along with the properties he accumulates

through work, passes on to the sons who uphold and add to what they have inherited before passing them onto their sons."

According to Shiva, women do not pass on such assets themselves but

"Are the vessel through which a man's vansha *is propagated and passed on."*

Nevertheless, women are also crucial factor in expanding a man's *purushartha*, Shiva claimed.

"His purushartha *expands and comprises of his own family clan, his wife's family, his mother's natal family, and his disciple. They are larger circle of a man's* purushartha*,"*

Here, it is important to mention that Shiva was using the local terms to explain lineal masculinity. Although a man's *purushartha* is defined by his ability to procreate a son, the ability, or inability, alone does not define the entirety of his *purushartha*. *Purushartha* encompasses the man's name and fame in the society, the properties he earned, his financial assets, and his virtuous conducts as well. These unique aspects that comprise a man passes onto his son through *virya* and hence Shiva argued that

"Only the child born from a man's virya *is called his* vansha*."*

However, according to Shiva,

"A son only qualifies as a good vansha *holder if he conducts honorable deeds, has good moral standing in his society*[138]*, and can add to the* purushartha *that he has inherited from his father."*

These are the similar properties, or symbolic estate, of lineal masculinity that King and Stone (2010) describe.

Moreover, by the end of the three-hour conversation, Shiva deconstructed all the common reasons that are given by people for why they desire children, viz., old age support, provide offerings after death and help in attaining liberation. Instead, he reiterated that the need to pass on the *purushartha* was the

[138] He used the word *maryada*, which loosely translates to discipline, good conduct, duty, limit, honor, dignity.

primary reason behind that desire. Shiva argued that it was not absolutely necessary for a man to have a child for his liberation or to make offerings to him after his death. According to him

> *"A man can earn enough spiritual merits through good karma while he is alive so that he is liberated after his death."*

Likewise, he argued that

> *"Neither is there a guarantee that one's biological child will look after the couple in their old age."*

Nevertheless, Shiva told me there are a few reasons that still makes it necessary to have a biological child. First, a biological child might not be necessary for one's funerary rites and liberation but through a biological child one repays the *pitri rin* or debts to the ancestors. Second, a man is like a plant according to Shiva. He cited a section on the description of human body from the fifth chapter of Bhagavat Purana that defines human body. Shiva explains,

> *"Just like a plant's essence lies in its growing and producing fruit, a man's life is only worth if he can produce and offer his fruit of labor to this world,"*
> *"A man does that by generating* purushartha *and passing that to posterity through his sons."*

Hence, a child is necessary in order to carry on the man's *purushartha*, not necessarily to liberate him after his death.

Thus, like Bishnu, Shiva also argued that adoption of an unrelated child cannot substitute for the biological child for the same reason that an adopted child does not form the *vansha* of a man. According to Shiva,

> *"in case a man does not have his own biological child and therefore brings someone else's child and raises him as his own, it is not called one's* vansha*. Such child is called* dharmaputra *by society. He is a* putra *nonetheless but only* dharmaputra*, not the biological child."*

For him, *dharmaputra* can only fill the void of parenthood but cannot uphold the *vansha*:

> *"Even if a man raises the son, provides him good education and gets him married, which are the duties of a*

father, the dharmaputra *will not carry on the man's* vansha*; the* vansha *ends after the man's demise."*

Dharmaputra lacks the connection that is formed through *virya*, which is a substance through which lineal masculinity flows. Thereby, the notion of the primacy of biological fatherhood over social fatherhood that childless men like Shiva and Bishnu hold deters them from choosing adoption as a solution for their childlessness.

6.3 *Dharmaputra*: Adoption and Kinship in Hindu South Asia

Despite such strong association of a male child with *vansha*, adoption and foster care were not a novel practice of family formation in Hindu South Asia. Adoption was culturally accepted and legally institutionalised alternative option of family formation. This can be discerned from the various Hindu mythologies, texts like *Manusmriti*, and the legal codes such as *Muluki Ain* and *Devani Samhita* of Nepal. For example, the figures like Karna and Shakuntala from the Hindu epic Mahabharat were raised by others beside their biological parents. They were born out of wedlock and therefore were abandoned by their biological parents. Karna was born out of wedlock from the union of the Sun god and Kunti. She abandoned Karna in a river for the fear of being exposed and stigmatized. Karna was found and raised by a poor charioteer who was childless. Later, when Karna discovered his royal origin and the identity of his biological mother, he remained faithful to his adoptive parents and did not abandon them for the biological mother. Similarly, Vishwamitra was a Kshatriya sage, who through his spiritual achievements was elevated to the Brahmin caste. His spiritual quest posed a threat to the King of heaven Indra and the latter sent an apsara[139] Menaka to distract Vishwamitra from his spiritual pursuits. Shakuntala was born to Menaka and Vishwamitra but was abandoned at a river bank where Kanva found her and he adopted her (cited in Bhargava 2005: 25). Although adoption like those mentioned above might not necessarily have been conducted to overcome

[139] In Hindu mythology, *apsara* are the female celestial beings that are singers and dancers in the heaven of the king of gods Indra. https://www.britannica.com/topic/apsara

childlessness, mythologies like these hint toward a broader acceptance of foster care and social fatherhood in Hindu culture.

Similarly, the descriptions of different categories of sons and the property inheritance rules for them in *Manusmriti* also provide templates for the various ways a man could become a father and relate to his sons. There are twelve types of sons according to the *Manusmriti*. They are: a) "a natural son"[140] (Olivelle 2005: 198)[141] (*Auras*); b) "a son begotten on the wife"[142] (*Kshetraj*); c) "a son given in adoption"[143] (*Dattak*); d) "a constituted son"[144] (*Kritrim*); e) "a son born in secret"[145] (*Goodhotpanna*); f) "a son adopted after being abandoned"[146] (*Apavidhda*); g) "a son born to an unmarried woman"[147] (*Kaanin*); h) "a son received with marriage"[148] (*Sahodha*); i) "a purchased son"[149] (*Krita*); j) "a son

[140] "When a man fathers a son through his own duly wedded wife, he should be recognized as a *natural son*—the principal son," (Olivelle 2005: 198).
[141] I have retained the translation from Olivelle for the rest of the categories as well.
[142] "When a wife of someone who is dead, impotent, or sick bears a son after she has been appointed in accordance with the Law specific to her, tradition calls him a son begotten on the wife," (Olivelle 2005: 198).
[143] "When during a time of adversity a mother or a father joyfully gives her son in adoption with the ceremonial pouring of water, a son belonging to the same class as the recipient, he should be known as a *son given in adoption*," (Olivelle 2005: 198).
[144] "When someone installs a boy of equal class as his son, a boy who knows right from wrong and is endowed with filial qualities, he should be recognized as a *constituted son*," (Olivelle 2005: 198).
[145] "When in someone's house is born a son whose father is unknown, he is a *son born in secret* within the house; and he belongs to the man whose wife gave birth to him," (Olivelle 2005: 198).
[146] "When a boy has been abandoned by his mother and father or by one of them and he is taken by someone as his son, he is called a *son adopted after being abandoned*," (Olivelle 2005: 198).
[147] "When an unmarried girl gives birth to a son secretly in her father's house, one should call him by the name *son born to an unmarried woman*. The offspring of an unmarried girl belongs to the man who marries her," (Olivelle 2005: 198).
[148] "When a pregnant woman is married off, whether her condition is disclosed or not, the child in the womb belongs to the man who marries her and is called *son received with marriage*," (Olivelle 2005: 198).
[149] "When someone purchases a boy directly from his mother and father so he may have a child, whether that child is of the same class or not, he is his *purchased son*," (Olivelle 2005: 198).

born to a remarried woman"[150] (*Paunarbhava*); k) "a son given in adopted by himself"[151] (*Swayamdatta*); and l) "a son by a Sudra wife" (*Shaudra*)[152]. Alongside the biological sons, adopted sons also were legitimate heir and were recognized as one of the twelve categories of sons of a man.

Apart from the natural son, rest of the eleven categories of son are considered to be the surrogate sons, which is allowed in order to ensure the continuity of the ancestral rites. The natural son is the sole rightful heir to the parental property but to be fair to other categories of sons, the natural son has to distribute the property among them as well. However, the other categories of sons only inherit differential amount of the parental property according to their position in the hierarchy of the categories (Olivelle 2005: 198-199). Nevertheless, there is a separate provision for the adopted son. Even though he has been obtained from a different lineage, the adopted son has a claim to the inheritance of the father's property if he possesses "all the fine qualities."[153] This, however, means that the adopted son cannot inherit his biological father's lineage and property. Similarly, a man has a duty to make *pinda* (rice-ball) offering to the deceased ancestors and perform funerary rites of his biological family only as long as he is the heir to the lineage and property of his biological father. In case he is given away for adoption, he no longer has a duty to make *pinda* offerings to his biological family but he now has a duty to conduct funerary rites of his adoptive father and make offerings to the ancestors of his adoptive family (Olivelle 2005: 197).

Likewise, adoption was legally institutionalized in Nepal through the legal codes at different times. These legal codes have a section on managing adoption. The previous legal code or *Muluki Ain* of 1963 also reflected this

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[150] "When a woman who has been abandoned by her husband or his widow marries again and begets a son of her own will, he is called *son of a remarried woman*," (Olivelle 2005: 198).

[151] "When someone who has no mother or father or who has been abandoned without cause offers himselfs up to a man, tradition calls him a *son given in adoption by himself*," (Olivelle 2005: 198).

[152] "When a Brahmin fathers a son by a Sudra woman out of lust, tradition calls him a Parasava, because while still able (*parayan*) he is a corpse (*shava*)," (Olivelle 2005: 198).

[153] Although the text does not elaborate on this, I presume the fine qualities also mean same caste and class as that of the adoptive parents.

practice prevalent in Nepal earlier. The *Muluki Ain* allowed adoption of a male child from a specific order of relationship: "children of full brothers; children of half-brothers; descendants of the same grandfather; children of daughters; descendants of the same great-grandfather; children of sisters; children of relatives of the same gotra" (Nepal Press Digest 1973: 1; cited in Stone 1978: 21; Khanal 1970: 165). The legal code further explains that the "order of preference" should be followed strictly and the adoption done by violating that order would be considered void (Stone 1978: 21; Khanal 1970: 169). The adopted son would then be considered a full member of the adoptee's kinship group; hence, he forgoes his right to his biological parent's property but has a rightful claim to the property of the adoptive parents. This type of adoption arrangement does not envision adoption of unrelated orphan children. One of the reasons for this could be to keep the property within one's larger family group. The other reason could also be to maintain the caste purity of the descendants as the caste background of the orphans who are abandoned in the hospital or roadside, which are the major sites from where the children are rescued and put into the orphanages, can remain dubious.

In his analysis of the *Muluki Ain* of 1963, Khanal argues that although adoption is practiced as an alternative to overcome childlessness and as a means to secure old age support and performance of death rituals, adoption is principally conducted for the economic reason (1970: 165, 169). This means it is conducted in order to safeguard a man's property and to ensure that it passes on to his line of the family. It can therefore be argued that the legal adoption enacted by the *Muluki Ain* was also based on the principle of lineal masculinity on two grounds: a) allowing adoption from only a closely related kin with a strict order of eligibility meant that the adopted child resembled the man's *vansha*, connected through blood[154], as closely as possible; this also meant that the caste purity was also maintained; and b) it ensured that the man's property stayed within his line of the family as it passed onto his adopted son and the subsequent generations.

The current legal code, *Devani Samhita* that was released in 2018 by replacing the *Muluki Ain*, also has a section on the management of *dharmaputra* but does not mandate such strict order of preference of kin for adoption. The

[154]I will discuss about the construction of kinship in relation to blood below.

Devani Samhita defines adopted children as "anyone who accepts another person's son or daughter as his or her own son or daughter, such children are considered to be *dharmaputra* or *dharmaputri*, [No. 169]"[155] (2018: 54). The term used for adopted child is *dharmaputra*, for male child, and *dharmaputri*, for female child. Dharma is a polysemic word, the meaning of which are varied: duty, religion, conduct, law. Therefore, the two words could be translated as "son by religion/law" and "daughter by religion/law." A significant difference in this legal code is that it allows for adoption of unrelated children from orphanages and also allows the adoption of a female child—the provisions that the previous legal code lacked. The *Devani Samhita* mandates that adoption should only be conducted if it serves the best interests of the children and ensures their rights. This is also another significant change in the attitude toward adoption and adopted children. Whereas previously adoption was considered as a means to overcome childlessness and thereby was focused on the need of childless men, contemporary focus has shifted to the rights and interests of the children.

This shift is further reflected by the practice of conducting adoption procedures in the district court instead of conducting it in the Land Revenue Office (*Malpot*); the latter was the case until a few years ago. Mr. Dangol, the director of one of the prominent orphanages Nepal Children's Organization (NCO or commonly known as Bal Mandir[156]), gave an interesting reason behind the practice conducting the procedure in the *Malpot*. According to him, usually people adopt children as a means to safeguard their property by declaring the child as their heir. Since the land revenue office is one of the major sites where

[155]My translation. See *Muluki Devani (Samhita) Ain, 2074.* www.lawcomission.gov.np. for Nepali text.

[156] Bal Mandir was established in 1964 by erstwhile Queen Ratna Rajya and received patronage of the palace until the monarchy was abolished in 2006. Located in Kathmandu, today, it is an autonomous non-profit making, non-governmental organization with no political affiliation that works "for the best interest of Nepalese children by shielding and promoting their rights in addition to providing residential care to the children at threat" (NCO n.d.). Currently, about 500 children are residing in the organization's children's home that are located in various parts of the country. The children comprise of those who are abandoned in the hospital or street, orphans, those affected by the decade long armed-conflict, those who have parents in the prison, and the like. It facilitates both national and inter-country adoption.

property transaction occurs, adoption was enacted in this site by legally formalizing the heirship of the adopted child there. However, Mr. Dangol argued,

> *"Such practice reduced the value of an adoptive child only to its function of being an heir to an adoptive parent in order to prevent the property from being usurped by the man's close kin. That is unfair to the adopted child as he or she also has a right to live a dignified life just like any biological children of a couple. Therefore, the venue for adoption shifted to the court from the land revenue office."*

Mr. Dangol's statement aligns with the overall mission of the NCO that works to ensure "[…] a dignified life and livelihood of the child," and "to protect and promote children's rights as per the convention on the rights of the child by collaborating with individuals and organizations throughout the world to strengthen a nationwide network and enhance the capacity to provide the best available care and support" (NCO n.d[157].). This rights based approach to understanding the value of children is a new shift in the rhetoric of meaning and value of children as previously children were not taken as separate individuals with their own rights and dignity. This has a big effect on adoption process as a whole and especially inter-country adoption[158], which is also promoted on humanitarian grounds (van Wichelen 2019).

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[157] https://www.nconepal.org.np/vision-and-mission/

[158] Intercountry adoption comes with many complicated issues such as race, class, religion, ethnicity etc. the discussion of which is beyond the scope of this chapter. Bal Mandir also arranges for inter-country adoption. However, inter-country adoption has been very controversial on various grounds. To briefly summarize the issues, there have been reports of children being declared as orphans whose parents are still alive; likewise, the agencies are also blamed for preferring the inter-country adoption for in-country adoption because of the large monetary benefits involved in the former. Similarly, the inter-country adoption also provided an easy channel for human-trafficking, especially during the adverse times like the 2015 earthquake. Hence, complications like these have led the US to suspend adoption from Nepal briefly in the past (http://news.bbc.co.uk/2/mobile/south_asia/8498005.stm; http://news.bbc.co.uk/2/mobile/south_asia/7588756.stm; https://www.loc.gov/law/foreign-news/article/nepal-international-call-for-improvement-of-adoption-process/; https://kathmandupost.ekantipur.com/news/2015-05-27/government-bans-child-adoption.html).

Despite such significant changes in how adoption and children available for adoption is framed, I found that in practice, adoption of unrelated children from orphanages is also enacted on the basis of the principle of lineal masculinity. Certain features of lineal masculinity such as a) maintenance of the caste purity, b) physical resemblance between the adopted child and adopting parents, and seeking to adopt a young infant to mimic biological reproduction, and c) high demand for a male child, are the criteria that guide adoption of unrelated children from the organizations like Bal Mandir. The caste of the child often becomes the central concern for the prospective adoptive parents who approach Bal Mandir. Mr. Dangol revealed to me that many adoptive parents ask the organization to provide them the child that belongs to the same caste group as theirs and say the child has to have physical resemblance to them as much as possible.

> *"Especially if the couple is Brahmin, they tell us to avoid the child from Dalit or other* janajati ["ethnic"] *communities like Rai, Limbu, and Newar. At most, they are willing to step down a ladder in the caste hierarchy and adopt a child from Chhetri caste but they will not go below that,"*

explained Mr. Dangol. He also explained that in many cases when the caste does not match, the prospective adoptive parents blatantly reject the child proposed to them by the organization. They are rather willing to wait for a few years until they find a child with the desired caste.

Likewise, the men and women want as much physical resemblance as possible between the adopted children and themselves so as to create some semblance to biological reproduction. On top of that, the prevalent stereotypical notions about a person's physical features and their correspondence with caste and ethnicity also determine how the semblance to biological reproduction is created. For example, those belonging to Brahmin and Chhetri caste groups are considered to have fair complexion and pointed nose while those residing in the south, Terai, are considered to have darker complexion; similarly, those

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Here, I only want to point out the shift in the rhetoric of the meaning of children and its effect on adoption practice.

belonging to ethnic groups like Rai, Gurung, and Magar are considered to have flat nose and small eyes. Thereby, the men and women who approach Bal Mandir for adoption seek for a child who fulfils these criteria.

Moreover, as adoption from organizations like Bal Mandir is largely kept secret by the adopting men and women, they apply for adoption of an infant that is as young as possible so that they can claim to others that the child is their biological child. I also found that some couples move away to another city after adoption and raise the adopted child as their own biological child in their new abode; while some return to their home with a child after staying away for some time and tell others that they were able to have their own biological child after pursuing biomedical treatment.

Mr. Dangol pointed out the irony in all of these practices in adoption as majority of the children who they shelter have dubious origin and defy the mandate of lineal masculinity viz. most of these children are born out of illegitimate union; likewise, the children born from inter-caste marriages that are not sanctioned by the family of the couple are also sometimes put in the orphanages because they are not accepted by the biological parents' larger kin circle. Therefore, these children who will be adopted do not fulfil the criteria such as the maintenance of caste purity. Similarly, depending on various factors, such as availability of the child, suitability of the prospective parents, and the bureaucratic procedures, the entire process of legal adoption can take two to three years. This means that by the time the adoption process is through, the child received by the adopting couples might be at least two or three years old. Unless the women fake pregnancy[159], it is impossible to hide the fact of adoption from

[159] This is not completely unfounded and is likely to happen. In her study of the meaning of children in Lucknow, India, Singh (2011) found that the women who approached Mrs. Farooqui, a retired counselor of the government family planning program, for arranging a child for adoption had resorted to the tactic of faking pregnancy. Singh writes: "Mrs. Farooqui told me that she had seen cases in which women simulated pregnancy by tying pillows around their stomachs, which gradually expanded until the time of their "delivery," by which time they hoped that Mrs. Farooqui would have located a suitable match for them. She even said that some women claimed that their husbands were unaware of this farce, since they had informed their husbands that their doctor had strictly forbidden their husbands from touching them until the baby's birth. Such simulations might conclude with frantic calls from the women, saying something to the effect of, "I'm in my tenth month now... will you have a baby for me soon?"" (2011: 249).

others and claim such adopted child as the couple's biological child. These facts, however, remain an open secret that gets glossed over during the process of adoption in Bal Mandir. Nevertheless, Mr. Dangol tries to match the demand of the adoptive parents as much as possible by finding them a child with some physical resemblances and similar caste background.

Since the legal adoption is cumbersome and lengthy due to various bureaucratic procedures, those who adopt opt for informal channels so that they can adopt an infant right after its birth. This also helps them to avoid leaving behind trails of adoption in the form of legal paperwork and create some resemblance of biological reproduction. Here, I am not including a practice of foster parenting or other informal ways that children are cared and raised by close kin other than the biological parents in Nepal. Studies have shown that such informal ways of raising children in foster care is very common in Nepal due to many reasons such as poverty, family conflict, and violence (Gale and Khatiwoda 2016). However, for the purpose of my study, I am focusing on the children adopted by couples who are childless and are not related to the child's family. There are many contacts that can help a couple to adopt a child informally; for example, contacts in hospitals, doctors, friends, and relatives could provide them information about the children that are available for adoption. Some couples directly approach their contact in the hospital they know or their doctor recommends them to a particular hospital. Sometimes, the friends of the couples also inform them about the doctors or hospitals who might help them to identify an adoptee. These informal channels operate discreetly so there is no authentic information about the details of the procedures. Much of the information that is discussed in the waiting room of the infertility clinic about adoption is based on the hearsay rather than the actual fact.

Nevertheless, through Anup Bhattarai, who adopted a male child through such an informal channel, I came to learn that there are no direct guidelines on how such adoption occurs. The doctor in his hometown who had treated Anup and his wife had suggested to Anup that he think about adoption. Anup told the doctor to help him with adoption as well and that is how he was able to adopt a child from a hospital in Bharatpur. He narrated his experience of adoption thus:

> *One morning I got a call from the doctor. He told me that a male child had been born in the Bharatpur hospital that*

morning and the parents of the child could not afford to raise him. The doctor told me that the parents were willing to give the child for adoption. I gathered few friends immediately and went to the hospital. A man, who acted on behalf of the hospital and the parents, gave us the child. He did not allow me to meet the child's parents. He said, if the child's parents know that I have adopted their son, they might bother me in the future and ask for money. The man also told me that he had not revealed to the parents that I was adopting their child. He had told the parents that a rich businessman from Kathmandu was adopting their child. The man asked me to give Rs. 45,000 to the parents of the child as a "token of appreciation" rather than a formal fee of adoption[160]. I am not sure if the parents received the money or whether that man pocketed all, or some, of the money himself.

Hence, as I mentioned above, Anup's narrative shows that there are no formal regulations on adoption conducted through informal channels. It is conducted privately with the involvement of a few people and is kept secret. The financial transaction that occurs is also not regulated.

Mr. Dangol opines that adoption conducted informally from the hospital should be discouraged. According to him,

"The hospital wants to get rid of the abandoned babies as soon as possible because raising a child adds to the operating cost of the hospital. The doctors in the hospital also do not want to take any responsibility for the upkeep of the abandoned children."

Hence, he argues that the doctors hastily arrange for private adoption through informal channels.

"Since the private adoption does not follow any legal procedures,"

[160] Bal Mandir collects 150,000 Rupees as the processing fee for arranging adoption.

Mr. Dangol described,

> *"it does not protect the rights of the adoptive parents and the child. This may result into legal complications later on whereby the child might not be entitled to inherit adoptive parents' property."*

Additionally, Mr. Dangol also pointed out the potential danger of exploitation by the mediator involved in the adoption process. As in the case of Anup, most of the private adoption is conducted in exclusive secrecy with the involvement of only a few people at most. Mr. Dangol argued that,

> *"If one of the mediators involved in the process is unhappy with the remuneration he or she receives, that person might disclose the secret to others or exhort more money from the couples in the future by threatening to disclose their secret. The couples will have no recourse to any legal support in those situations."*

Thus, even though adopting a child informally, might allow the couples to maintain the façade of biological reproduction as they can bypass the lengthy bureaucratic procedures involved in legal adoption and adopt an infant right after its birth, it is a risky choice that might not fulfil the couple's original intention to pursue it.

The case in Nepal has many similarities and a few differences to what Bhargava (2005) found in Delhi, India. Unlike in India where the adoption laws are not uniform and apply differently to various social groups (Hindu, Muslim, and Christian), Nepal's adoption laws are not divided along the lines of caste and religion. However, one may assume that given the Hindu hegemony in the country, the laws are influenced by the Hindu values just like the case of *Muluki Ain* that derived its contents from *Manusmriti*. There was a clear preference among the upper- and middle-class Hindu upper caste couples in Bhargava's study for the children from upper caste and class for adoption. The skin color and physical features of the child stood as the markers of the caste and class among the prospective adoptive parents in Delhi. She argues that "[t]he negative attitudes towards children in institutions with unknown caste, class and religious background are a reflection of caste and class prejudices. Stereotypes that relate to a particular caste, class or religion seem to pervade extra familial adoption

orientation" (2005: 63). She further argues, "the notion that 'fair is beautiful' and 'fair is class' brings in considerable resistance to accepting a child who is dark and has certain kinds of features. A child who has a flat nose is referred to as one with 'tribal features' and does not gain acceptance in the 'usual' upper- and middle-class families that come to adopt," (Bhargava 2005: 67). The adoptive parents approached the adoption agency and requested for a child from a "good family": "*Acchhi family se baccha chahiye,*" (Bhargava 2005: 67); by 'good family', they implicitly meant the upper-caste and upper-class family (Bhargava 2005: 68). Other features like education of the biological parents, their "personality and social characteristics" (Bhargava 2005: 67) also determined what is meant by a 'good family' by the adoptive parents who approached the adoption agencies in Delhi. Additionally, the adoptive parents were curious about the occupation of the biological parents, which gave them some assurance about the class background of the child.

Religion of the child also seems to be a matter of concern for some adoptive couples in Nepal but that did not play as big a role as the caste. This might be so because of the implicit assumption that if the child comes from the upper-castes, i. e., Brahmin and Chhetri, that automatically makes him or her a Hindu. Singh (2011) has described a similar situation in Lucknow, India. Some Hindu and Muslim couples in her study were also concerned about the religious background of the children they planned to adopt. Mrs. Farooqui, an agent who arranges private adoption from the hospital, told them that "the child's origins did not matter, telling them something to the effect of, 'So many Sitas have gone to Maryam's place, so many Maryams have gone to Sita's place'," (Singh 2011: 251). By mentioning the two most common Hindu and Muslim female names in her example, Mrs. Farooqui was trying to convince those couples that the children do not have any religion as such and thereby could be adopted into any household regardless of the adoptive parents' religious background.

6.4 Male-child preference in adoption and son-preference

Furthermore, the strong preference for the male child in adoption also reflects the fact that men and women who seek to adopt a child are guided by the values of lineal masculinity whereby the adopted male child will inherit their

property and continue their family line. Mr. Dangol also confirmed that there is a strong preference for the male child among the men and women who approach Bal Mandir for adoption. He said,

> *"Only those who are influenced by development and modernization and identify themselves as liberal and educated actively choose female child for adoption, rest of the people prefer to adopt a male child"*

The data published by the organization in its magazine *Awaj Smarika* corroborates that fact. The trend of adoption from the year 2011/2012[161] to 2016/2017 shows that more male children were sought for adoption than the female children. For example, out of 7 children given away for adoption in 2011/2012, 5 are male child and 2 are female child. In the span of those 6 years, 19 male and 14 female children were adopted (NCO 2016 [2073 BS]: 15). Although the difference in those numbers might not look significant, they do reflect the trend of adoption with a preference for a male child rather than a female child. This trend of preference for male child in adoption is a reflection of a larger phenomenon of what scholars call "son preference" in many countries in Asia that have patrilineal and patrilocal kinship system (Das Gupta . 2002; Bennett 1983; Levine 1982; Stash 1996). In the comparative study of son preference in China, India, and South Korea, Das Gupta et al. (2002) have found high prevalence of son preference in these countries due to the patrilineal kinship organization. Men in these countries have a tremendous pressure to father a child in order to continue their lineage by any means because, "[…]belonging to a lineage confers membership of society, so enormous importance is placed on the maintenance of genealogies, carefully recording lineage ties between men for generations on end" (Das Gupta et al. 2002: 7). The high value of son also brought prestige to both women and men in these countries. The women's position in their household significantly improved after she gave birth to a male child. Likewise, "[…] for men, too, having a son brings full membership of society as he has now performed the critical function of social reproduction" (Das Gupta et al. 2002: 18).

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[161] Nepali official calendar is based on the Bikram Sambat era (BS), which begins from mid-April of the western calendar. Therefore, 2068 BS corresponds to 2011/2012 AD. The difference between the two calendar is 57 years.

As the trend in adoption practice reflects, there exists a high preference for male child among Nepali couples as well. Using the 1996 Nepal Demographic and Health Survey (NDHS), Leone, Matthews and Dalla Zuanna (2003) studied "the sex ratio at birth and at last birth," "ratios of male-child to female-child mortality rates," and "the distribution of women according to the sex of the last child" and found that women stopped reproducing only after having a male child even if it means they already have multiple female children. The authors also inquired the effect of sex preference on contraceptive use and found "Nepal's patrilineal social structure discourages women from practicing contraception until they have a son" (2003: 70). Stash has also come to a similar conclusion from her field research she conducted in Chitwan, one of my study sites as well, in 1993-1994: "Husbands are consistently more willing than their wives to pursue the birth of sons at the expense of larger family sizes, and that the birth of daughters is not pursued to a similar degree by wives or husbands" (1996: 1).

In a recent study, Brunson (2010) also reports the high proclivity for sons over daughter among the women in a semi-urban village near Kathmandu. Brunson conducted her study among two generations of women, the "mother-in-laws" and the "daughter-in-laws", and found different reasons for preferring sons among these two groups of women. The women from the former category argued that they needed a son for "the funeral rites to light his parents' pyres and ensure their passage from this world to the next"—a function that a daughter is forbidden to perform (Brunson 2010: 93**).** However, interestingly, the younger generation women in Brunson's studies revealed that they "do not prefer sons over daughters, rather they feel compelled to produce a son" (Brunson 2010: 89). They had internalized the social expectations of the need for a male child. These women faced pressure to have a son from various sources such as popular media, "their in-laws, their husbands, sometimes their neighbors, and notably through their own attitudes" (Brunson 2010: 95). Therefore, Brunson argues that "[d]espite modest improvements in gender equality, levels of education, and economic conditions, the practical knowledge that daughters will be lost to other lineages and households pressures couples who might otherwise be willing to invest in daughters to continue procreating until they produce a son" (2010: 89).

Similarly, in their comparative study of son preference, gender, and

masculinity in Vietnam and Nepal, Nanda et al. (2012) also report prevalence of high preference for son in Nepal. They conducted their study in rural and urban towns in the three districts—each from eastern, central and western Nepal, and found that majority of the men in their study agreed that the primary reason for the need of a son was to carry on the family lineage. The other reasons that men gave for the need of a son was "support in old age," and "performance of religious rituals;" to protect the family property and social status (2012: 53). The authors argue that "Men's views about the importance of sons and daughters are highly influenced by traditional customs and gender roles that dictate only boys can carry on their father's name and continue the family lineage while girls provide emotional support and are expected to be dutiful and hardworking" (2012: 53). Therefore, since there is such a high prevalence of son preference in Nepal, it is not surprising that the adoption also follows the same pattern whereby the male children are the preferred choice for adoption.

As I have mentioned in the previous chapters, men who fail to uphold the lineal masculinity by fathering a child at all, and also a male child, are considered to have *kamjori* and are therefore emasculated by others. Das Gupta et al.., also found that the men who cannot father a male child in their study "[…] suffer private grief at their lineal coming to an end, a sense of having let down the ancestors, and fear of being unattended in one's own afterlife" (2002: 20). Moreover, these men also faced a lot of public humiliation and "[…] commonly reported that other men taunt them" (Das Gupta et al. 2002: 20). Mr. Dangol also speculated that the high male child preference in adoption practice in Nepal could be related to stigma.

> *"We live in a society where a man who is not able to father a male child is called* namarda*. This is true even in my own friend's circle,"*

said Mr. Dangol, and added,

> *"They are all well-educated. Yet I have heard some of my friends teasingly ask those friends who do not have a male child, 'are you sure you are not a* khasi[162]*?' When even the*

[162] *Khasi* is a neutered he-goat. This term is usually used as an insult to a man's masculinity. It implies impotence and also a man who has undifferentiated, or

ones who have daughters are not spared from being labeled as namarda*, you can imagine what kind of mental torture childless men go through."*

Beside the sense of loss and "private grief" that men feel for not being able to continue their lineage, they also have to deal with social scrutiny and stigma. Even though men who already have a daughter also face such social humiliation and stigma for not begetting a son, childless men face such pressure and stigma more poignantly. Therefore, they opt to adopt a male child if they ever choose to adopt so that they can ward off the stigma and also create a sense of continuity of their family line.

6.5 Secrecy in adoption and mimicry of biological reproduction

Once the adoption is complete, the couples do not come in touch with the adoption organization and do not want to be known as adoptive parents. According to Mr. Dangol they even keep it a secret from their own adopted child as well. Instead, he argued that

"The children must be told that they were adopted so that they do not face any trauma if they find out indirectly through others and not directly from their adopted parents. They might feel betrayed by their adoptive parents and might not bond well after the revelation."

He further insisted that

"It is the right of the children to know that they were adopted and also know the identity of their biological parents."

However, he is aware that discussing such a sensitive issue might be painful for some parents. Besides the difficulty that the adopted child might face, according to Mr. Dangol,

"The adoptive parents also feel an implicit threat that if the child finds out that he or she was adopted, the child

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even lacks, sexual organ. Hence, it is humiliating to be called a *khasi* by someone and is akin to being called a *namarda*, or not a real man.

might abandon them and search for his or her biological parents."

Therefore, Mr. Dangol argued that although the adoptive parents should disclose the adoption to their adopted child, they should do so cautiously and only after proper preparation.

Herein lies the contradiction of the adoption practice, Bhargava (2005) argues. She points out that adoption has been modelled as closely as possible on biological parenting by policy and practice. "The concept of biological parenting is still the chief reference point," she argues (2005: 76), which sends a confusing message to parents. Although agencies like Bal Mandir describe that adoption is different from giving birth to one's own child, they try to match the physical features of the child with that of the adoptive parents. Additionally, they, and even the clauses in Devani Samhita, advocate that the adopted child should be allowed to contact their biological parents and have what Bharagava calls "positive identification with their origins (birth parents)" (2005: 67); however, the adoptive parents do not get any support to cope with the feeling of loss and inferiority resulting from infertility and potential feeling of threat from the biological parents (Bhargava 2005: 67).

Moreover, even though the majority of the men who adopt want to keep adoption a secret to create a sense of biological reproduction and also to avoid exposing their inability to father a child, there are few exceptions to this. There are some couples who do not shy from publicly revealing that they have adopted a child; yet even in some of those cases, men seek some connection with the adopted child based on the principle of biological reproduction. Forty-four-year-old Basu Dev Kandel and his thirty-six-year old wife Shakuntala Devi Kandel are one example of such couples who have proudly presented their story of adoption to the media. Their story was covered by the Annapurna Express, an English language newspaper based in Kathmandu, under the title "Science, stigma and changing adoption rules," (Manandhar 2019). The couple, who hail from Dang district in the western Nepal, were childless for 11 years when they decided to adopt a child. Their treatment in Om Hospital in Kathmandu and Lucknow Hospital in India had failed them. They fell victim to social gossip and felt heavily stigmatized, which Shakuntala expressed thus: "'I cried myself to sleep every night. The people in our community gossiped about us as we were a

childless couple, which was horrible. I was ready to die because I felt incomplete without a child" (Manandhar 2019). Basu also did not fare well as he felt threatened by the prospect of not having anyone to care for him and his wife in their old age.

Hence, the couple approached Bal Mandir and the entire process of adoption took three years. They brought home an eleven-month-old female child in 2015. They avoided adopting an abandoned child directly from a hospital, which they had considered at first, because of the fear that the biological parents of the child might approach them later and ask them to return the child. Even though Mr. Dangol insists that the adoptive parents should tell the child from early on that he or she was adopted so as to normalize the process of adjustment and child development, the Basucouple have kept it a secret from their daughter. Shakuntala justified their choice by saying, "'we are not worried even if she comes to know from someone. Much like we accept her, we know our daughter will accept us too,'" (Manandhar 2019). Therein lies the contradiction about the Basu couple; by allowing to publish their story in a national newspaper, along with two clearly identifiable pictures of their family, they stand out as bold pioneers of social change. Nonetheless, they have not revealed the fact of adoption to their daughter, which they are well aware she will come to know at some point through other sources.

Therefore, it seems that the adoptive parents wish to keep the fact of adoption from their adopted children a secret not only because they fear that the child might leave them after finding out the truth, which is most likely to be revealed anyway, but primarily because they cannot themselves accept and cope with the fact in the first place. Mr. Dangol clearly points that out: "most parents cannot accept the truth that their children are adopted. So they shy away from the topic" (Manandhar 2019). The reason behind adoptive couples' unwillingness to accept the fact of adoption could be that it reminds them of their failure to reproduce their own biological child. That is to say, they internalize the stigma of childlessness. One strategy that the childless couples might employ to mitigate such feelings of lack is to avoid dealing directly with the pain caused by such a reminder. They try to placate themselves by finding some semblance of a biological child in their adopted child. Basu is not an exception to that; he remarked, "'As our daughter has tanned skin, I think she relates to me more as

my skin tone matches hers. Her mother is fair-skinned,'" (Manandhar 2019). Though he might have said that jokingly as Manandhar points out, his statement also resonates his deep desire for a complete sense of belongingness to the child that a biological relation would provide.

Even the ones who do accept the truth of adoption have to face stigma and social scrutiny for adopting unrelated children. Manandhar writes about a case of a couple, Bhusan Tuladhar and Shriju Pradhan, with two daughters. They have fostered one of their relative's child for seven years. They are planning to legally adopt the child and plan to provide him the share of their property as well. However, the woman lamented that people point out the lack of resemblance between the couple and the child: "'We cannot go around telling everyone that he is our foster child. When we meet someone and introduce him as our child, sometimes people point that he does not look like either of us, right in front of him which can be hurtful. Even when one says such things to a biological child, it can cause psychological harm. I wish people were more thoughtful!'" (Manandhar 2019). This is an interesting case that illustrates the primacy of lineal masculinity and son preference at play. The couple already has two daughters and have fostered a male child whom they want to legally adopt. It can be correctly speculated that the reason for this couple to foster another child, that too a male child, despite having two biological children is guided by the son preference. Likewise, they chose to foster and adopt the male child of their relative so as to maintain some sense of biological relation between the child and themselves. Hence, as these examples suggest, even though adoption might be a solution to childlessness, biological reproduction and mandate of lineal masculinity still governs the practice of adoption; for the same reason, the adopted children and the couples who adopt become target of social scrutiny.

The men and women whom I met in the infertility clinics also refrained from choosing adoption as the solution to their childlessness due to the felt need to enact lineal masculinity and the fear of social stigma if they failed to enact that. In our informal conversations in the waiting room of the clinic, many men and women would tell me that they needed at least one child of their own and therefore would not consider adopting an unrelated child. Although many men told me that they would not adopt a child at all and would rather remain childless, some men said they would first consider adopting someone from within their

family circle and only then, as a last resort, would adopt an unrelated child. They would, however, not consider adoption without exhausting all the possibilities of actualizing their desire for a biological child. Hence, they opted for many other treatments and healing options like the ones I described in the previous chapter instead of pursuing adoption right away.

6.6 Biological connection vs. nurturance: blood and kinship formation

Some of the concerns of the men and their attitudes toward adoption can be gleaned from their spouses whom I met in the infertility clinic in 2018. From the conversation between women who shared their experiences of childlessness among each other while waiting for their consultation with the doctor, it is obvious that childless men do not consider adoption as a solution to their childlessness. Below I present the excerpts of the conversation of three women I met in the waiting room of the infertility clinic:

Kamala: *Both the husband and wife should agree first* [to adopt a child]. *But most of the time, the family members see the adopted child negatively.*

Urmila: *Everyone sees the adopted child negatively that is why nobody wants to adopt a child right away. The in-laws—brother-in-law, father-in-law, mother-in-law, sister-in-law, none of them will accept the child as their own. If they say it's not our nephew, our grandson, it's brought from someone else and therefore he is only a foster child, where did you pick him from, then imagine how hurt will I be?*

Geeta: *Yeah, my* [husband's] *family also does not allow me to adopt a child. I live in an extended family with the in-laws. I would be hurt if anyone in the family scolds the adopted child or discriminates against it. But it is better to adopt a child than*

remain childless. One should not pay any heed to the family and adopt anyway.

Urmila: It is not so easy to do that if the husband does not approve of adoption at all and says that only his own child is acceptable to him otherwise he is willing to remain childless. I have tried many times to persuade him to consider adopting a child but he says that the identity of the father of such an illegitimate child will be unknown. Otherwise, one woman I know had already offered to give her child to me. She told me that I could return the child if I give birth to my own child but I could as well also keep the child and raise it along with my own child. But my husband did not give consent at all. He said we would be responsible if anything happens to that other person's child. I was talking about adopting the child and making him ours and my husband would call him the other person's child and wouldn't accept him as ours. When someone else suggests him to adopt a child, he gets cynical and says,

> *"now that they have their own child, they wish us to not have our own children."*

I dropped the idea altogether after I realized that the issue would only create further dispute between me and my husband. Beside that I realized that other people—in-laws, neighbor, and relatives—might also torment the child by reminding him that he was adopted.

Geeta: How is the child who is raised by us right from the very young age considered as someone else's child? Let the extended family oppose, but instead

if I teach the child good sanskar[163]*, he will do good in life and will also treat me well. With the good education and upbringing, he will turn out to be a good person.*

Urmila: Well, even though the good education and upbringing might make the child a good person, the child will automatically change into who he is when he grows. His svabhava *(nature) will come out even if we groom him well.*

Few things stand out from the conversation above. One common thread that runs in the conversation is that even though women desire adoption, they lack agency to act on their desire. It also shows that for some women the reproductive choices are not made through a mutual dialogue between a husband and wife but are determined largely by the mandates of the husband and other family members. These women represent those who have undergone treatment for their childlessness for a long time. Therefore, they might also be more willing to adopt a child because of the disproportionate torture that they suffer at the hands of their in-laws and kin because of the childlessness. The other reason also could be due to the lingering threat of her husband remarrying for the sake of a child.

What is more interesting in the conversation above is the tension between the women and their husbands and kin's perception of an adopted child. As can be gleaned from Urmila's remarks, her husband and in-laws are opposed to adopting an unrelated child on the grounds that the child is "someone else's" and not theirs. Contrastingly, Urmila and Geeta argue that they would make the adopted child into their own, what they called "*aaphno banaune*,"[164] through nurturance and good education. This is an interesting issue on what makes a child one's own and raises questions about social parenthood and biological parenthood. For men, it is the purity of descent and lineal masculinity that governs who they will accept as their own child and who they will discard. Even the childless men who take recourse to adoption will first choose to adopt from their larger family circle so as to maintain some sense of purity of descent and

[163] *Sanskar* is a word that carries multiple meanings. Broadly, it is used to describe the moral characters, behaviors, values, conducts etc.
[164] Which literally translates to "to make one's own."

connection to lineal masculinity. However, as can be discerned from the conversation above, women like Urmila and Geeta believe that their nurturance could establish the lasting relation with the adopted child that would be akin to the relationship they would have with their own biological child. It might not be strange for the women to hold this view as growing up in a patrilineal and patrilocal culture, they are socialized from their childhood to leave their natal home and embrace their husband's family and kin circle as their own.

However, Urmila also fears that despite providing good nurturance and grooming the adopted child to make him her own, she cannot control the "nature" of the child and hence it will grow to become "who he is". By change she did not mean regular physical changes a person undergoes while growing up. Instead, she was pointing towards biological determinism and meant that the nurturing alone would not be enough for a child to be loyal to the adoptive parents; implicit in her argument is the fear that, at some point, the child's biological destiny would catch up to him and that he might display some undesirable traits that do not fit well in the family. This is a risk that prospective adoptive parents do not dare to take. Urmila's concern also reflects a common fear that the people have about the background of the adopted child. As I mentioned above, most of the children who are available for adoption have dubious origins and hence people are fearful about how the child turns out to be when it grows. This fear also stems from the insecurity that the adopted child, not being one's own biological child, could abandon them or show some untoward behaviors when he grows to be an adult.

Bhargava also points out similar fear of adopting children with unknown origin prevalent among the adoptive parents in Delhi. She argues that the caste and class stereotypes and prejudices, which are perpetuated in mass media like film, affect people's attitude toward adoption. For example, one of the prospective adoptive mothers asked her:

> Do you recall the film in which two children accidentally get exchanged at birth; a smuggler's son is brought up by an honest policeman and the policeman's child by the smuggler? Do you remember what happens in the end? The child brought up by the policeman becomes a murderer and thief whereas the child brought up by the smuggler succeeds in getting his father punished for his bad

deeds (2005: 63).

The woman was making a reference to a classic Bollywood movie *Awara* from 1951 that raises some questions about the power nurturance and social structure have on the life of a child. The movie deals with this issue using "the idea of blood (*khoon*) versus environment in how children turn out as they mature" (Singh 2011: 244). Citing this example she encountered, Bhargava argues that "[t]he message seemed evident to the couple: nature is more powerful than nurture" (2005: 63). This was further made evident by the people's frequent use of sayings like "*Chor ka bacha to chor hi bang* (the child of a thief will also become a thief)" (Bhargava 2005: 68).

Singh also found that similar anxieties about the role of nurture and the intrinsic nature of the child was prevalent among the Hindu and Muslim community of Lucknow. The women she spoke to expressed concerns that the adopted child would not be accepted by their kin and wider "society" on the grounds that it was not the result of an appropriate reproduction. This notion of what constitutes a family was described by the idiom of blood (*khoon*) by these women. There was a cultural understanding that "[k]hun is generally seen as being inherited from the father, and as being of crucial importance in the development of a child's behavior and temperament" (Singh 2011: 241). The majority of the women who spoke to Singh in Lucknow were hesitant to adopt somebody who was not related to them or "shared "blood" (*khoon*) or background as the rest of the family" (Singh 2011: 225). The difference in the "blood" between the adoptive parents and the child was seen as a "[…] barrier to his or her adjustment in the household" (Singh 2011: 225). Therefore, the women who expressed their anxiety to Singh about the child's "blood" were implicitly implying the "undesirable inborn traits likely to come along with the child's unknown caste and religious origins" and the impact that "might have on his or her ability to fit into an adoptive home and to develop affection towards members of the adopted family" (2011: 240).

Like in India, the notion of blood is crucial for the construction of kinship in Nepal as well. In his study of kinship among the Chhetri in Kathmandu, Gray describes that "[b]lood is a common metonym for an individual's or group's essence or substance, an important part of which is purity" (1980: 32). The Brahmin Chhetri kinship comprises of two major relational concepts, viz. nata

and *kutumba*, which are also closely linked to the concept of blood. Nata is a broad relational concept that includes relations of various types—"one's agnates and their wives, one's cognates, one's wife-giving and wife-taking affines and the affines of one's affines" (Krause 1980: 181). Thus, it encompasses the "relationships of shared substance and marriage which can be traced" as well as the relationships that are established through rituals or consent (Krause 1980: 181-182). However, the strongest and immediate ties are between the ones who share certain bodily substances such as blood (*ragat*), bone (*haad*), and flesh (*masu*). This type of relation is referred to as *ragat ko nata* (blood relation) or *haad ko nata* (relation of bone), which is shared by the immediate family (*pariwar*) of a man; *pariwar* might constitute of "a nuclear household to a joint-family including a father, several brothers and their families and sometimes even their grown-up sons" (Krause 1980: 171). Individual *pariwar* makes up *kul*, or lineages, which is again organized into larger unit *vansha*, the members of which also share the common substance of blood, flesh, and bone. These substances flow patrilineally and can be traced to common ancestors, usually going back to the *gotra* founding sages or rishi of the mythic past (Krause 1980: 174). Hence, relations established through these shared substances form the basis for "[v]*ansha* , *kul* and *pariwar* as exogamous units within which marriage and sexual relations amount to incest" (Krause 1980: 182). Women also share the substances of their father until they marry and hence are considered to be *haad* or *ragat ko nata* until then. They do not pass the blood to their offspring but establish their relation with their offspring through breastmilk (*dudh*) (Krause 1980: 182).

Likewise, a relation that is established by marriage between two *pariwar* is called *kutumba*. The relation is generated not only in between the immediate families of those who marry but also expands to the relatives of both sides. Kutumba includes people such as wife's brother, wife's sister, wife's father, wife's father's sister, wife's mother, wife's mother's brother, and sister's husband, sister's husband's brother, sister's husband's sister, sister's husband's father, sister's husband's mother, sister's husband's mother's brother and the parents of one's children's spouses (Krause 1980: 183). For women, marriage establishes nata relation with the husband's family and relatives whereas for men marriage creates a relationship of *kutumba* between him and his wife's family and relatives. Kutumba relation can be further divided into two other categories:

sasurali and *jwainchhori*. The former is the relationship established between a man and his wife's natal family and the latter is the relationship created between a man's *pariwar* and his married daughter and sister's *pariwar* (Krause 1980: 184). Nevertheless, depending on the context, nata is also broadly used to describe *kutumba* due to the proximity of relation that is established through *dudh* (milk) (Krause 1980: 183).

Hence, in this scheme of kinship construction, a child is related to his or her parent through shared substances like blood and milk. Since adoption does not fulfil the requirement of either of the two ways of kinship construction as described above, by that logic an adopted child from outside these two kinship categories technically cannot form a relation of son with a man. In a similar vein, an adopted child cannot pass on the man's lineal masculinity, which is only passed through shared substances like blood and *virya*.

6.7 Reconfiguration of *vansha* and its flexibility

In the previous section, I discussed the primacy of the notion of blood in the construction of kinship, especially to form *vansha*. However, not all men can father their own biological children and hence they have to resort to other means of fathering a child if they do not want to remain childless for the rest of their life. For those men who want to overcome their childlessness, taking recourse to adoption and reproductive technology—by using donor sperm in particular, are two prevailing options. Both of these means of fathering a child lack a direct relationship between a man and the child that is established through a shared substance like blood or *virya*. As a consequence, the notion of *vansha* and the flow of lineal masculinity is disrupted as well as the purity of descent is also not maintained.

Nevertheless, I found that there is a certain flexibility in how the idea of *vansha* is conceptualised by some men to fit it into their vision of *vansha* and lineal masculinity. Anup was one such man who had a different opinion on *vansha*. Anup belongs to a brahmin caste but has adopted a child that belongs to a different caste group directly from a hospital in Chitwan. His decision to adopt came after going through eighteen long years of childlessness. He confessed to me that he

"did not want to be seen as a failure in the family"

for not being able to father a child that could inherit his property and continue his *vansha*.

Anup was not worried about the potential stigma that he and his adopted child, who belongs to a different caste than his, would face. So far only a few people have pointed out to him that the child is not his.

"What can I do when people point that out? I just grin and brush off such remarks,"

he told me, and argued,

"It is the same people in society who call the man namarda *or* napunsak *when he is childless. Both a man and a woman face a lot of stress due to childlessness so it does not matter by whatever means they manage to finally have a child."*

Anup does not plan to disclose to his son that he is adopted.

"But wouldn't he find out himself or wouldn't others point out to him?"

I inquired.

"How can we disclose it to him? Absolutely not. Others might tell him what they want to but I am sure he will not believe them. He might have different physical features than ours but he will still see us as his parents,"

said Anup. He further argued,

"That would only matter a lot to the child if he was homeless and someone pointed out that he does not have a father, which is not the case with our child. We have taken good care of him, so for all practical matters everyone will call me his father. He will also call me his father and will look after us when we are old."

He continued to justify himself,

"even there is no guarantee these days that the biological children will look after their parents,"

and asked me,

"Haven't you seen the movie Baghwan*?"*

He narrated the major scenes from the movie to make his point. I will briefly summarize the movie to clarify Anup's reference.

Baghwan (or The Gardener) is a Bollywood movie that released in 2003 and raises issues of biological parenthood, social parenthood, foster care, and adoption. It centers around a family of a banker, his wife, and their four (biological) sons. The couple has also adopted a child from an orphanage and raised him as their own child by providing him equal education and financial support as their other children. The movie juxtaposes the protagonist's pre-retirement life that is filled with happiness and care he receives from his four sons and his post-retirement phase when he and his wife face neglect and even harassment from his sons and their wives. Discussion of the movie at length is out of scope of this chapter, but in a nutshell, the movie shows that despite receiving good nurturance, affection and generous support in every aspect of their life—financial, personal etc., the biological children may, for their selfish reasons, neglect their parents in the latter's old age and not look after them. Instead, the movie shows that the adopted child, out of feeling of gratitude for the nurturance he receives, takes better care of his adoptive parents and fulfils their needs after they retire. The dialogue such as "it is better not to have any children than to have ones who forget the parents' sacrifices in raising them and instead mistreat the parents," spoken by a character to his wife after seeing the protagonist suffer, drives home the message of the movie. The character is himself childless and has fostered many children. The movie ends with the protagonist denouncing his four biological sons and moving on with his wife to live with their adopted son.

Although the narrative in the movie is exaggerated and full of melodrama, perhaps to achieve cinematic effects and emphasize the central message, the message it conveyed was well received. The popularity of the movie can be gauged from the fact that even after 16 years of its release, people make reference to it to discuss issues such as the sacrifices parents make while raising their children and the possibility that biological children may not look after the parents at old age but instead an adopted child fulfills that responsibility. In fact, many childless men and women I met during my research made reference to this movie while discussing childlessness and adoption. Such representation of the adoption in a mainstream movie, that too acted by influential superstars of Bollywood—

Amitabh Bachchan, Hema Malini, and Salman Khan, has definitely created a positive image of adoption and has thus succeeded to provide an assurance of some sort to the childless men and women who hesitate to adopt an unrelated child for the fear that they do not know how the child will turn out to be as an adult.

Since Anup gave such an elaborate argument about the role of nurturance in creating a father-son relation that might in some case be stronger than the biological ties, I was curious to know what constitutes a *vansha* in his view. He also gave a regular answer that everyone else gave me, i.e., it is an unbroken flow of a man's lineage:

> *"Don't we count three generations, grandfather, father, and I when we describe our family generation to others? That is* vansha*,"*

Immediately, he seemed to realise that his concept of *vansha* does not account for adoption of unrelated child such as his own adopted son. He quickly added that his adopted son also can be considered as his own *vansha* holder because he adopted the child only a few hours after his birth. He argued:

> "*It's only that we didn't have him biologically; otherwise, we adopted him immediately after a few hours of his birth and have raised him ever since. Some people make a ten-year-old or twenty-year-old child their* dharmaputra *and pass on their property to that child; that child is fully considered to be the man's* vansha *as he inherits the man's name and property. We brought our child after only a few hours of his birth, so everyone should automatically consider him as our* vansha*."*

This again connects to the earlier discussion of how a child is made one's own. Like the women in the clinic's waiting room who argued that they wanted to adopt a child and make the child their own (*aaphno banaune*) through nurturance, Anup also argued that his adopted son was made his own through nurturance. He even argued that since he adopted the child within a few hours of its birth, even though the child is not his biological child, it is not any different than one.

Moreover, using ritual and legal basis, Anup gave further reasons about how the adopted child will continue his *vansha*. He emphasized that the child will carry on his *vansha* even though he is a *dharmaputra*.

> *"How so you might wonder,"*

he said and added,

> *"when people remember me if I pass away childless, they would say there were three brothers from Parbat* [his place of origin]*, these are the children of the two brothers and one of the brothers died childless. That would be the end of my story. But now they will say there was Anup and this* [pointing to his adopted child] *is his son."*

That way, Anup argued, his *vansha* will continue through his *dharmaputra*. He reasoned that

> *"Only a few people know that I have an adopted child now, about which the later generations after me will have no clue. Therefore, the child will be taken to be my own by others in the later generations."*

Additionally, he argued that his *vansha* would be established while performing ritual worship of the ancestors. He said,

> *"The child will recall my name first as his father while counting three generations of ancestors during the ancestor worship rites (*shraaddha*)."*

Similarly, Anup gave another interesting reason about how his adopted son would be considered his *vansha*; viz., his son would get a citizenship by descent, which is commonly known as *vanshaj*. In Nepal, there are three kinds of citizenship: a) citizenship by descent or bloodline; b) citizenship by birth; and c) citizenship by naturalization. Citizenship by descent is issued to a person whose parents[165] are already a citizen of Nepal. A citizenship certificate has sections that

[165] Until 2006, the citizenship was issued only through the name of one's father but now there is a legal provision for a child to receive citizenship through his or her mother as well. However, in practice, it is very difficult to get a citizenship certificate through the name of one's mother (http://fwld.org/news/successful-in-obtaining-citizenship-in-the-name-of-mother/).

specify the type of citizenship, date and place of birth, and the name and address of father[166]. Anup reasoned:

> *"My name on the section of "father's name and address," and "*vanshaj*" written on the section "type of citizenship," provides a solid proof that my* dharmaputra *is my* vansha*,"*

This way Anup ingeniously appropriated the state's mechanism of citizenship to redefine and modify the idea of *vansha* to include his adopted son into his lineage.

Anup's is an interesting case that shows, on the one hand, that the concept of lineal masculinity is flexible and is appropriated by childless men like Anup to redefine their masculinity that conforms with other men who are able to father their own biological child. On the other hand, it illustrates that even for men who adopt a child and have concluded their reproductive journey, it is still important for them to uphold the lineal masculinity by any means possible, such as by reclaiming adoption in terms of lineal masculinity or using adoption as a means to induce biological conception.

6.8 Reproductive technologies, adoption, kinship, and lineal masculinity

So far, I have discussed the relationship between lineal masculinity and adoption. Although adoption provides an alternative means to overcome childlessness and create family, it is not a preferred option by many childless men and women in Nepal. Instead, today the childless couples in Nepal take help of the reproductive technologies such as IUI and IVF to overcome their childlessness. The medicalization of childlessness/childbirth and ubiquity of the reproductive technologies has made adoption an even a lesser of a choice for overcoming childlessness. In this section, I will explore how reproductive technologies have impacted adoption practice and kinship construction in Nepal and elsewhere.

One of the ways the reproductive technologies have impacted adoption practice is reflected on the regulation of adoption. The legal code, *Devani*

[166]The current citizenship certificates also have a provision for mother's name and address.

Samhita, provides mandates on the basis of which Bal Mandir operates its adoption practice. One striking clause in the *Devani Samhita* is about the eligibility of the prospective adoptive parents: a couple who are not able to have any children even after 10 years of marriage is deemed eligible for adoption (GoN 2018: 55). This has to be verified by producing a certified medical proof. Mr. Dangol pointed out to me that previously the married couples who were childless for 4 years after marriage were eligible for adoption. The time window was increased to 10 years, according to Mr. Dangol, because of the availability of reproductive technologies in the country these days.

> *"The reproductive technologies have made it possible for the couples to have their own biological child, even though it might take some years of treatment for some,"*

he said, and added,

> *"people continue to pursue medical treatment for as long as 4-5 years."*

Hence, the logic behind changing the time window to 10 years was to ensure that only the couples who were serious about adoption and were medically unfit to bear their own biological child would apply. Interestingly, one underlying assumption behind increasing the time window to 10 years was, according to Mr. Dangol,

> *"Also that those couples who rush to adopt a child and later succeed to have their own biological child through medical treatment might discriminate or abandon the adopted child."*

The *Devani Samhita* also has a provision to prevent such potential problems, and therefore, mandates that if the couples succeed to have a biological child after adoption, the right of the adopted child to be treated equal to the biological child remains intact (GoN 2018: 58). Thus, the availability of reproductive technologies has modified adoption practice to ensure that the biological reproduction takes precedence over adoption; by way of which, the principle of lineal masculinity is also reinforced.

Moreover, reproductive technologies have also impacted the construction of kinship in general. In many Euro-American countries, the basic way kinship is constructed is through the "blood" relation and marriage (Taylor 2005: 189). As I

have discussed above, this is also true for Nepal. Whereas before the advent of the reproductive technologies like IVF and IUI, the biological relatedness was a given natural fact, the reproductive technologies have challenged this natural fact by creating multiple possibilities of kinship construction. For instance, due to the use of donor gametes, made possible by the reproductive technologies, motherhood now can be separated into at least three aspects, viz., "genetic, gestational, and social," which were all "previously unified elements of reproduction" (Taylor 2005: 191). Similarly, even the fatherhood is now distinguished into social and biological aspects (Strathern 1992) due to the use of donor sperm to beget children. The reproductive technologies have also made it possible to create kinship outside the heteronormative order (Hayden 1995; Sullivan 2004). As Taylor argues, the reproductive technologies "create new categories of kin and the fact of birth is no longer proof of genetic connection or biological relatedness…the kinship links that a child has been able to claim through its biological mother or father are no longer clearly defined and the boundaries between the biological and social basis of kinship have become blurred" (2005: 194). This has led some scholars to argue that the reproductive technologies have fundamentally changed our understandings of kinship (Strathern 1995; Franklin 1995; Edwards 2000).

Despite such claims of a radical shift in the understanding of kinship created by the reproductive technologies, some scholars have argued that the use of reproductive technologies are "conceptualized in terms of traditional notions of kinship" and "are used in conformity with existing cultural and religious values and need not alter ideas about kinship and moral conduct" (Levine 2008: 381-382, 384; Ragoné 2003; Becker 2002). They show how the use of reproductive technologies is determined by the cultural mores of the particular countries where these technologies are being used. For example, since gestation justifies the relatedness between a mother and a child in Vietnam, egg and embryo donation is not seen as problematic solution to overcome childlessness. In the UK, donation of egg within the family members is even seen as an altruistic act (Taylor 2005: 194). Therefore, egg donation within family is also acceptable in these cases. Contrastingly, since sperm donation carries sexual connotation in the US and the UK, donating sperm within the family members, for instance father donating sperm to his daughter, is not an acceptable choice

and can even be considered as an act of incest (Becker 2000; Edwards 2000). Similar concerns about using donor sperm is seen in Egypt as well, where third-party sperm donation is not allowed (Inhorn 2003). Through these studies from different parts of the world, it is evident that even though reproductive technologies provide multiple possibilities to create alternative kinship, they "draw equally on conventional ideas and radical ones, and often draw on ideas about kinship that reference biogenetic connections" (Levine 2008: 377). For instance, the fact of donor sperm is usually kept a secret even from the children to portray the conception as a biological conception. Likewise, in the UK, the children born through the use of donor gametes can access the information about their biological parents, which also indicates that "biological *relatedness* remains a fundamental" (Taylor 2005: 189, 194) factor in kinship construction.

Similar relationships between biological relatedness, reproductive technologies, and adoption in the context of heterosexual marriage is seen in the study of childless couples in India as well. In his multi-sited study of infertility in India, Bharadwaj (2003) also found that the infertile[167] Hindu couples would rather consent to use donor sperm for conception than adopt a child. Since purity of descent is of utmost importance for the upkeep of Hindu patriarchy, the use of another man's sperm to beget a child seems counterintuitive at first. However, as Bharadwaj argues, according to the Hindu cultural imaginings, reproduction is intimately connected to corporeal relation of a body to its offspring; that is to say, semen, womb, and fetus are inextricably bound to a larger triad of father, mother, and child. These two sets of triads, which Bharadwaj calls a "double conceptual bind", link the invisible, private, biological aspect of reproduction with the visible, public, and social aspects of reproduction such as kinship relations and make the correlation between the social and biological as an immutable "taken-for-granted fact". The sacrosanctity of marriage lies in upholding this correlation between the biological and social aspects of reproduction, argues Bharadwaj. Infertility, and childlessness at large, destabilizes this double conceptual bind, thereby resulting in the stigmatization of the couple (2003: 1870-1871**).** Therefore, according to Bharadwaj, the need to restore the double conceptual

[167] I use this term to denote biomedical diagnosis of childlessness in the study cited here.

bind provides an impetus for a childless couple to take recourse to the assisted reproductive technologies: "Both the resort to assisted conception and its presentation are attempts to manage infertility and the stigma attached to it in a manner that causes minimum injury to the relationship between the social and the biological," (2003: 1871).

Bharadwaj argues that this management of infertility is thus tacitly done in the infertility clinics through the tactics of "systematic misrecognition" and "veil of silence" (2003: 1871). Borrowing Veena Das' concepts that she used to describe the sexual violence during the partition of India, Bharadwaj describes systematic misrecognition as "ability of a group to conceal what it perceives as a (stigmatizing) normative transgression," (2003: 1871). This is also achieved through keeping the fact of, in the case of infertility treatment, donor sperm and adoption, a secret and by tacitly subsuming the child born through these arrangements into "a legitimate kinship unit" (Bharadwaj 2003: 1879). While it is easier to keep the secrecy of the use of donor sperm as the couples, or at most the family members, along with the help of the doctors can collude to maintain a façade of normalcy, adoption renders infertility public and visible argues Bharadwaj.

Additionally, as discussed previously, adoption also comes with double stigmatization in the sense that the childless couples are stigmatized for not being able to reproduce and the adopted child is also stigmatized for its unknown origin. The majority of the children that are acquired by the orphanages come from various unfortunate circumstances like abandonment by their biological parents for being born out of illegitimate union or are born to parents from a poor socio-economic conditions (Bharadwaj 2003: 1876). Therefore, the fear of people about the adopted child's background is high because, according to Bharadwaj, "the idea of a "bastard child" is seen as contaminating family formation in the eyes of the community," (2003: 1876). This gives the childless men and women an impetus to give consent to the use of donor sperm because they reason that at least one parent's gamete is being used for conception; the use of donor sperm still maintains some degree of biological connection of a couple with the child, which is not the case in adoption.

The need for biological relatedness has become a basis for similar debate in India recently about making surrogacy an option for childless couples instead

of pushing them to opt for adoption. Although the stakeholders involved, which include doctors as well as child welfare agencies, are divided over the issue. While some argue that to have biologically related children is a reproductive right of a couple, others argue that adoption should be promoted as a solution for childlessness as it is an altruistic act of improving someone else's life. However, a range of assisted reproductive technologies are widely available to those who want to pursue for a biological child, while adoption is a lengthy process with many bureaucratic hurdles. Hence, the advocates of surrogacy argue that adoption cannot resolve the problem of childlessness in India (Sharma 2017).

Even though the principle of lineal masculinity and biological relatedness determines if men choose donor sperm over adoption as a solution for childlessness, the case in Nepal is a bit complicated than what Bharadwaj describes. When asked whether her patients preferred adoption or use of donor sperm to overcome childlessness, Dr. Sweta answered,

> *"Donor sperm by far; at least the husband can console himself by saying his wife's egg is being used, which he cannot claim if he adopts a child."*

This is similar to Bharadwaj's argument. However, as I have described in chapter four, some men like Krishna were vehemently opposed to the idea of using unknown donor's sperm to father a child. Krishna even told me that he would rather adopt one of his brothers' children than give consent to use donor sperm for the treatment of childlessness.

Likewise, Shiva also did not see the use of donor sperm as a solution for overcoming childlessness. He was even opposed to adoption of an unrelated child. Shiva was opposed to the use of donor sperm because the identity of the sperm donor is unknown:

> *"who knows what kind of a man that sperm comes from,"*

he said skeptically. Additionally, he was also skeptical about adoption of children from unrelated family for the same reason.

> *"Maybe a Muslim man's sperm was used; or a Christian's; or maybe it is the sperm of a Damai or*

> *Kaami*[168]*. Besides, a woman might have sold her womb due to financial precarity and desperation to anyone who paid her well. Who knows what kind of child will result from such unions,"*

he expressed his doubts about the use of donor sperm and adoption of unrelated children. He was cautious about adopting an unrelated child on two grounds: a) someone might disclose to the child that he was adopted, which will have damaging effects on the child; and b) there is no guarantee that the child will look after the adoptive parents once the child finds out that he was adopted. As he explains,

> *"These days even the biological children do not take good care of their parents and sometimes they kick them out of the home. The adopted child might do anything tomorrow if he finds out about his status,"*

This is the same fear that the women in the waiting room of the infertility clinic and many others expressed on the matter of adoption. His fear stemmed from the uncertainty of how the adopted child would turn when it grows and whether it will look after the adoptive parents. In addition to that, he was also concerned about the purity of descent with regard to caste and religion. Thus, Shiva argued that it is better to take recourse to spirituality and generate a path for one's liberation rather than father a child using donor sperm or raise an adopted child.

Although these examples from Nepal might seem strikingly different from Bharadwaj's findings, there are similar underlying factors in both of these studies. In both of these studies, the need for biological connection with the offspring was the basis that guided men to make their decisions. Bharadwaj argues that the men in his studies gave consent to use donor sperm to create some semblance of biological reproduction; secrecy and misrecognition of the sperm's origin were the means through which such semblance was created. Men in Nepal who give consent to the use of donor sperm also use similar strategies to create the appearance of biological reproduction. But others who are opposed to such strategies of family formation, the lack of purity of descent and a direct biological

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[168] Damai (tailor) and Kaami (ironsmith) are the lower castes that are put under the category of dalit these days. The dalit are discriminated as being untouchables.

connection were the basis by which they argued against the use of donor sperm or adoption of an unrelated child.

6.9 Conclusion

In conclusion, adoption might be an alternative option available to the childless men and women in Nepal to resolve their childlessness but as I have shown above, it is not an easy and straightforward option as it seems. Adoption comes with a double stigma, i.e., the men who adopt are considered to be lesser men for their reproductive failure and the adopted children are subject to scrutiny and ridicule for their unknown and un-esteemed origin. On top of that, the current proliferation and easy access to the reproductive technologies have normalized and biomedicalized reproduction, which adds an extra layer of stigma on the childless men and women and pressures them into pursuing the biomedical treatment for their childlessness while keeping adoption only as a last resort. People in this study expressed a strong desire for their own biological children and therefore subjected themselves to biomedical treatments at great length. Even the ones who adopt or aspire to adopt keep the fact of adoption a secret and mimic biological reproduction as much as possible. The positive representation of adoption by popular media is a welcome step toward creating a greater awareness of social parenthood and its benefits. Nevertheless, the fear of stigma and the anxiety about the outcome of adoption still abounds among the childless men and women. There are few pioneers of change who openly declare in the media that they have adopted a child. However, even they hesitate to disclose to the child that he or she was adopted, which is one among many such contradictions that are inherent in the practice of adoption. Other contradictions include the fact that the prospective adoptive parents ask for upper-caste and upper-class children in the adoption agencies, while the children acquired by the agencies almost always come from lower socioeconomic backgrounds or are abandoned because they were born from illegitimate unions; likewise, the very practice of mimicking the biological reproduction by either adopting a newly born child or relocating to a new place and declaring the adopted child as their own biological child is inherently contradictory. Additionally, even though adoption might temporarily resolve childlessness of men, their very desire for a

child that can uphold and continue their lineage is not met by adoption. However, the religious understanding of lineage and its management has been redefined by some men to suit their purpose by taking recourse to modern legal framework of citizenship. Hence, this also reflects the complexities inherent in the issue of adoption that calls for a nuanced understanding of men's desire for children and masculinity.

Chapter 7: Some observations on masculinity vis-à-vis childlessness in Nepal

The primary motivation of this study was to understand what it means to be an adult man in Nepal at large. I did so by investigating childless men and the primary motivation behind their desire for children. I started this research as an adult unmarried man with no child; and hence I had no capability to directly understand the experience of my interlocuters who were childless despite desiring a child. In the due course of my research, this topic became intimately relatable to me after I was diagnosed with a benign tumor in my brain. I was treated by chemotherapy along with a few other treatments. Chemotherapy is known to have damaging effects on a man's sperm and therefore men who are planning to have children are advised to freeze their sperm to preserve the sperm before the doctors proceed with chemotherapy. I was also given the same advice. Up until that time I had not given a serious thought to whether I would like to have a child or not. Like many other men of my age, I had taken for granted that I could father a child at my will without any problem.

Therefore, when my family and relatives frequently asked me when I was going to get married (and have children, which is a taken for granted implication in Nepal), I dodged them by giving different excuses. When they passed many other comments similar to what my interlocuters told me they had to face, I simply would tell them that I was not interested, or was not ready, to get married at that point of my life. But when I was confronted with the issue directly, it was shocking on the one hand, and difficult to fully grasp on the other hand. I was not aware how deeply engrained this need to save the *vansha* was: I felt a sense of responsibility to uphold the family line, which was passed on to me directly from my father if not from the mythic ancestors. I also felt like I would fail my father if I failed to continue to pass on that family line. It was at this point that I could imagine and relate to what my interlocutors must have felt when they desperately sought for a child and tried multiple therapies to overcome their condition of childlessness. Initially, I had conducted this research with a simple motivation of bridging a gap that exists in the field of gender studies (specially masculinity

studies) and medical anthropology (with a focus on the health seeking behavior of childless men in Nepal). However, as I described above, it somehow turned into a personally relatable topic in due course.

One of the finding of this research is that the hegemony of Hindu values such as purity of descent and patrilineage that prevails in Nepal conditions the experiences of involuntarily childless men and women there. Those values were even officially institutionalized by the Nepali nation-state in the 19th century and served as a means to perpetuate and strengthen already existing caste system. In this frame of state governance, men from the higher caste were deemed to have higher order masculinity than the men from lower caste. This discriminatory masculinity was propagated in many different ways by the state to create an ideal form of normative masculine identity.

These ideals, therefore, also directly affect childless men and women today as well[169]. Childlessness is a distressing and stigmatizing condition for both men and women. Even though men and women might be affected differently, the cause behind their suffering is largely similar: men feel the pressure to save their lineage (*vansha*) from ending (King and Stone 2010) and to pass on their share of ancestral properties (*ansha*) to their children (Kunreuther 2009), which forms the core identity of adult masculinity in Nepal. In the same way, women also feel similarly obliged to save their husband's lineage. They feel intense guilt if they are the cause of the demise of their husband's lineage. Since *vansha* and *ansha* pass vertically downwards along the line of male side of a family, these terms can be understood as lineal masculinity (King and Stone 2010).

In the context of South Asia, fatherhood is an important milestone of adult masculinity (Osella and Osella 2006). Nepal is not an exception to that. However, only the achievement of fatherhood is not enough there; it has to be achieved within a certain timeframe after marriage. Otherwise, men are considered to be *napunsak* (impotent) or *namarda* ("no-man"), both of which are emasculating terms that brings shame to a man. Inability to achieve these norms of masculinity is also understood as a man's weakness, or *kamjori*, which has many different connotations such as weakness of character, failure, bodily

[169]Although Nepal converted into a secular republic state in 2015, the hegemony of Hindu religion and culture still persists in everyday life.

weakness, inadequate sperm etc. that I discussed in chapter 2. This partly explains the behavior of men in the clinics who were distressed and ashamed by their condition. Likewise, one of the normative mandate of adult masculinity in Nepal is a breadwinner man who has control over his life in general, for example finances, family, emotions in public etc. Childlessness illustrates the shortcomings of such ideals. Childlessness also exposes men to the exploits of their neighbors, healers, doctors, and other social environment. In addition to that, the arrangements for therapies, such as traveling from long distance for treatment, and managing their and their wife's stay in these places adds extra pressure on the men who seek treatments elsewhere than their hometown. Those pursuits strain men financially as well, which threatens men's role of a breadwinner at home. This also makes men vulnerable and prone to social mockery, both of which is a man's *kamjori*.

In the space of the biomedical clinic, childlessness manifests as exposure of the men's inability to father a child and the shame that comes with it. This in turn gets related to men's sexuality due to the conflation of impotency and infertility. Therefore, as I described in other sections above, not being able to father a child is an emasculating experience for men since it exposes men's vulnerabilities in various spheres of their life—social and private. Likewise, the failure of the treatments in the clinic also creates bitter feelings of frustration and anxiety. Besides the frustration of the failure of the treatment, the guilt of secrecy, lying and hiding while making travel arrangements also adds to the suffering of the childless men. This explains the behavior of men in the clinic who remained silent or tried as much as possible to evade the clinic visit.

Nonetheless, clinic is not only a space of frustration and anxiety, but it is also a space where men feel hopeful that their desire for children and, by way of that, fatherhood will be actualized. Since fatherhood also is one major factor that defines masculinity of adult men in Nepal, men who do not have a child after a certain age are emasculated through various means in their daily life. That is one of the main reasons that motivates the men to repeatedly visit the clinic even when their treatment fails multiple times. Additionally, the hegemony of biomedicine also is another reason why childless men consider biomedical treatment as a default treatment for their childlessness while they hold skeptical view for other modes of healing. However, they do not totally disregard other

treatment options since the biomedical treatment is not failsafe despite its hegemony over other available treatment methods.

In the clinic, childlessness manifests as a bodily failure of a man, which is measured through the number and quality of sperm. Infertility is a marker of *kamjori* of a man, which denotes not only low sperm count but, by way of that, it also means overall weakness and failure to express lineal masculinity. This weakness enacts differently in different spaces within the clinic. During consultation with the doctor, the normative patriarchal ideals of masculinity that men hold is challenged by the doctor through coercion and ridicule. Men feel embarrassed, exposed and emasculated in the waiting room, which is filled mostly by women. In the laboratory of the clinic, *kamjori* is defined by the sperm count and its parameters that are printed in a report, which is interpreted by the doctors to the men. *Kamjori*, or low sperm count in the report, holds men accountable for their inability to impregnate a woman. As a result, men feel emasculated at large. They also immediately feel guilty for failing to continue their lineage and maintain the responsibility that passes to them from their father and forefathers.

Moreover, even among the men who father a child through the aid of medical treatment, there is a pervasive fear among men that the clinic is not a safe space for safeguarding the purity of their sperm. There is always a possibility of miscegenation, these men argue, which introduces impurity in their lineage. For the men, this is a valid argument, as they are responsible for upholding and passing on the lineal masculinity.

Overall, the journey of childless men comprises of traversing through various healing spaces and the different ways the men negotiate their childlessness in those spaces. The combination of these healing complex forms a therapeutic assemblage that comprises of biomedical treatment, astrology, visits to temples known for fertility rituals, healing through spirits, pursuing herbal healers, conducting *puja* of certain Hindu deities that help men to overcome their childlessness and the like.

In contrast to the clinic where childlessness is marred with shame, guilt, and fear of being exposed or emasculated, religion and worship (*puja*) mask those negative feelings. In the public spaces like *mela* and temple, there is a spectacular display of the men's condition of childlessness, which is normalized

and sanctioned by religion. By removing the shame of being childless, religion provides legitimacy to childlessness even if it is for some short moments such as the duration of the ritual or the evening. The other reason for the men's feeling of assurance also comes from the fact that since *virya* is not directly used in the worship, the purity of descent is maintained, which is not "guaranteed" in the clinic. The public display of their condition, releases the men from the pressure, or burden, they carry due to the stigma of childlessness and hiding their condition in their day to day living. Even though the men return to the same constrictions of their society after the ceremony is over, *mela* frees them for that moment. This opportunity to participate in the carnival-like festival with other men who share similar suffering is relieving for the men.

There is some sense of a camaraderie for a brief time in the clinic as well. Nevertheless, it lacks that jest and merriment found in the environment of the temple and *mela*. Contrary to the *mela* and temple, there is some sense of eerie silence and boredom among men in the clinic. Similarly, during the lamp offering and other ritual puja, the husband and wife both participate equally by holding the lamp together, whereas in the clinic, husbands do not have to participate after they provide their semen. Therefore, at any given time, there are more women than men waiting to see the doctor in the clinic. Although the doctors try to make the consultation space inclusive by counseling both partners together, men feel vulnerable and coerced during the clinical consultation. Likewise, men are included in the initial stage of the consultation and treatment while rest of the other procedures are asymmetrically conducted on women.

Childlessness challenges the norm of the purity of descent itself. The purity of descent requires that men pass on their lineage (*vansha*) to the subsequent generations of men without any miscegenation of sperm. Childlessness creates a rupture in the continuity of a man's lineage and creates a possibility of adulteration by adoption of an unrelated child from a different caste. The effect of caste could be vividly seen in the case of childless men in my study who were hesitant to adopt children from other castes than their own because of the fear of miscegenation of semen. Such miscegenation would adulterate the purity of caste and lineage of a man. Therefore, men in the fertility clinic were highly suspicious and fearful about the potential error that could happen during semen analysis. Such error could be for example mixing or

switching one man's semen with some other man's semen. Adoption of an unrelated child from a different caste than one's own raises a question of whether introduction of the impurity in a lineage can still be considered to have maintained the lineal masculinity.

Apparently, as some childless men in my study have argued, adoption can be redefined and appropriated to be lineal masculinity by taking recourse to secrecy or legal framework like citizenship. In these cases, semblance of lineage is legitimized through citizenship, not sperm. Therefore, the need to maintain the purity of lineage is a fluid norm that has been appropriated by the men to maintain the semblance of the norm. This again demonstrates that despite the inherent contradictions, it is the normative patriarchal ideal of lineal masculinity that defines and creates the childless men's desperation to father children in whatever way possible.

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