Chapter 2

Introducing the Field: Methodological Issues at Hand

In understanding engineering family values and kinship in West Bengal, the first methodological question that one needs to confront is why Bengali Kinship per se is the focus of the present study. There are several answers to this question and I will like to discuss them sequentially. To begin with, focus on Bengali kinship stems from the fact that in an attempt to understand the implication of ARTs, it becomes necessary to focus on the kinship ideology, symbols of any particular region. This is because to talk about pan Indian kinship structure and then to trace the dents in the face of these technologies becomes a mammoth task at hand. Such an endeavour also runs the risk of over generalization and glossing over particularities, as then we have to first concentrate on what Indian kinship formulation has to offer us. This becomes an unmanageable construct to deal with at this juncture as the notion of kinship is not fixed but is in constant flux. This is also because of the implicit local and cultural variations and marked regional differences colouring the concept of kinship. The focus of a particular domain is believed to give a bird's eye view of the practice of kinship. Having answered that question as to why a particular region has been thought of as more adequate a field of study vis-à-vis the broader study on Indian Kinship, the second question that needs to be answered is what made me choose Bengal over other regions of India.

The choice of this particular domain is eclectic. The choice, beyond any doubt, reflects both my personal bias and practical necessity. The personal bias stems from the urge to know a society that I have been part of and grown up in through a more systematic sociological lens. The practical necessity to choose Bengal as the field area, surfaced from the familiarity with the region and the language spoken. In order to start a conversation on issues related to fertility, infertility, procreation, conception, notions of sexuality and conception of body and medicine, it becomes mandatory to know the local language, its idioms and way of life as it is this understanding that will prepare us with the knowledge base for entering the field. As these issues are often close to one's heart
and are often perceived as private and sensitive, expressing them in one’s mother tongue is often the only way to bring out the feelings and experience of such emotions. Hence, the choice to concentrate on the Kinship in West Bengal as the focal field area is not to connote the idea that it is the case. But this is merely to use it as an example, and the analysis of any other locale with its distinctive beliefs and practices would have sufficed just as well.

In order to understand how family values and kinship connections are engineered (or whether they are not) we have chosen the infertility clinic/s as the site of such negotiations. This is not in any way to say that individuals outside the clinic do not practice kinship in their everyday life or do not contribute in any significant way in the engineering of family values. This is neither an attempt to trace the life trajectory of infertile women and men nor of clinicians per se, which would definitely extend beyond the clinic in a multitude of sites and locales. But as the focus of the study is to tease out the intersection between technology and subjective understanding of relatedness, the clinic site becomes the appropriate locale to identify such interactions between lives and technologies. It is in these infertility clinics that women and men are confronted with certain technologies, which promise them the ability to have a child and, hence, recraft what constitutes the grounding factor to be a parent.

To look for this engineering of social relationships within clinics, however, also means leaving out those who have used adoption as a method to make a family and, hence, defined kinship and parenthood in a different light from those who chose technological intervention. Located in clinical setting, we also tend to lose those individuals who attempted to pursue these technologies but left it in between either because of financial hurdles or because using a third party in their private sphere of reproduction was perceived as obnoxious\(^1\). The clinic as a site also provides us with the space to have

\(^1\) Interviews with providers of the technologies revealed that a significant proportion of couples left treatment when suggested procedures with donated egg/sperm or through surrogates and even procedures involving external handling of gametes (conventional IVF). Though this set of population would have provided us with a rich narrative as to where and how boundaries are drawn, and to what extent, a certain technology is seen as beneficial and lending a helping hand; for the present study we would have to concentrate on those who have decided to continue treatment, at least till the time the interviews were carried out.
conversations with providers of reproductive technologies, who intervene not only in the process of reproduction but also in defining who the real parents are, both legally and socially.

I. Research Methods in Use

The clinical space and the activities within and around it are fairly self-contained which makes it an ideal site for the use of ethnography as the primary method. However, exploring an area with which we are closely familiar has its own advantages and disadvantages. An ethnographer, who is working in a familiar setting, is less likely to be flooded by the exotic character of far-off culture (Yanagisako 1978b). However, there also lies the risk of being oblivious to minute nuances as obvious, or brush aside anything that appears unfamiliar and new. There is also a tendency to impart truth in line with preconceived standards and an assumption that she/he has the understanding of what is actually going on (Thompson 2005). Hence, while familiarity with the larger field area (in this case Bengali society) helps in analysis of the symbolic and cultural aspect far beyond its descriptive level it also asks for a conscious effort in stating my Bengali middle class bias with which I have grown up and looked at people, symbols and values around me.

What we have to definitely caution ourselves against is not to assume that family, or kinship for that matter, has a particular definite structure or suppose that they emit certain specific characteristic and values. To presuppose such an ‘ideal type’ would be to impose one’s own assumption onto the experience of others. In order to deal with this methodological complexity the practitioners, clinical staff, donors and the treatment seekers are themselves taken as spontaneous participants. As such we take on the feminist methodological position, which guides the researcher to be conscious of her/his “positionality”, knowledge and their impact on “how [it] inflect and shape ... [the] topic,... data and particular form of representation” – the ethnographic writing in general (Lewin 2006: 26).
The study being focused on addressing issues which are sensitive in nature and generally treated as private to one's life, a range of ethnographic methods was employed. These included participant observation, semi structured and unstructured interviews, analysis of the documents like guidelines, brochures, patient information material, informed consent forms and medical records in order to understand the context and the events, through the eyes of those in the clinical setting. The ethnographic fieldwork was substantiated with a wide range of primary and secondary literature review. Media reporting on this issue was followed to trace the public understanding and concern with ARTs and systematic Internet review was carried out on infertility support groups and clinical advertising.

Being an observer to the interaction carried out between patients and doctors, patients and other staffs and among the staffs themselves, gave significant insight into this multifaceted reality. Informal communication with different people involved, also helped in a significant way, to gain insight and develop an understanding of this complex fact. In order to elicit responses, specific research tools were employed – unstructured and semi structured interview schedule with various groups of informants, depending on their diverse locale and nature of social positioning:

i. Semi-structured interviews were conducted with the physicians and other staff of the clinic
ii. Unstructured interviews with couples/men/ women who are using ART
iii. Unstructured interviews with donors

As this is primarily a qualitative study the idea is not to arrive at generalizations or to project trend but to cull out the multifaceted reality in terms of individuals' lived experience. The attempt is to circumvent the limitations of a small sample through multi layered narratives in order to draw out the intricacies in this field.
II. The Social Setting being Studied

An extensive description of the social setting will help us to have a clear picture of the space in which the fieldwork was carried out. West Bengal State Government estimates that there are 2500 infertility clinics in the State. This estimation of infertility clinics includes gynecologists who practice IUI with the husband’s sperm and rarely IUI with donor sperms. However, according to media reports, this is a conservative estimate as artificial reproductive clinics in the city till recently have been registered as ordinary clinics (Dhar 2003). According to rough estimates, over 100,000 couples in the city and its peripheries have visited infertility clinics at certain points of time in their life (Majumdar 2002). But if we take a count of infertility clinics, as the ones technically defined to provide the State-of-Art facilities including IVF, IVF with donor egg, with embryo donation, surrogacy and IVF-ICSI, cryopreservation of embryo, then the count of infertility clinics in West Bengal would not be more than ten. The data regarding existing clinics was obtained from the list of clinics in India in a professional website (http://www.pregnancymd.org/art-ivf-india.htm) and the Outlook C Fore Survey of ‘India’s Best Hospitals’. The website mentions:

1. Institute of Reproductive Medicine (with its two buildings deemed as different clinics)
2. Ghosh-Dastidar Institute of Fertility Research
3. Surgi Centre

The Outlook C Fore Survey (Biswas 2002) identifies five institutes and hospitals of repute in infertility treatment in Kolkata. These are:

1. Institute of Reproductive Medicine
2. Ghosh-Dastidar Institute of Fertility Research
3. AMRI – Apollo
4. Calcutta Medical Research Institute
5. Ramkrishna Mission Seva Pratishthan
When I visited these clinics it was made clear that though AMRI – Apollo had started a unit with the idea of running a State-of-Art infertility clinic but it had been closed down after a trial run for a certain period of time. Similarly, when contacted Dr. Bani Kumar Mitra, who heads the Surgi Centre and the Hope Fertility Centre said they are no more into the practice of Assisted Reproductive Technologies. A similar scene was reported in the case of Calcutta Hospital\(^2\). There are also some new clinics, which have come up in recent years, namely ‘Genomee’, The Fertility clinic, as part of the Bhagirat Corporate Hospital and Repose, which do not get cited in any of the lists available, but were mentioned to me by the doctors and patients. It is estimated that within a couple of years there will be around 15 clinics in the city\(^3\). It is difficult, however, to access an exhaustive list of clinics, as there is no functional Central Registry.

Among these infertility clinics, fieldwork was carried out at the Institute of Reproductive Medicine, the Genomee Infertility Clinic and the Ghosh-Dastidar Institute of Fertility Research as other clinics refused to cooperate in the research. Interviews with doctors and providers of technology were carried out at all these three clinics. However, interviews with women and men accessing treatment and donors were only carried out at the Institute of Reproductive Medicine. The other clinics did not encourage interaction with patients or donors on the ground that this would be an intrusion in their private space or because the decision of the management does not pertain to such research activity based on past experiences\(^4\).

These clinics, though are located in Kolkata, the capital of West Bengal, but being tertiary centres they cater to a wide range of population, not only limited to West Bengal.

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\(^2\) While reasons of closure of these clinics in a field which is claimed to be lucrative must be an interesting point to take into consideration, but they fall outside the purview of the present study.

\(^3\) According to interviews carried out with the doctors, though, at present seven-eight clinics advertise for carrying out IVF, the clinic which are “really doing it would not be more than four. All others either did it for some time and closed down because of no success or aspire to set up the infrastructure sometime in the future. However there are serious plan from the part of various renowned corporate hospital and other entrepreneurs to set up at least 10-12 centres within a couple of years.”

\(^4\) According, the IVF coordinator, “The clinic allowed a BBC reporter to interview a couple using surrogate but after that the couple did not continue with the procedure. As they lose on patient due to journalistic intrusion the management have stopped allowing any one to talk to patient. Being a corporate hospital they are driven by sheer profit motive.”
and its neighbouring States but from all over the country and even from abroad. As such, locating the fieldwork in such tertiary centres gave the opportunity to study Kinship relations in West Bengal without physically accessing numerous small clinics in different parts of the State. Two of the three clinics catered to a diverse range of population in terms of their socio-economic background, education level, and place of residence while the third clinic, being part of a corporate hospital, catered only to a select ‘clientele’, belonging to the higher class of the society, often highly educated and professionals. As put forth by the IVF in charge of this clinic, “we prefer to restrict ourselves to a particular set of people to whom you can communicate what their treatment modalities would be. In this way they have reasonable expectations and it is better for us than having some illiterate low class people who would put you in the pedestal of god and expect you to do magic”.

The primary fieldwork was carried out at the Institute of Reproductive Medicine (hereafter to be referred as IRM), which is located at Salt Lake, Sector – III, Kolkata-700106. It was the primary site for interaction, both with providers and users of technology. The Institute was established in July 1989. “The idea of initiating the treatment of infertility as a subspecialty” was conceived by Dr. Baidya Nath Chakravarty “in 1983 following the tragic death of Dr. Subhas Mukherjee” (Internal Document, IRM). The techniques that are offered in this clinic include the entire gamut of ARTs. The institute also offers surgical investigations and management of high-risk pregnancies

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5 A review of the Booking Register for IVF cycle in IRM for a period of six months from September 2006 to February 2007, lists the places from where the patients were coming for treatment. The list mentions people coming from various parts of West Bengal: Calcutta, Howrah, Hooghly, Kalyani, Asansol, North 24 Parganas, South 24 Pargans, North Bengal, Medinipur and Purulia. The States and Union Territories listed, apart from West Bengal, are: Bihar, Delhi, Manipur, Orissa, Arunachal Pradesh, Assam, Madhya Pradesh, Uttar Pradesh, Tripura, Rajasthan and Union Territory of Andaman and Nicobar islands. There were couples coming from abroad as well – in these six months, patients coming from Bangladesh and USA were mentioned. These include both Bengali and non-Bengali speaking population. Though I did not have an access to medical and official record keeping in the other two clinics where fieldwork was carried out, the information from these clinics mentioned similar happenings.

6 In the absence of a Central Registry it is difficult to trace smaller inconspicuous clinics, which have mushroomed in different corners of the State. Though it is not to deny that doing fieldwork in these clinics would have given insight to different other complex issues.

7 This includes Conventional IVF, Frozen Embryo Transfer, Egg donation and IVF, Intracytoplasmic Sperm Injection (ICSI), Surrogacy and Donor Embryo Transfer (IVF Procedure Booklet).
which are carried out in a separate building. The structure of the building and the way the waiting-area is done emanates a clinical look which is clean but not ornamented. The only picture that it showcases, is that of a collage of children at the clinic either with their parents or with Dr. Baidya Nath Chakravarty, most commonly referred to as ‘Sir’. There is a notice board featuring upcoming seminars, the cost of the first consultation and the cost of the institute’s publication.

The second site for interview was Genomée, The Fertility Clinic (hereafter referred to as Genomée), which is an association between Bhagirathi Neotia Women and Child Care Centre and Herzliya Medical Center, Israel located at 2, Rawdon Street, Kolkata-17. Bhagirathi Neotia being a corporate hospital, this clinic is totally different in its make-up and ‘clientele’ in comparison to IRM. The clinic which is located in the second basement of the hospital has a well-appointed reception area and huge posters with catchy visuals and captions. The doctors’ chambers are also decorated with framed photographs of different courses and seminars attended and the certificates for the same. The floor I was given access to, had the reception area, doctor’s chamber and examining rooms. The clinic officially started functioning in April 2006 and offers all the ‘services’ mentioned in case of IRM. The patient information booklet introduces “Genomée... The Fertility Clinic as a general fertility center, [which] treats both female and male infertility problems...[and a] one-stop fertility clinic with both diagnostic and therapeutic functions under one roof”.

The third site for carrying on interaction was the Ghosh-Dastidar Institute of Fertility

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8 These include:
- Diagnostic Laparoscope and Hysteroscope
- Infertility surgery both – endoscopic and open laparotomy surgery
- High risk pregnancy measurement and delivery (those becoming pregnant following treatment of infertility) – mostly following IVF/ ICSI and viable continuing pregnancies following previous repeated pregnancy loss

In addition to indoor patient care, an andrology clinic operates once a week for examination and counselling of PESA and TESA to be followed by ICSI.

9 I did not have any access to the rest of the clinic and neither any written or oral information was provided on the infrastructure.

10 The programmes and techniques available include General Fertility Program, Ovulation Induction, Intra Uterine Insemination (IUI) or Artificial Insemination (AI), In-Vitro Fertilization, ICSI (Intra-Cytoplasmic Sperm Injection), PESA, Egg Donation/Sharing, Embryo Donation, Gynaecordiology, Cryo-Preservation, Ultrasound Services and Laboratory Services.
Research, (hereafter referred to as GDIFR) which is situated at 208, Rashbehari Avenue, Kolkata-29, near Gariahat, the hub of South Calcutta. The clinic, which is headed by Dr. Sudarshan Ghosh-Dastidar has been one of the pioneers and is associated with the field from as early as 1980s. As he recalls, “I have been a student of Dr. Subhas Mukherjee and was working closely with him. It is his tragic death that brought me back to India from America and I started off the work from where he has stopped. In those initial years along with Dr. Baidya Nath Chakravarty we carried on the pioneering work of giving birth to the test-tube baby”. The floor I was given access to, has the reception desk, patient’s waiting area and the Director’s room. The notice board beside the Director’s room, displays press releases and media coverage of ‘achievements’.

III. The Entry in the Field

The entry to these three infertility clinics and the nature of interaction carried out, differed significantly. The first visit to IRM, after the initial interaction over phone, was to meet the founder member and the Director of the IRM. It was a brief interaction, mainly focusing on how and when to start talking to patients and doctors, without disturbing the everyday working of the clinic. His suggestion was that, probing on “kinship issues and concerns around bonding” might create tension among “patients”, as it would bang on the idea that the child is “not naturally their own”. His suggestion was to talk to the counselor (who is mainly involved in taking preliminary history of patients on their first visit) of the institute and get acclimatized with the functioning of the clinic as well as have a first-hand experience of how initial communication and rapport is established with the patients through “history taking”. Subsequently, I was given access to the IVF OPD, and was given a place to sit in a room adjacent to the

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11 That is how he translated my research problem.
12 The general format for such history-taking included – name, age of couple, menstrual history of woman, previous diagnostic tests undertaken (blood, hormone, laparoscopy), previous surgical and medical history (operation of stomach, disease like typhoid, jaundice, chicken pox), semen analysis of husband (partner and husband being used interchangeably); allergies to drugs; history of married life (how long married, how long they are trying to conceive); obstetric history (previous conception, if any, Medical Termination of Pregnancy done; spontaneous abortion, previous procedures undergone like IUI, IVF); family history of diabetes, blood pressure; the problem that they have come with.
doctor's chamber. I was introduced to the junior doctor who was doing his fellowship for a period of two years, the nurse-in-charge of the IVF OPD (associated with the clinic for the last nine years) and the injection room, and the in-charge of the IVF OPD section, who has been with the clinic for 18 years. Informal chats with these individuals gave an idea of the protocol of treatment and the techniques used. I was also given access to the medical history of patients and medical terminologies and abbreviations commonly used were explained to me.

In Genomée, interview with the IVF in-charge, Dr. Rohit Gutgutia, was arranged with much difficulty, after repeated requests. Once contacted, he was eager to share his experience and his interest in this field. However, he made it clear that to talk to patients in the clinic I would need to seek permission from the management. The latter, however, was not at all willing to let me carry on interaction with the 'patients'. For an appointment with Dr. Sudarshan Ghosh-Dastidar of GDIFR a request was mailed, explaining the scope and purpose of research. Following this, an interview was fixed with the Director wherein the general schedule of the fieldwork was worked out, according to the convenience and availability of the Director and the Counsellor-in-charge.

IV. Process of Interview

The interview was carried out with 'treatment seekers' (using IUI with donor semen or IVF with donor egg or donor embryo and surrogacy), donors and providers of technology. The interviews with recipient couples undergoing IVF and egg donors were carried out in the anteroom of the doctor's chamber, in the IVF department. Those undergoing IUI were interviewed, either in the examining room or in the consultant's room, depending on the availability of space. The counsellor of the clinic, generally introduced the woman/men/couple as the case may be. It was mentioned by the clinical staff if they were already undergoing or had decided to undergo donor procedures. No

13 His vision of being in the field of assisted conception stems as a middle ground to provide him the opportunity to handle machine (he meant instruments and techniques) while practicing medicine as he was interested in studying machine (engineering) but forced to take on medicine due to family pressure.

14 He especially mentioned the 'malkin' (the non-Bengali lady owner) and also communicated that if he allows me without her permission he would lose his job.
further information was disclosed to them by the clinic\(^\text{15}\). For me, this posed deep ethical question as to whether these interviewee would have otherwise agreed, if directly approached by me\(^\text{16}\).

In case of women interviewees, some of them felt that their husbands would have been better placed to give the interview because they were the ones who keep tab of medical proceedings. However, once the interview started off and a rapport was built, such inhibition often took a back seat. Interviewees especially women, said as there was little space to talk about these issues outside the clinic and really no one to pour out their hearts to, they felt relaxed to speak about their thoughts, apprehensions, hope, fears, confusions, doubts and their convictions\(^\text{17}\). As these interviews were intense with people’s emotion so my position often altered from “total participant” to that of “researcher participant” to “total researcher” (Gans 1968 cited in Bodemann 1978: 393).

Most of the interviews were conducted in clinical settings as one-time activity, as most of the respondents were reluctant to provide their contact information\(^\text{18}\). Some of the interviews did not progress much further, as the individuals broke down or informed that they had not thought so much of the intricacies and “were just doing it for the heck of

\(^{15}\) Hence the recipient couples did not have an option of not revealing the fact that they are undergoing donor programme. The clinical staff just informed them that this “didi (elder sister) would ask you some questions”. This definitely highlights that there is a hierarchy in place within the clinic setting. Not only did the clinical staff feel it unnecessary to take their informed consent, neither did the recipient couples (except a few) asked for any clarification.

\(^{16}\) Before starting off the interview, the interviewees were briefed about the research study and were informed that the information provided by them would be kept confidential. Some of the respondents accessing treatment, also enquired about the extent to which confidentiality and anonymity would be maintained and whether, there were any chances of media coming to know about it and hovering over their lives.

\(^{17}\) While for some, it was easier to confide as they identified me with their younger sister “tumi boner moto tai bolchi kauke konodin bolini”; for others because I was a distant researcher and not someone inherently related to them, confiding in me was like having a sounding box without any threat of being judged, ridiculed and looked down upon. Still for others, these interviews were a productive space for clarifying their doubts about the procedure, their future courses of action, for asking opinions which they were apprehensive to ask the doctor for fear of drawing his dislike or which had not been answered even after repeated asking, and for requesting the clinic to reduce the cost. In these cases, questions ranged from “Can we have sex after the insemination” to “Whether we should tell the child”? While some interviewee did identify with me, others felt I would not be able to understand their plight and would do so once I am married because it is “different to be not married and being married without a child”.

\(^{18}\) Though, over a span of time, the respondents became familiar faces but once they had been through with an interview session, they were not ready to talk about it any more.
Interviews were continued for a span of 30 minutes to even a period of one and half hours depending on the respondent's willingness.

The interview with women, who already had a child through these techniques, was conducted at the 13th Annual Test-Tube Baby Get Together organized on 28th January'07 by IRM. This gathering was attended by almost 100 couples with children and this became an important interaction point with the couples who have been "blessed" with children. This was a different platform compared to the clinic setting. The interviews carried out here, were qualitatively different in nature from those of individuals who are still striving to have a child against all odds. Such interviews were carried out for half an hour to one hour, depending on the availability of the respondents and their interest to interact.

The aim was also to draw on the donors' and surrogate's understandings and how they look at their roles in this process of childbirth. But, the recipient couples were reluctant that any conversation be carried out between the donors/surrogates in their absence. Among the few instances, where such requests were agreed upon, conversation with donors had to be carried out in the presence of the recipient couple. The interviews with doctors, laboratory technicians and other clinical staff in IRM were carried out in phases, depending on their availability. Though these interviews were carried out on a one-to-one

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19 It was in such instances that I, as a researcher, was confronted with ethical dilemma as to whether I had the right or the necessity of inflicting people with questions and issues which they were either ignorant about or had chosen to keep their eyes shut on.

20 This get-together is an annual platform to bring together both the parents and test-tube babies "so that... they can share their happiness, achievement with every one around. ... [So that there are] smiles in the faces of those in whose eyes we have seen sorrow, pain and desperation" (Inaugural lecture).

21 In contrast to the clinic setting, which projects an idea of a mechanically busy atmosphere on one side and the constant waiting, frustration and desperation to have results on the other, the Annual Get together offers a space for celebration and festivity.

22 As these clinics played no role in arranging the donor and surrogate, it totally depended on the recipient couples' discretion as to whether I would be able to talk to donors.
basis\textsuperscript{23}, there were times when it was intervened by others and they spontaneously poured in their perception, ideas and anecdotes.

The interviews were carried on in a mixed language of both Bengali and English, depending on the respondents’ comfortability. Medical terminologies and diagnosis suggested, were in most cases, told in English. The Bengali interviews were transcribed and translated in English. The names of the doctors, clinical staff and names of the clinics are used in original with prior permission\textsuperscript{24}. The names of the treatment-seeking interviewees were abbreviated\textsuperscript{25} and their initials were used in order to maintain confidentiality. Only few treatment-seeking respondents and all three donors chose not to reveal their names and they have been coded as XY, XIYI and so on. My observation has been that the respondents, who already had a child through technological intervention were most reluctant to divulge their name, locality and other personal details.

V. Profile of the Interviewees

The profiles of the ‘treatment’ seekers were restricted to the Bengali population, who were either using IUI with donor semen or IVF with donor egg, donor embryo and surrogacy. All of them happened to be Hindus\textsuperscript{26} and married. The idea to restrict myself to Bengali population was because the task at hand was to understand kinship implication in West Bengal. However, my field experience made me realize that it is quite a difficult task at hand and one is bound to confront the problem of defining boundaries. This is because, a sizeable population of people, living in West Bengal and accessing treatment,

\textsuperscript{23} The interviews with providers at other clinics were more structured compared to interviews carried out at IRM, which often had the potential to turn into “adda” with which, Bengalis are so familiar with.

\textsuperscript{24} Some of the clinicians categorically enquired whether they will be acknowledged for the thoughts they have shared. They felt that some of the thoughts and reflection they were sharing, had not been previously documented and they would very much like to be visible and responsible for what they have communicated.

\textsuperscript{25} In case where there was a repetition of the same initials, the initials have been suffixed by a number: for example, as there were three women with the initials MS, the first interviewee has been called MS, the second MS1 and the third MS2.

\textsuperscript{26} Though there was a considerable amount of Muslim population visiting the clinic the interviewed treatment seekers happened to be Hindus.
belongs to different regions of the country. There is also a sizeable population who, at present, resides in other parts of the country and even, in certain cases, outside the country but is Bengali by birth or through marriage and often has someone near or distant living in the city. It is not possible to say in clear-cut terms, whether to understand kinship implication in West Bengal, one can strictly limit oneself to the political boundaries of the existing State; rather, in my understanding, there is a necessity to transcend these boundaries and encompass people outside it, in order to have a comprehensive understanding of the Bengali culture and its kinship.

The rationale for identifying only those, who were either resorting to procedures involving donors/surrogates or have decided to do so, was to see how family values are engineered in the light of ARTs. However, we have chosen to leave behind those, who are undergoing AIH and IVF with their own gametes, which do not involve ‘third party conception’, for the present study27. This is so because those undergoing procedures with ‘third party’ intervention, present us with the widest spectrum in which foregrounding and practicing kinship and engineering family values become quite visible, as they are faced with situations where they are made to choose one component over the other. This conscious or unconscious decision-making, gives us a glimpse of which family values and grounding factors are considered as more integral than others. It is in this situation of ‘crisis’ that values and norms of a particular society and culture surface and become an important field to understand ‘social facts’28.

In all, 50 individuals were approached, of which ten declined to be interviewed. 40 respondents including men, women were interviewed. They were going through the following procedures like IUI with donor sperm, IVF with donor egg, and IVF with

27 It is not to deny that people, who are resorting to IVF with their own gametes, do have the potential to engineer family values. In IVF, the first step of bypassing ‘nature’ takes place as sexual intercourse becomes redundant in the process of conception and procreation.
28 However, in two cases we have integrated individuals undergoing IVF with their own gametes – those who were interviewed in the IVF Get together and conversations which revealed posthumous conception with own gametes.
donor embryo or surrogacy. Among these, 37 interviews were carried out in the clinic and three interviews were taken at the 13th Annual IVF Baby Get Together organized by the clinic. Among the 37 respondents, who were seeking treatment, 34 were women and three were men. All the three interviewees, who were interviewed in the IVF Baby Get-Together, were women. Given the nature of the study and problems of access, it was neither possible to interview the couple together, nor was it possible to talk to both the husband and the wife. Though there was no conscious effort to focus on women per se, the study at present predominantly represents voice of the women as far as treatment-seeking interviewees are concerned. The two men, who were ready to be interviewed, came to report to the doctors about certain investigation that their wives were being subjected to. The third male respondent was present because his wife was being inseminated with donor sperm on that day and it was mandatory for him to be there for signing the consent form.

14 of these 34 women, were at different stages of the treatment protocol of IVF with egg donor, three were undergoing IVF with donor embryo, three were in surrogacy arrangements and 14 were undergoing IUI with donor sperm. Two of the three male respondents' wives were undergoing IVF with donor egg and the third one's wife was undergoing IUI with donor sperm. The three interviewees of the 'milan me/a' claimed to have resorted to IVF with their own gametes.

29 The initial aim was to interview the couple and talk to both the partners separately so as to have an understanding of how the couple operates as a unit and in order to understand their differential perception, if any, towards the issue. This was not possible in most cases. In most of the cases interviewing only the women was possible because they were the ones to come for a long stretch of time and would have long waiting periods between the subsequent blood tests, reports to be taken and doctors' appointment. These women generally came by themselves. Even in cases, where the husband was present, it would be the woman who would enter the doctor's chamber either to deposit her slip, or her reports. As the clinical staff referred these women from the doctor's chamber to the antechamber where the interviews were conducted, it was mostly these women that I would have access to. At times, both the partners were spoken to, not separately but simultaneously. When men were approached, they often said that their wife would be a better person in handling the interview because she was the one, actually going through the procedure. It seems that men were reluctant to talk about these issues because deep down to them, the infertility clinic was predominantly a woman's space, being intrinsically associated with reproduction and childbirth. Though there were instances where we were able to speak to the man, such occurrence was less frequent.
The 37 men and women, who were interviewed in the clinic, were undergoing different procedures involving third party intervention. 15 of them were resorting to IUI with anonymous donor sperm, 16 were undergoing or had decided to start off IVF with donor egg, three had decided to go for IVF with embryo adoption and three were in surrogacy arrangements. In case of IVF with egg donor and surrogacy, the donor or the surrogate was either a relative, or known but not related, or unknown and contacted for the specific purpose. Eight recipients chose egg donors who were relatives, one was contemplating to approach a relative either a brother’s daughter or a sister’s. Among these eight, in five of the cases, the egg donors were the recipient woman’s brothers’ wives, and three were sisters of the recipient woman. Of these three, one was a distant sister, a cousin uncle’s daughter and she was paid for the service provided. For five recipients, their egg donors were known but were ‘unrelated’ to them. For one, the donor was the husband’s friend’s wife, for the other, she was a colleague; and the rest three did not specify the nature of their association. One recipient was undergoing IVF with a commercial egg donor and one was still in search of a suitable egg donor. Among the three women in surrogacy arrangements, the recipients knew two of the surrogates but commercial transaction was in place; the third recipient couple was contemplating a relative as a surrogate.
The marriage duration of the respondents ranged from one year to 25 years. The period of trying to conceive and the time spent in treatment varied between six months to 15 years.
Among the 37 respondents, 15 women were undergoing procedures for male factor infertility, 17 women for female factor infertility, four were undergoing procedures for both male and female problems, one was undergoing procedures for unexplained or idiopathic infertility. Three women had prior children, one of them had a girl child through IUI with donor sperm, two of the other respondents had a child of 17 and 18 years respectively but both passed away. Among the 17 women undergoing treatment, nine were on treatment because their ages were on the higher side and hence the quality of egg had deteriorated. Two of these nine women were those whose children have passed away; a few of them said that they were married late while for others age increased while they were making rounds of treatment for correct diagnosis.

Chart: 2 Reasons for Undergoing Various Procedures

The age of women included in the study, both as respondents and as partners of respondents, varied from 25 to 50 years of age, the average age being 34.97 years. The
age of the men included in the study, both as respondents and as partners of respondents, varied in the range of 32 to 54 years, the average age being 42.03 years.

The interviewees were traveling from all over West Bengal and even from outside the State to access treatment. Nine respondents were from Kolkata, five from Howrah, four from Hoogly, three from Bankura, three from Mednipur, three from Bihar, two from Nadia, two from 24 Parganas (North), two from Bardhaman, two from Orissa and one each from North Bengal and UP. 17 respondents described their family arrangement as joint, 17 described them as nuclear and three said that they were in a nuclear family but with in-laws.

Interviewees were often not forthcoming on certain issues whereas they were vocal about certain others. Information on familial composition, marital status, age (though they were not always precise), years spent in treatment were forthcoming. They were most reluctant to part with information about their personal details like name, caste background, educational qualification and, especially, employment and income. In cases they did provide information about themselves, yet they did not feel confident to share their husband’s details on his behalf. In most cases, they said they did not know the monthly or yearly income or were not comfortable discussing it. Some of the women respondents said that as their husbands were the ones to handle finance, it would not be possible for them to make an estimate. Hence, it was not possible to have any systematic data on the socio-economic background though there was passing reference to either their affluence or the financial drain that they were subjected to, in spite of their meager income. This is surprising, given the fact that they were quite comfortable on talking about issues, which would generally be thought of as sensitive and hence, difficult to probe and elicit information.

The education level of the respondents varied widely, ranging from illiterate to those who had a Doctoral Degree. Among the 34 women respondents and three women who were wives of the male respondents, six had completed Masters Degree and above, nine were graduates, five had completed Higher Secondary education, 15 had educational level of
tenth standard and below and two were illiterate. The education level of 37 men included in the study, both as respondents and as partners of respondents, ranged from illiterate to that of Masters Degree and above. Two of the men did not disclose their educational details. Five of the men had completed Master's Degree and above, 17 of the men were graduates, six men had passed Higher Secondary examination, six had studied upto the tenth standard or below and one was illiterate.

Chart: 3

![Educational Background of the Respondents](image)

Among the 37 women undergoing procedure including three of the male respondents' wives, 26 women were housewives while nine were working.

Chart: 4

![Employment Status of the Female Respondents](image)
Among the 26 women, one woman was a professor at a college but had left job to take care of her ailing mother-in-law; among the nine working women, two were nursing staff, five school teachers, one was a government clerk and the others did not specify their nature of employment. One of the nursing staff was on leave due to the ongoing procedure. Among the 37 men included in the study either as respondents or as husbands of respondents, 14 were businessman, four were government service holders, three were school teachers, two were bank employees, two were doctors, two were daily wage earners, two were in the Army, one was an engineer and one was an agricultural labourer and six did not specify.

<table>
<thead>
<tr>
<th>Employment Nature</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Doctor</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>School teacher</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Government employee</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Business</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Bank employee</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Daily wage earners</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Army</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Engineer</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Agricultural labourer</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

The socio-economic background of the respondents varied widely from monthly family income being as low as Rs. 2000 to that of Rs. 25000 and above. However, 12 respondents said that they would not be able to tell the monthly family income and three said that they were not willing to part with this information. Three respondents said that they were quite well off, belonging to affluent business family or to the upper middle class but they did not specify their monthly family income. Among the rest, two said that their family income would be around Rs. 2000, five said it would be in the bracket of Rs.
4000-6000, three said it would be around Rs. 10000, and nine said it would be between Rs. 20000-25000. If we do a procedure-wise break-up, we would find that those going for IVF with donor egg/ surrogacy / donor embryo, are the ones who are more likely to belong to the higher socio-economic groups; whereas concentration of couples having lower socio-economic standing, would be more among couples going for IUI with donor sperm.

Chart: 5

The three recipients, who were interviewed at the IVF baby Get-Together, were most reluctant to provide any personal information regarding their socio-economic background, their educational level, and the locality of their residence or family background. Hence, no information on age, educational level, occupation, socio-economic background, obstetric history could be obtained from these respondents. The profile of the providers interviewed included doctors, laboratory technicians, administrators, counsellor, trainee doctors and research fellows. 12 providers were interviewed from the three clinics. Two providers refused to take part in interview. One of them refused on the pretext that he had discontinued practicing and there was no point

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30 Their reluctance was from the fact that once they had a child they did not want their personal details to be exposed to the outside world and preferred that their intimate family secrets did not come out in the open. They were only eager to share their achievement of having a child and the effort that had been put forth, both by them and the doctors of the clinic, in achieving their dream.
in talking to him; the second refused on the ground that he had no time to devote for such
interviews. The doctors varied in their specialization including gynecologists,
embryologists, and ultrasonologists. They also varied in their experience of handling
these techniques. While there were some, who had been dealing with these techniques for
more than two decades, there were others, who were still in the process of training.

The detailed profile of the donors was not available as, neither the donor nor the recipient
couples, were eager to disclose their personal information. Three interviews were carried
out with egg donors; among them two were sisters of the recipient’s and one was a
commercial donor. However, all the three donors were in the age range of 25-30, were
married, and all of them had at least one biological child.

The profile of both treatment seeking interviewees and providers is diverse bringing in
multiple dimensions to the study. The users are varied in terms of age, years of marital
life, attempted years of conceiving and negotiation with infertility, educational status,
working status, habitat and socio-economic background. In case of users the socio-
economic background and educational qualification have been quite wide ranging. This
apparently gives us a glimpse that people, from all classes, are using these technologies
irrespective of the high price. This is true to an extent that people often go beyond their
paying capacity to use these technologies. But if we leave aside AID which is relatively
cheaper from the gamut of ARTs we will find there is a concentration of individuals
coming from the higher rung of the society. In spite of the diversities all the treatment
seeking respondents also form a class in itself identified by their infertility status and
their quest to have a ‘child of one’s own’. Though other social determinants crisscross
with their identity as childless and often manifest in different life trajectories, their fellow
feeling becomes significant pointers in their life. With these experiences of going through
years of childlessness, the attempts to overcome this through technological assistance, we
will delve into unearthing engineering family values in the succeeding chapters.