This chapter draws on my fieldwork in the different infertility clinics of Calcutta, on the interviews conducted with recipient couples, the egg donors and the medical fraternity. Here we delve into the intricacies of kinship as it is practiced in these infertility clinics, which become cultural sites laden with intense desire for biological child – child of one’s own ('nijer santan'). However, as we move through the narratives of the respondents we find ourselves intrigued by the multifaceted way kinship gets constructed and erased. In this process we also encounter how definition/s of what it means to have one’s own child becomes fluid and dynamic, drawing both from biological fact and cultural categories which, in turn, are manipulated and tampered with.

When faced with the incapability to have a child\(^1\) through the normal route the couples start pursuing other means of having a child. With the visibility of technologies assisting infertility and making ‘miracle babies’ possible, most people with financial capability\(^2\) start their journey by seeking medical assistance in order to fulfill their aspiration to parent a child. The initiation into this realm of assisted reproduction in most cases starts off with the local gynecologist and use of fertility drugs and corrective surgery. However, they end up coming to tertiary center offering the State-of-Art facility “when nothing

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\(^1\) This is not to claim that all men and women who approach the infertility clinic or pursue this treatment are infertile. They are often in the clinic – either because one of the partner is infertile, or because they have conceived earlier but want a second child or that their child have died and they are way past the ‘normal reproductive age’.

\(^2\) This at present is limited to middle and upper-middle class population as the technologies are offered in private health care. However, if we consider IUI as part of ARTs, which we do for the present study, then we find the class restriction getting blurred and people like wage earner, daily labourers also accessing treatment in infertility clinics.
happened"\(^3\). It is here that the recipient couples resort to procedures using donor gametes or surrogacy after they have exhausted all other treatment\(^4\) options.

I. Purpose of Engineering

Restoring the Normal/Natural

The purpose of embarking in this process of engineering is geared towards satisfying two primary interrelated goals i.e., to restore the normalcy of marriage and have a child of one's own. This is rooted in the Bengali Hindu normative order and the pronatalist value system that it propagates. Longing for parenthood and the desire to parent a child of one's own ('nijer santan') is articulated in terms of being normal and natural. In this normative order, the importance of a progeny to carry one's generation becomes the central purpose of marriage and the birth of a child marks the fulfillment of the shared body of husband and wife. In India, it can be said "infertility – like fertility – is socially visible and hence an object of social control and management" (Bharadwaj 2003: 1870). A childless marriage becomes more apparent than having children, and the latter is seen as normal and natural. It thus becomes necessary for the infertile couple to engineer existing situation to the extent that they are able to reinstate the normative fold and restore any disjuncture that has been created by infertility. As there is an important link between a married body and her progeny in the Bengali understanding, the relationship between parents and offspring derives both from the socio-cultural realm of reproduction and invisible biological aspects of sexual reproduction. In order to correspond to this "double conceptual bind" and keep the picture of the emerging "social triad" perfect it becomes mandatory to seek assistance and hence restore the "unproblematic visuality" (Bharadwaj 2003: 1871) of fertility.

\(^3\) Recipient’s narrative was fraught with the expression “nothing happened” which came up again and again and brings out both their hope (that their effort will yield result) and the concomitant feeling of despair. This is what Mulkay call ‘Rhetoric of hope’ and ‘Rhetoric of fear’ (Mulkay 1966 cited in Bloomfield and Vurdubakis 1995: 533).

\(^4\) Though the terms like ‘treatment’, ‘patient’ are common usage in the field of ARTs, it is important to keep in mind that neither ARTs treat infertility nor can infertility be seen as a disease.
As, RN who is a nursing staff on leave for the treatment protocol and have gone through three failed IVF-ICSI cycles with her own eggs and her husband’s sperm and has been suggested surrogacy at last puts it:

*There is no social pressure as such but when you lead a life you want it to be normal and you do not want to stand out.*

Or as, BM a male respondent whose wife is going for IUI with donor sperm articulates,

*We thought we were normal human beings, leading a normal life and after marriage we will have a child normally.*

This notion of normalcy is being built around ideas and values that are imbibed from the cultural milieu which define certain situations, happenings as not only desirable but as the way it is and should be. Any transgression from this given seems to threaten the normal life course and hence often faces negative sanctions. To have a child after marriage is such an unquestioned linear progression that the presence of the child in the marriage is seen not only as making an apparent statement about the shared body of the husband and the wife but also mediating the relationship between them. UK, one of the respondents, talks of a life without a child as having “no meaning”. To her what is important is the transmission of blood, which is both metaphorical concept for mediating identity and nurturance. UK’s conceptualization of ‘nijer santan’ becomes the ideal type which draws completely from Inden and Nicholas’s (1977) model of Bengali kinship where what makes a relative is not only sharing genes, but blood, food, nurturance, property and residence.

*When I am alone I think in my life there is everything but it has no meaning. There is no fulfillment of soul if you do not have a child. We are a landed family and have 10-12 acres of land and my husband is also in service. Who will inherit and benefit from all these... No one of my blood will ever live in this land. This thought that bothers me. With this measure at least we will have a child to save the lineage; we need to save the Vansh.*

Her understanding of having a child is drawn from a single order of being which is “both natural and moral, both material and spiritual” (Inden and Nichoals 1977: xiv). Hence to her, having a child biologically related to both the parents is essential for fulfillment of
soul and carrying the lineage forward. It is by transmitting the shared bodily substance, through the flow of blood that one's self perpetuates itself.

Defining their Aspiration: A Child of One's Own

The initial contact of the couples with medical establishment then is with the quest to realize their aspiration to have a child of their own. It cannot be denied that in Bengali schema of cultural understanding, substance and code have nuanced meanings. It draws both from nature and culture alike and often intermingles these categories. Having said that, it is also essential to mention that the union of husband and wife through which husband's seed is received by woman's uterine blood is understood essential for production of babies. It is this intermingling of semen and uterine blood that gives the child its identity and routes its belonging. Hence, when the couple enters the world of modern biomedicine their notion of having a child is rooted in biological understanding of reproduction.

In this conceptualization, having one's child is guided by biological or genetic model of reproduction. The concern is to safeguard the use of one's own gametes especially, the sperm, which unlike oocytes or eggs have an external existence in the cultural understanding of conception and pregnancy. In contrast to Inden and Nicholas's (1977) claim of the existence of monistic social order, the Bengali couples who accessed technical assistance in reproduction in this case choose to draw only from biological fact of nature. They, however, choose to do so as long as they are confident of their ability to have a child through their own gametes with the support and assistance of the medical fraternity. In doing so, they are ready to meddle with nature to the extent of bypassing sexual intercourse in having conception and pregnancy, but not to the limit of accepting someone's gametes or surrogacy. So, what we encounter is that the initial contact of the couple with the providers is guided and aimed at having a child biologically their own.

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5 It also contradicts Schneider's (1984) proclamation that to base kinship on biogenetic criteria is solely Euro-American.
6 As we move through the chapter we will find how this conceptualization of biology, nature, culture changes and takes on different meanings and connotations.
In this particular instance kinship is being routed through biogenetic substance (Schneider 1984) which Schneider claims is only peculiar to Euro-American construct, as sharp or consistent distinction is made as to what 'travels in blood' and what is assimilated through the environment. In this schema then normal and natural are used as expansive words, connoting having a child of one's husband, and carrying the child to term by the wife without any medical intervention in place. It is with this quest that the long process of interaction, confrontation, negotiation, and manipulation with the medical establishment starts off once the couples have decided on their incapability to conceive naturally and to bypass it. What would now be interesting to find out is how this notion of what constitutes biology and social, nature and culture gets restructured as the respondents move through years of treatment in infertility clinics, and as such, become part of the collaborative project of reproduction that occurs in the clinic site.

Adoption: A Disused Option

▷ Pronounced Visibility of Infertility

Technologically assisted reproduction becomes the chosen route for most couples, as adoption is not considered a viable and feasible option. This social arrangement for making parents (adoption) though crisscrosses and intersects, with that of the technical assistance of making parents, but the potential of the former is often undermined. It is only in case of a handful people that this becomes a viable option to be pursued further. As, UD points out,

\[
\text{In this case (IUI with donor sperm) at least the outside world will know that it is my child, as I will give birth. Nobody will know the inside story. But if we adopt someone, then everybody will come to know that the child is not ours.}
\]

The technological reproduction involving third party conception becomes a chosen option then because "the links between an adopted child and the social parent become a

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7 This attempt is limited in the sense it does not include respondents who have used adoption as a mechanism to become parent. The voices that we hear in this study are the ones who have definitely chosen ARTs over adoption. However, it would have been interesting to hear the former speak, as this would have provided us with a different dimension of what makes a parent.
public, vocal, and visible admission of infertility that cannot be subsumed like gamete conception, under a conspiracy of silence" (Bharadwaj 2003: 1867). The disruption of the fundamental biological triad of mother (womb), father (semen) and child (foetus) (Bharadwaj 2003) can be glossed over through the use of these techniques. The decision then to use ARTs over and above adoption is with the hope that this is the best option at hand to portray the visibility of fertility and marriage.

Dr. Sudarshan Ghosh-Dastidar, GDIFR, also echoes this concern:

*Adoption for infertile couple becomes a signature of their incapability, a glaring truth, and a reminder for rest of their life about their pain of being unlike others. While for fertile couple the act of adoption become a noble act, a deed, and a socially responsible action. The infertile couple will hence go through everything possible before they decide on adoption as the last option.*

In preserving the normalcy, the arrangement of third party conception seems to bypass nature more silently and discretely than adoption. Adoption, thus, does not become a chosen avenue of child making because it threatens to disrupt the visibility of pregnancy that is possible to be crafted through narratives of technological assistance.

**Unease with the Blood of the Adopted Child**

Adoption also becomes a disused option because for the treatment seeking respondents donated sperm or egg does not evoke the skepticism and the trepidation of the same order as the blood of the adopted child does. Now, it might seem that there is a contradiction in this conceptualization in which the adopted child’s identity is grounded in genetic understanding of reproduction and kinship; whereas the child born through ARTs is rooted through the “cultural imaginings of visible, social triad of mother/father/child” (Bharadwaj 2003: 1870). To look at this as contradictory would stem from equating blood with genes and glossing over the thin line that exist between cultural understanding of blood and gene. In this context blood is more than a mere biogenetic substance and it cannot simply be conflated with biology. It is rather a metaphoric usage for the flow of

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life, relation and emotional attachment (*rakter tan*). If blood, which is a marker of life and death, health and fertility, vehicles of passion and relationship, is surrendered and equated with genes then we would be running a fallacy of superceding biology at the cost of a condensed biosocial concept. If genes become the sole basis for determining relationships, identity, belonging then historicity of socio cultural existence becomes "surrogate for reality" (Strathern 1992a: 179).

In case of sperm or egg donation, sperm/egg is seen as nothing more than "a mobile package of chromosomes" (a commentary in a documentary titled, "The world of the Unborn", quoted in Franklin 1995a: 336) which does not have the capacity to mediate relationship or inflict identity. The focus in gamete donation is on information and code that the chromosome mapping shows but in adoption the flow of blood is not an alienable biogenetic substance and flow of it is assumed to constitute a relation. Gametes in gamete donation often assume the character of asexualized, inhumane, medical substance assisting in the process of reproduction. Secondly, the gametes are being alienated from the body with the idea of helping someone or providing someone with the much-needed biogenetic resource required for conception and pregnancy (Widdows and MacCullum 2002). Thirdly, it is the intention of the recipient couples to parent a child which has initiated the process of producing a baby only for them. It can be even said that as long as egg donation and surrogacy are concerned, the process of donation or providing of one's womb has been initiated to satisfy the recipient couples desire to have a child. Hence, neither when the gametes were donated, nor when fertilization was initiated was it conceptualized by all those concerned, that the donated gametes or gestation have the potential to imbibe feelings of being related.

In contrast, adoption is seen as significantly different as the child is not the result of medicalized fertilization of gametes in a sterile petri dish in a laboratory setting, devoid of humanness. It is the result of sexual intercourse between a man and women through

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9 The "intentionalist theory" (Hill 1991, cited in Roberts 1993: 288) proposes a child's parents are those who first intended to raise the child. In addition to "forming their intentions prior to the time of conception" individuals also need to satisfy that it is "morally feasible" and that they satisfy "minimal standards" (ibid.: 289) of "parental adequacy" (ibid.: 289). For criticism of this theory see Roberts (1993).
which their bodily substance has been shared. In this process not only a child has been born, but also they have also assumed, new roles and responsibilities by passing on their bodily substance to the child. In case of adoption what is feared is that, given such an understanding of blood, to have an adopted child is to have a child with a history, with *rakter tan* to some other couple. Hence to give that child for adoption, is to sever the relationship that has been established through sharing and giving of substance. To sever an already established relationship with a past, present, and future, with a sociocultural identity and belonging, is in essence seen as different from giving of sperm or egg. It is also believed that severance in the former case is never complete (see Carsten 2000b). It is this remnant substance, the sense of belonging to one’s birth parents that drives the adoptee’s search for real parents.

AS, who is undergoing IUI with donor sperm, compares the severance of the child from the family of birth to the family of rearing to that of a girl’s severance from her natal family and assimilation of her in the family, clan, kula of her husband. She believes because the child has certain established family connection, a community to refer to as his/her “significant same” (Finkler 2001) to uproot the child from that and give it a new identity, new parentage is difficult and constraining:

> You can well imagine how difficult it will be. When it is so difficult for a girl to get accepted in her in-laws family once she is uprooted from her parent’s home. It becomes much more difficult for an uprooted child to be accepted in the family and the child to accept the family once the child comes to know of it. It is all the more difficult because everyone will come to know that the child is not ours.

As such, in adoption the presence of genetic parents as real parents is a more prominent concrete threat than gamete donors in ARTs. A corollary concern of this threat, is also the anxiety over the purity of blood and the bloodline. ST talks of this threat and also illustrates why adoption is not a chosen option:

> It is not that the thought of it (adoption) has not come up in our mind but I have not agreed to it. Once my husband told me “will you raise a newly born child”? He told me that “a colleague’s unmarried daughter has given birth to a child and they are not being able to marry her off”. I did not agree to this “as God knows
with whom she has slept with and whose child is this". Moreover, if we adopt we will adopt a niece or a nephew and not someone we are not sure of the bloodline.

We are forced to read from her narrative that "whose child" is solely determined by the contribution of the father, as the mother is known and the entire sanctity of the child's birth is disrupted because of conception taking place outside marriage with no definite claim of paternity. She also questions the other woman's sexuality, her uncontrolled passion which has made her conceive out of wedlock and not within the normative order of marriage and family. Here she mingles both the concept of unknown blood of the father and untamed sexuality of the mother as the reason behind the child's polluted existence. In this apprehension with the child's bloodline, blood does not emerge as medical biogenetic substance alienated from body, devoid of sexuality and spread over time and space.

As we hear the voices of recipient women and men it becomes clear that their denial to adoption stem from multiple reasons. It is guided both by the urge to have a biological child and an effort to gloss over one's incapability to fulfill the desired role and maintain the normalcy of a married life. It is in this context that the individuals, couples start off the process of medical and social engineering with the assistance of technological reproduction in order to actualize their aspiration and normalize their life and marriage.

II. Embarking on the Journey: The Process

Seeking assistance in medical realm is thus, not a spontaneous choice\(^\text{10}\) but the only available avenue to have a child. The apprehension with this process of medical and social engineering, though weighed over and above adoption, has its own limitations\(^\text{11}\).

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10 According to Klienmann (1988, cited in Kirmayer 1992:324) sickness raises two fundamental questions for the 'patient', "why me" ("the problem of bafflement") and "what can be done" ("the problem of order and control"). Even though infertility per se is not a disease but it transforms the 'normal' man into a 'patient'. Hence the infertility treatment seekers journey can be seen as a negotiation and response to questions that Klienmann raises.

11 According to Bharadwaj, assisted procreation poses threat to disrupt the normative values of marriage and family by making conception and pregnancy visible in public at two levels:

Firstly, the fear of an alien input or third party – on account of an inclusion of donated sperm/ovum/surrogate womb – causes genuine harm to the conception of an invisible tripartite biological base on which the official image of a marriage and the family is erected. Secondly, in cases where
Though in this study my focus is on respondents who have resorted to procedures involving third party intervention it will be wrong to think that all men/women/couple who are suggested IVF either with their own gametes or with donor gametes or surrogates end up pursuing it or that the acceptance is often spontaneous\textsuperscript{12}. However, once they have considered all other avenues of becoming parents and have been made to realize that the procedures with gamete donation or surrogacy is the only option left, they seek mechanisms and devise strategies\textsuperscript{13} to combat the problematics. There is hence a high level of resolution involved in making and actualizing such a decision which is flagged both by the medical fraternity and the users. Dr. Sanghamitra Ghosh, Ultrasonologist at IRM, brings in her experience of revealing to a “highly educated, English speaking, jet set Bengali woman” that she would need a surrogate which exemplifies the process of acceptance:

\textit{While looking at the monitor at her uterus, I told her you will not be able to carry a baby and you would need someone to do it for you. She was lying on the bed with the ultrasonography\textsuperscript{14} machine on her but she jumped up and said in a very}

\begin{quote}

\textup{a couple’s own biological material is used to induce a pregnancy, the very act of substituting sexual intercourse (which is confined to the private invisible sphere) with a clinician’s expertise (a quintessential third party) becomes a source of anxiety as instrumentation deployed in inducing conception renders the most intimate part of marriage (making babies) visible and public (Bharadwaj 2003: 1871).}

\end{quote}

\textsuperscript{12}It will be wrong to think all women and men who access treatment end up going for IUI, IVF either with their own gametes or with gametes of someone else. As, Dr. S.K. Goswami who has been in the field for more than a decade observes, “We have two kinds of patients coming to IRM. As it is a tertiary centre we have majority of patients coming here after they have been advised IVF and they come here mentally prepared to go for a particular procedure; there is this other set of people who are undergoing treatment here and we are the one to suggest them to go for IVF. Among this later group, 40% of the patients would not go for an IVF immediately but would try out option at other places so that they can either bypass it or delay it. Among this 40%, 60% of the patients are unable to resort to IVF due to financial reasons. But the 40% do not resort to treatment due to prevailing misconception. They are not comfortable with the idea of their sperm being handled by an external agent in the laboratory. Moreover, they are anxious that donor sperm might be used without their knowledge. This anxiousness though is common with sperm is rarely evidenced in case of egg. As sperm is easily available, patients fear, it can easily be tampered with”.

\textsuperscript{13}In labeling individuals’ responses as strategies, we follow Ellen Lewin’s (1985) definition of strategy which is in turn based on Whitten and Whitten’s formulation (1972, cited in Lewin 1985). Whitten and Whitten define strategy as a “pattern formed by the many separate, specific behaviours people devise to attain and use resources and to solve the immediate problems confronting them” (1972: 255, cited in Lewin 1985: 125). A strategy, in this context is a “choice made by an individual, not necessarily consciously, between various options or competing ways of achieving satisfaction with respect to some external or internal exigency or constraint” (Lewin 1985: 125).

\textsuperscript{14}The vaginal ultrasonography is one of the major diagnostic techniques used in infertility clinics. The ultrasonographer covers the ultrasound probe in a sterile condom, coating it with cold jelly and inserts it in women’s vagina. Through rotation the probe highlights the view of the ovary on the screen (Cussins 1996).
rude way that this does not happen in our culture. I did not argue with her but wrote down my diagnosis. The same lady came with a surrogate after a month or so all geared up to go for surrogacy.

This is also echoed by ST, who is a 42 years old housewife from Midnapore and considers her late marriage being the reason for her problem and talks about her submission to this medical procedure:

*The first IVF cycle was done with my own eggs, as I was insistent to give it a try. Then the doctors told me that given my age it would have been better to have a donor. In spite of this advice we carried on treatment for egg production. We thought we would give it a last try. But as there was no result, we agreed to use donor egg.*

The fact that ST decided to carry out treatment with her own egg in spite of initial doctor's advice shows that the acceptance of donor gametes is not a spontaneous step but is more an attempt to come to terms with her inadequacies. The decision to resort to third party intervention is thus a long process of negotiation and ultimate surrender. It forces the commissioning couple to enter "myriad of micro-practices, struggles, tactics, and counter-tactics" (Sawicki 1991:81). Throughout this chapter we will focus on such negotiations and micro-practices in understanding how and at what point this artificial intervention is *normalized* and *naturalized*. Hence we will focus on what are the problematics, how certain preferences are made over others and what are the strategies adopted to actualize such preferences.

**The Problematics**

▷ Problematics of the Externalized Sperm

In this process, reproduction is no longer an intimate act between the husband and wife but a well-coordinated structured process with outside intervention, in which all the parties concerned work towards a definite goal. Hence, the initial reaction of the couples/individuals when they are suggested to use donors or surrogates is often that of denial and skepticism given the prevailing cultural milieu which considers conception and pregnancy as an intimate affair between the husband and the wife. In case of third
party conception, the donor sperm, egg and surrogate represent presence of an external agent in the otherwise intimate process of reproduction\textsuperscript{15}. The perception of the donor sperm as something outside the body, having a distinct identity of its own and belonging to the \textit{other} is the problem which needs to be overcome in order to smooth the artificial process in place. In the perception of the treatment seeking women respondents, donor semen is something external, inherently remote, vis-à-vis their own husband’s sperm which is treated as part of the same shared substance. While technically speaking, sperm in both cases are external substance, the cultural assumption of husband’s body being shared at marriage and sharing of particles through sexual intercourse does not guide one to see it as something outside one’s own. However, when the sperm comes from the donor routed through distinct avenues in contrast to sharing of bodily substance, the reception of the sperm is seen as conscious self-motivated process in which “it is best not to think about it something external and out of wedlock”.

\textbf{Reasons Behind the Apprehension}

The apprehension of using donor sperm stems from various reasons. Firstly, the corollary that follows from perceiving donor sperm as an external object is that the introduction of the same is often considered to be an encroachment on one’s body. Though women do accept donor sperm they initially in most cases look at it as violating their body and bringing in the “yuck factor”\textsuperscript{16} (Haimes and Williams 1998: 143 cited in Bharadwaj 2003: 1874). UD, who has resorted to IUI with donor sperm after their attempt to conceive through IVF-PESA failed, brings up issues as to why a donor sperm is a problematic to be dealt with:

\begin{quote}
Initially the thought of having someone’s sperm in my body made me anxious. I felt it is revolting and as if my body will get polluted.
\end{quote}

\textsuperscript{15} Lesbian women using ART for creating family, in contrast to the heterosexual couples, did not associate donor insemination with “adultery and extramarital sex” or “as a substitution for something that would otherwise have come from their sexual partner; their link to the donor was patently non sexual” (Kath Weston 1991: 171, cited in Hayden 1995: 53).

\textsuperscript{16} According to Haimes and Williams, “an instinctive repugnance or the yuck factor, has most force in the connections between the child and the source of that child’s gene” (Haimes and Williams 1998: 143 cited in Bharadwaj 2003: 1874).
KM, further details out the inherent reason of the apprehension:

Initially, I felt bad that someone's semen will be in my body. It is almost like taking another man inside you. The thought of it as an external thing, having existence in a man's body, who is not my husband, is repulsive.

As an external object the introduction of sperm in the body is seen as polluting and in violation of one's body. This apprehension further accentuates with the uneasiness of sperm quality. The notion of pollution and purity dominates the thought process of most of the respondents. This notion revolves around purity regarding both medical and social categories alike.

- Is it medically pure?

The concern with the purity of the sperm is often defined in terms of infection free over other cultural categories like caste, religion, and social background. This points towards the fact how interaction with medical regime creates a knowledge base in which medical criteria supercedes cultural realities. This reception of medical knowledge does not depend on the respondent's educational level but on the long and strenuous association with infertility treatment. As, UD who is educated till the primary standard but has been undergoing treatment for a period of 14 years expresses her concern with medical purity of the semen:

Different anxieties cloud my mind. I am also anxious where they will get 'it'. There are so many diseases these days, what's the guarantee that the child will

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17 This concern with medical purity is not confined to transfer of semen alone but is also evident in cases of transfer of other body fluids namely breast-milk, blood etc. Though transferring of these body fluids may be necessary at times, "but ideas about contamination – the risk of passing pathogens or toxins – are always prominent in thinking about body-to-body transfers" (Loudon 1977, cited in Conklin and Morgan 1996: 666).

18 Through the process of "anticipatory socio-naturalization" (Cussins 1996:582) women and men view their bodies through medical jargons and terminologies. This applies to all treatment-seeking respondents cutting across class and educational qualification and is primarily dependent on years of acquaintance with the medical world of conception. In these cases, often, English words, for e.g., embryo, semen count, donor, and surrogate, expired, were used frequently in an otherwise continuous Bengali narrative. Often such words helped them in distancing themselves from the experiences that they were narrating and gave them the required solace in talking about something, which was otherwise painful.
• Is it socially pure?

The concern with social purity of the sperm stems from the assumption that sperm is more than a bundle of chromosomes. It is also seen as a carrier of a person's attributes, historicity and social positioning. As, LS mentions,

*My husband was ready at that time to take donor but I was hesitant as I was not sure whose fluid would be introduced in my body. How would it be? With this thought in my mind I delayed the process.*

The concern here revolves around "how would it (sperm) be?" Though the respondents do not bother to explain it further, the question "how would it be" can be interpreted in multiple ways. If we focus on the pronoun used - "it" ("ota kemon habe") - then this can be seen as an attempt to look at the sperm as a medical substance having an existence of its own devoid of the baggage of the person who carried it. But if we move our focus on the usage of "how", and the way it is spelt out, it might be that the concern is about the source of the sperm and with the donor's socio-cultural locale. In this perception, the sperm gets equated with the blood which is thought to emanate not only coded genetic information but cultural attributes as well.

• Probable absence of physical resemblance

The child's resemblance in terms of physical features with the commissioning parents is thought to be important to conjure identity and a sense of belonging. As, it is through resemblance in physical characteristics that a child gets identified to a certain set of parents, to a certain family, vansh, kula and the entire kin line. With the use of donor sperm there is a probability that physical resemblance with the resultant child might not be achieved. The rupture of the genetic connectivity in most cases is explained in the

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19 Ferrell comments "the attribution of intimacy and identity simply through knowledge of biological similarity seems striking and even odd when put alongside other expectations of kin, such as love, care and involvement in each other's lives." (2004:5)
language of physical resemblance²⁰. According to MG, a 23 year old respondent using donor sperm:

Initially I was not too keen. I wanted a child from him so I was a bit resistant to this idea. I told him "I want to have child from you. If I take it from someone else it won't be your blood. I am not sure how the baby will look like". It is ok with us but the neighbours and relatives will tell that the child is neither like the father or mother; nor like anyone in the family (vanish er karur moto noy).

The probability that the child might not resemble anyone in the family is problematic. As, the aim to use ARTs is to have a child who seems to be born "within the wedlock"²¹. But in case the child stands out on her/his own and does not get assimilated within the family there is a chance that questions will be raised regarding the child’s birth. In order to seal any curiosity, any gossip that might stem from this it becomes essential that the child resemble the commissioning parents.

• How the insemination will be done?

The apprehension with using of donor sperm also stems from the partial knowledge that treatment seekers often have, at the beginning of the treatment. There being a lack of communication on part of the providers, as to how the procedure will be carried out, the treatment seekers who do not have access to other sources of information often develop a skewed understanding. As, AM who is an illiterate and is about to go through the first IUI shares her apprehension:

But he (her husband) is also hesitant because he is not sure how the donor will be used. He does not articulate it clearly but he is apprehensive that I have to sleep with someone, to have sex... I am also not sure of this. He says, "even if it is like that it will be only for half an hour or one hour. We have to accept that". But I said to him, "I do not think they would do such a thing, will they"? I told him "let me go", "if something untoward happens I can even come out at the last moment". But I am not sure myself, that’s why I am asking you, is it that I have to sleep with someone?

²⁰ Whereas for AS, a respondent, the logic with which she would accept a child who does not essentially carry her husband’s physical features is that often “normal” child also looks very different from their parents”. To her having a child, in the sense of replica of one’s own who occupies the same place, as that of parents is not something she is looking for. She accords the child his/her individuality who, even when unlike them, will belong to them.

²¹ Dr. Gutgutia made this comment in the interview while talking about AID.
In absence of a detailed understanding, there is unease with the process of sperm insemination. The insemination of donor semen through a syringe in a medical chamber under the medical gaze is accepted as medical procedure. But till the time this procedure is not clearly explained, treatment seekers often assume that the donor insemination in essence is nothing but what existed as the ‘niyog’ in earlier times. Hence, to them such a procedure becomes a problematic to be dealt with as it not only introduces an alien substance in the conjugal relationship but also hints at having sexual overtones.

> Problematics of the Externalized Egg

The problematics with the use of donor egg however, is not as pronounced as that of sperm. None of the respondents mentioned that having to use donor egg was in violation of their body or that they were apprehensive of “somebody else’s body fluid entering” their body. The problematics with the egg donor is often significantly different from that of externalized sperm. Moreover, unlike the procedure with donated sperm, where the sperm is nothing more than body fluid in a vial, the egg donors were women with whom the recipient had face-to-face interaction. It is hence surprising while the semen in a vial was seen as polluting and intervening the normal process of birth the intervention of someone else’s egg did not feature so strongly in their narrative. It is perhaps as eggs unlike sperms do not have an independent existence in the cultural narrative and cannot

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22 The modern society is often thought of having “coalesced time into the synchronized, and always in principle synchronizable, forward-running, finely and evenly calibrated time of clocks” (Thompson 2005: 10). But unlike in other technical field, in the realm of ART we came across different ‘relevant’ kinds of time. This is important because people’s perception and understanding varies over a particular time frame. There are menstrual cycles and treatment cycles which are different and need to be synchronized; there are menstrual cycles of the egg donor and the receiver which have to be timed at a particular period in a cyclical and repetitive manner (Thompson 2005). There is the “bureaucratic time” (Thompson 2005: 10) of the daily working routine in which doctor appointments, blood test and ultrasonography procedures to be fitted in. There is also the biological age which is lineal unidirectional but at the same time there agents in the form of hormonal drugs which tries to captivate and arrest this unidirectional age. There is also an understanding of normalcy in time in the sense that marriage within a certain age is normal whereas above and over it becomes abnormal; there is also normal time frame for ‘natural’ conception i.e., within a year or two of marriage.

23 In case where the husband was infertile, the wife was required to mate with another man in order to continue the line. This was known as niyog pratha. We find ample evidence of niyog in the Mahabharata for e.g., Dhritarashta, Pandu and Bidur were born through niyog pratha.
be parted from body without rigorous medical procedure it does not become visibly problematic. Instead, the egg donor as the other woman and not the egg becomes the problem to be dealt with. This is because it is the former who steals away the medical gaze from the recipient woman for a considerable period of time during egg extraction and fiddles with the fundamental axiom of mother-child bond.

In a few instances, unease with the use of donor egg has been mentioned. This has occurred in cases where the donor was a woman from other religious communities. This, in particular, has been explicitly pronounced in case where a Hindu woman had to accept egg from a Muslim woman because there was no other option left. SC who is 47 years old and is a nursing Staff in Jalpaiguri and is undergoing IVF with commercial donor brings up multiple strains of thought as to where and how boundaries are built and unbuilt and how explicit handling of not only biological but also socio-cultural categories takes place:

*When I started the second round of treatment we were told that I would need a donor who will give egg... [We] could arrange for only a 'Mohammedan' donor. Initially I was not at all ready to accept it. Even now I have somehow digested the fact as I have been left with no option. But I feel repulsive that a 'Mohammedan' woman’s egg is in my body. I wouldn’t have created such fuss about this if the egg had come from a Hindu woman. I am still trying hard to throw away the apprehension that I have.*

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24 SC was married late and has been going through treatment protocol for a considerable period of time. She explains the number of years she is in the treatment protocol:

As I was married late we never used any contraceptives. But when nothing happened within six months I went to a doctor in Jalpaiguri. But she referred us here. Then when we got an appointment here and went through a series of test it was detected that there were cysts in my ovaries, which were operated. Then I could not resume treatment just after the operation, as I had to take a gap of six months. When I started the second round of treatment we were told that I would need a donor who will give egg. But this search was very difficult as it is awkward to approach anyone on this sensitive issue. Initially I approached my brother’s wife and she agreed. We did not know that she had to be under treatment and take injections for giving eggs. She came with me to the clinic to donate. We thought it was like blood donation - she would come, donate and go away. When they came to the clinic and the doctors told them that there is a series of test/s to be performed and there are injections to be taken for a period of 15-20 days and during that period they need to come to the clinic frequently they got scared and did not want to continue. After that we had to start with a thorough search for donors. Hence at 47, I am still trying to become pregnant.

Some NRIs have also hosted personal website in their search of surrogates and donors. One such website is [www.oneinsix.com](http://www.oneinsix.com), hosted by Bobby and Nikki, a couple looking for surrogates.
In her search for a commercial donor, what becomes her primary reason for disquiet is that she had to resort to a Muslim donor. The fact that she has to have biogenetic substance from a person of different religion has been difficult for her to accept. She sees in the egg not a medical, depersonified medical object but a microcosm of person with different beliefs and practices. For her, having the egg of a Muslim woman in her body brings in the same kind of notion of pollution and purity she has internalized to be true with sharing food, residence, water with someone from a different religion or caste. To her, if the donor would have been from a Hindu family with similar cultural, religious influence and shared history then it would have been easier for her to accept the donor. Having similar religious rooting their substance-code at one level would have been same, and it would have been easy for the recipient to assimilate the substance of the donor. So, genetic makeup for her are coded in terms of similar religious background. The separation of shared bodily substance and genetics and the notion of new biology in the context of these procedures rewrites both the biology and sociology of making babies.

**Problematics of the Externalized Uterus**

The problematics of renting the other woman's womb for having a child is the most crucial as in case of surrogacy the statement of infertility becomes quite apparent. In this case, the commissioning woman is not visibly pregnant with the child even if her genetic materials have been used. Hence this is an option which is used much more rarely in comparison to the use of donor gametes, be it sperm or egg. The very fact that surrogacy segregates the genetic mother from the gestational one, and the latter being the signifying cultural metaphor of child birth and pregnancy – to deal with this disjunction becomes a challenge in itself. RM makes a comparison between IVF with donor egg and surrogacy and opines that the latter is much more problematic:

> *When my sister-in-law donated egg it could be kept within the family. But this would not be possible in case of surrogacy. Why will they face so many questions just because of me? Nobody would do that.*

25 There is a deep-rooted psyche of looking at different religious communities as the 'other'. This is made explicit by respondents (who happened to be Hindus) in reference to donors from Muslim communities.
CS who is 35 years of age and has undergone six IUIs, one IVF in the last ten years narrates her negotiation with surrogacy:

Though scientifically the baby is ours (because the embryo is from my husband's sperm and my egg) but socially the child will never be mine. It will be the woman's who would give birth. In our socio cultural Bengali understanding there hardly exits any notion of egg. The mother's contribution is seen in terms of giving birth to the child. In my case this unique linkage will be severed. Nobody takes the pain in finding out where the seed has come from. They associate the plant with the soil from where it germinates.

CS does not naturalize her genetic contribution as the sole contributor in making the child. To her she is unable to be the primary contributor, as she cannot gestate the child. Using an analogy of the soil and the plant she explains her incapability to gestate the child as equivalent to being unrelated. Equipped with the scientific understanding of child making, she knows that the genetic contribution is given prime importance, however, to her mind it is the cultural understanding that is of importance. Thus, having access to both the scientific and cultural model she chooses to understand her role in the process of conception and pregnancy through the latter. Though the scientific model was capable to provide her solace in naturalizing her contribution in becoming a mother, she opted for the cultural model, as it is through this model that her family and the larger society would look at her pregnancy. While at one level there is an acceptance of surrogacy as a medical procedure, there is also a concomitant apprehension of the disjuncture and the intrusion.

RM, who is still contemplating surrogacy after the demise of her first child at the age of 17, brings in the intricate issue of class and caste and talks about her apprehension of using a commercial surrogate:

Neither I am keen to hire a surrogate from outside the family. Women who will come forward to become surrogates will be women predominantly from the slums and their only incentive to come forward is to earn money. If I have a child from such a woman from the slum who is carrying the baby only for money will the child be of good birth/ a good child (‘susantan’)? My son was a jewel. He was well built, fair, handsome, looked like he was 22 when he was just 17 and good in studies. He looked like a kid from the Brahmin-Kayastha community.
Being of lower caste but of well off economic background she is eager to transcend her caste line by projecting that her son was easily assimilated in the Brahmin-kayastha community through his looks and education. She fears that to have a surrogate from the lower class, driven by money, would not be instrumental in delivering a child of good blood, like that of her earlier son. Here interestingly, the blood of the surrogate is not derived from her caste substance but through her class positioning and her demand for money for an act, which is otherwise humane, noble and filled with emotional well-being.

Dealing with the Problematics: The Preferences

The Preference: Choosing the Family Way

Choosing a relative from the family as the egg donor or surrogate is an important attempt to reconnect to the conception and the pregnancy, which has the probability of being severed by use of donor egg. The egg being from a family member gives an assurance that the rupture of genetic ties, which is supposed to have occurred, has been bypassed to the extent possible. As one of the respondents said,

As the egg was coming from the family (natal) we were not concerned.

What makes her naturalize the process of third party inclusion is the fact that the egg is “coming from the family” and that too from the woman’s natal family. The choice of using a donor from the natal family, rather than the husband’s family, is guided both by medical as well as social dictum. The medical diction to use egg donor from the woman’s natal family is to substitute the woman’s genetic material with that of someone from the natal family so that the medical equation remains constant with 50% of the genetic material coming from the father and 50% from the mother. The social dictum which promotes taking the donor from the natal family is based on the thumb rule that the

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26 It is mandatory that donor sperm should be anonymous and taken from sperm banks. As said by the providers and users, this guideline was strictly followed. Interaction in clinics in Delhi as part of the pre-study fieldwork, however, revealed that there is a strong demand from the treatment seekers to use donor sperm from the father or brother of the husband in order to preserve the bloodline and clinics often comply with such demand.
woman's own family can be taken into confidence about her inadequacy of having a child while the husband's family cannot. The choice of a relative from the natal home, over an unknown donor, then seemed to be an important part of reconstructing the experience of conception and pregnancy that has been broken down by their decision to use donor egg. If conception did not take place with their eggs then women were quite certain to at least make sure that they share blood attachment with the donor. To her the flow of blood that she still shares with her natal family becomes the point of significance\textsuperscript{27}, as through this blood her severed relationship with the child will get amended.

SC: \textit{Initially I approached my brother's wife and she agreed... [But later on she] got scared and did not want to continue. After that we had to start with a thorough search for donors.}

SC's narration of looking for an appropriate donor started from the family that too with the brother's wife in the same logic and enthusiasm followed by others. However when her attempt to do so failed due to the reluctance of her boudi (elder brother's wife) to be part of the rigorous medical regime\textsuperscript{28} she had to resort to commercial donor.

\textit{Boudi/Bhaj vis-à-vis Sister as the Preferred Donor: A Glimpse into Understanding Kinship}

In this study women preferred their brother's wife, i.e., her sister-in-law as the egg donor. Though the sister-in-law is from a different family and does not share the genetic make up with commissioning women, this biological fact is not taken into account. But what gains importance is that with the marriage the substance – code of the boudi / bhaj (elder

\textsuperscript{27}This reminds us of Goody's illustration that even in "extremely patrilineal" societies like India total assimilation of women into their husband's kin group is a myth. Women are in general "carriers of property as well as of sentiments, ties and relationships" (Goody 1990: 480). This myth has been propagated by the Eurocentric understanding of 'other' cultures which is dominated with perceptions of market metaphors and economic relations. In similar lines, Lamb also portrays marriage as "obscuring and greatly reducing, although not obliterating the connection" with natal home (Lamb 1997: 291). She shows in her ethnographic study that fundamental connection with the natal home remains as one "feel[s] a pull (tan) of \textit{maya}, of blood or of the womb" (ibid.: 292).

\textsuperscript{28}The fact that donation of blood and that of egg are seen both as parallel processes of bodily substance being given to someone in need becomes questioned once the encounter of the recipient couples started with the medical fraternity. The rigorous medical procedure for egg extraction in comparison to blood donation flags the issue as to what extent someone is eager to part with one's own bodily substance and which medical procedure are seen to be threatening, invasive and in violation of one's own body.
brother’s wife/ younger brother’s wife) has been assimilated in her brother’s clan. Hence to have the egg from her is to have it from the family since through marriage, two unrelated and separated bodies have been united (Inden and Nicholas 1977). MS2 who is 43 years old and married for the last 25 years and is trying to conceive through her sister-in-law’s egg articulates the reason behind this choice:

I also have a younger sister whom I could have approached. But I did not bother to tell her because then her husband and their family would know about it. So it can become an issue to be discussed outside family. Whereas my brother’s wife belongs to our family, my sister is part of a different family now. Here it’s my brother’s wife so my brother will understand. Moreover my brother is related to me by blood so the child will carry my blood. Though my husband was keen to get it from outside I thought at least in this way the child would be at least from my family.

The choice of the boudi/ bhaj over the sister is then guided by the assumption that the latter no longer belongs to her family. This is where most treatment-seeking respondent (women) took on the role of the anthropologist29 at work. To them, the substance of the sister being assimilated with that of the sister’s husband and their family is remote than the brother’s wife who though originally not a part of their family has become closer through sharing of their brother’s blood. The dichotomy that is drawn here, however, is interesting. While treatment-seeking women feel they still retain the blood of their natal home even when they are married, similar connection in case of their sisters are seen to be totally cut off. Such a dichotomy also stems from the preset idea that the man has control over his wife’s body in a patriarchal society like ours. Thus for her sister to donate, it is essential that her husband should know about the proceeding. Similarly in her bhaj / boudi’s case such power rests totally with her brother who is part of her family and will give priority to her interest over her sister’s husband. As such she places importance on her relation with her brother through blood and her bhaj / boudi who is now her husband’s shared body. But while she in her case stresses this linkage and down plays the assimilation of her blood, substance-code with that of her husband; in case of her sister

29 Jeannette Edwards (1993, cited in Floyd 1995: 1068) in her ethnographic study of “All-town” also comments that the residents “like most of us, are experts in kinship”. This spontaneous vision of the social world is termed “spontaneous sociology” by Bourdieu (1989: 18).
and sister-in-law it is this attainment of shared body at marriage that she bases her argument on.

In this study we find predominantly brothers’ wives becoming the egg donors and are often chosen over their own sisters. We find a different picture, if we bring in narratives from a California infertility clinic (Thompson 2001). Jane in this case, who is a surrogate, is the sister-in-law of the recipient couple who is also the genetic mother. As Thompson writes “Jane, was related, but only by marriage, ... staff members [were] complaining that her heart was not in it.... the psychologist felt ...demands of emotional contract [were] necessary to undertake a pregnancy on someone else’s behalf.... she voiced a strong preference for close girlfriends or sisters over relations by marriage when a noncommercial surrogate was needed” (2001: 185). Here the psychologist speaks with her Euro-American understanding of kinship, which has often placed blood relatives over relatives by marriage following the strict compartmentalization between order of nature and order of law. However, in Bengali conceptual understanding the relations by marriage do not strictly fall short of blood relatives and this cultural notion of belonging surfaces in the choice of egg donors as well.

A Widowed Sister is Closer to Heart

In cases where sisters have been the donors, the preference has been for widowed sister. Though such generalization cannot be made but being widowed the sister has been seen closer to her natal home than a married sister. In this case SG, a 40 years old housewife from Raniganj who is going through IVF with her widowed sister’s egg justifies why she thinks that the genetic material coming from her own sister is almost the same as hers.

*I approached my widowed sister and she agreed to give me her eggs. My sister’s husband died 12 years ago and she had a girl of her own. So she said that she would be ready to help in any way. I have agreed to this because I am taking the egg from my own sister so it’s almost mine; it’s the same blood flowing so I did not have any problem accepting. Moreover it has been common in our culture where both sisters have raised a single child as co-mothers. I do not know if I would have agreed if the egg had come from someone else.*
By referring to the social practice already in place of co-mothering a single child and by claiming their blood or genetic pool\(^{30}\) being the same, she justifies her otherwise out of the ordinary action. She legitimizes the bypassing of the normative order by highlighting the social basis of such association. For her, it is acceptable to give birth to a child with her sister’s egg, as bringing up a child jointly by sisters has been in practice for long in Bengali culture. It is not seen as a sweeping departure from social practice of the socio-religious community she belongs to. Moreover, she makes it explicit that had the gene come from somebody else then her idea of aberration from the normal would have prevailed. While some of the respondents chose not to have a sister as a donor because they believed that her body fluid no more matches with her as she is married, SG did not voice this concern. She also justifies that as two sisters marrying one man and a man marrying his deceased wife’s sister has been in practice in Hindu communities this does not call into question the mingling of their sexual fluids through him as obnoxious. To her, having her sister has been a preferred choice. This is so, because her sister being a widow and staying in their natal home has been both culturally and practically a more viable donor. Though the widowed sister still belongs to her husband’s family but devoid of the constant mingling of their body fluid the sister’s blood is seen as belonging to same blood pool and almost a replica of hers own.

\[\text{Providers’ Preferences/Prescriptions}\]

\[\text{Cultural Ideas of Sameness}\]

The ways in which the couples look for specific characteristic in donor sperm\(^{31}\), matching

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\(^{30}\) In case of lesbian women using ARTs for constructing family, Hayden (1995) observes similar happenings. In this case couples may choose donors whose physical characteristics resemble the co-mother, for e.g., brother of the co-mother. This according to Hayden is a signifier of “genetic continuity, whether literal or implied” being an “integral resource” (Hayden 1995:53) for constructing relationship.

\(^{31}\) In case of egg donors and surrogates though there are concerns with characteristic, the narration by couples portrays that their search for specific characteristics is not rigorous as their aim is to find a donor anyhow which is quite difficult. But in case of sperm donation often requests regarding characteristics are put forth providing us with a glimpse of which traits are valued in society:

- Most Hindus say that they would only accept sperm from Hindu donors and not from Muslims.
- They also ask for socioeconomic background, educational level and often caste and religion. Fair complexion and height are also valued.

However, if we look at advertisements for egg donors and surrogates we find there is craving for physical attributes. An analysis of 33 surrogacy related advertisements in two women’s magazine namely Women’s
their own or the way the clinician or the embryologist does the job of matching – seem to
be guided considerably by the principle of the cultural ideas of “sameness” (Bestard
2004: 258) rather than on medical criteria. Here gene and genetic coding to a significant
extent gets translated in and equivalent to physical resemblance (Bestard 2004). Thus if
we see in sperm donation the characteristic specified for each semen sample have only
one medical characteristic to be matched that is the blood group32, all other characteristics
merely ensure that the child looks like the commissioning father and as Dr, Gutgutia says
“we want the couple to have a socially acceptable child”. In IRM the semen sample is
routed from a company in Aurangabad called Sperm Processor. According to the
laboratory technician IUI department, IRM,

_We buy sperm from sperm bank and match it with husband of the recipient
couple. What we definitely try to match in case of sperm is the blood group and
colour of eye. If the colour of the eye of the husband is brown or cat’s eye we try
to match, but if the colour of the eye of the wife is black we do not bother as it is
difficult to have different eye colour among sperm sample. If the colour of hair is
different (other than black) we try to match. In case of educated patient we try to
match as closely as possible – height, eye colour, hair colour, built. But in case
of less educated patient we do not take so much effort. Education does not
feature in the pro-forma sent by the sperm banks. However, we are assured they
are from educated (graduates) and from middle socio economic background. We
take down the education level of the husband so that we would take the extra
effort to match. If the height is 5’6” we can go up to 5’8” but not more than that._

In these situations, the otherwise clinical arena is flooded with social categories of class,
religion, caste and ethnicity. In these locales, classification based on these categories
becomes explicit in order to fertilize those sperms and egg, which are most likely to
resemble the recipients. It is assumed that such identity matching is important and it is
sensible to draw semen sample, which remotely belong to either same class of people,
people of same region, and locality and so on, with that of the recipient33.

_Era and Sarita by Sama – Resource Group for Women and Health (2006) finds out that 40% advertisement
specified looks of surrogate (fair, good looking, beautiful), 15% specified desired marital status, 66%
specified free of any infectious disease, 10% specified caste background. There were also references to the
surrogates having good moral values.

32 However, this matching is considered often insignificant compared to the matching of physical
characteristics.

33 Surprisingly, often in the society at large there is an attempt to make these social categories implicit
through State policies in order to resist inequality and discrimination. However, the same social categories
are made explicit in the clinical arena._
The selection depends totally on the will of the medical fraternity who use their own discretion to match the characteristic within a certain given parameter; however there are certain clinics in which the recipient couples are themselves thrust with this responsibility. Genome, which caters to a specific clientele coming from middle and upper middle class, gives this sense of agency to the couple by giving them the authority to choose. Such choice, however, is limited in the sense that “if the husband is jet black they cannot choose fair complexioned sperm...[they are] not here to shop for a designer baby”. When embryologists match eggs and sperms in terms of social categories what they are working at is not primarily a scientific neutral endeavour but an act loaded with cultural meanings and norms. By using kinship as an everyday tool,

34 In order to diffuse the identity of the sperm donor, different semen sample are used in case of repeated DI. Though the basis characteristics remained the same, it was a conscious decision on the part of the clinical staff to use different semen sample (communication with the laboratory technician). In the same way genetic and gestational contribution were often dispersed between two women in case where the recipient would need both a gestational surrogate and an egg donor. Traditional surrogacy where the surrogate was also the genetic mother is not a preferred option as in such case the maternity claim of the surrogate is strengthened through her genetic and gestational contribution.

35 According to Dr. Rohit Gutgutia of Genomee:

For sperm we have tie up with one sperm bank in Mumbai and another in New Delhi. We have an exhaustive list with six essential features like blood group, height, hair colour, eye colour, body built and complexion. We give the list to the couple and ask them to choose from the list. However, the recipient couples do not have an open choice – if the husband id is 5'8, then they can choose from 5'6 to 6'.

36 For an overview on various theories on human agency, see McNay (2000).

37 It is important to state that there is strong son preference still prevailing in our country (Bal 2006) and this has been further speeded up through reproductive technologies like amniocentesis. This is more than often marketed in the name of choice. However, what we encounter in the field of assisted procreation where women and men are striving to conceive and have a child is that son preference takes a backseat. It is not that these women and men consciously or deliberately question the patriarchal obsession of having a son but to them it is more of a logic dictated by feasibility. The fact that they want to have a child which is their sole priority they are ready to do away with the fact whether the child is a boy or a girl. However, according to Dr. S.K. Goswami of IRM, if the couple comes back for a second child through IVF, then they do articulate their preference for a son.

38 Taussig et al (2003), labels this as “flexible eugenics” as amidst “biomedical free choice, technology and technique become objects of desire invested with diverse meanings that surely vary for producers and consumers, for research scientists, clinicians and individual patients, all of whom may imagine their relationship to choice and perfectibility quite differently” (2003:65).

39 Dr. S.K.Goswami to a couple: Both of you are carrier of this disease. But there is no manifestation of the disease in both of you. It might be so that there is a 25% chance that the disease gets manifested in your child. But that is a risk that you can take. While you are pregnant we will do a test taking fluid from the uterus and if it tests positive you can abort the child. This is my suggestion that it is worth taking the risk but it is better to get the test done during pregnancy and terminate it rather than drag a disabled child for the entire life”. This is the desired prescription given by the doctors in order to have a ‘perfect’ (Landsman 1998) baby. Dr. Anita Ghai, a disability specialist, in her presentation on genetic improvement (2006) cited a case in which a deaf couple was having a child and their child was also detected to carry similar genetic impairment. Though the couple was ready to raise the child they were never given an option to do so.
they craft social realities, based on an existing normative structure and interspersed by social hierarchies in place. In this endeavour, kinship not only bases itself either on social/biological facts of nature or on both, but also becomes a tool of rendition between nature and culture.

*Appropriate Egg Donor: A Catalogue*

It would be however, wrong to assume that the recipient couple’s are the sole actors in crafting kinship ties in case of IVF with donor eggs. The medical fraternity also plays their own part in making this definition full proof. Though their involvement in selection and choosing the donor practically is minimal, unlike, AID\(^{40}\) but their advice as to who should be the appropriate donor does not limit itself to medical criteria but spill over social criteria as well. This becomes apparent in RM’s narration who is 50 years of age and is undergoing treatment in IRM for the last 5 years after the demise of his only son at the age of 17.

*I first got my niece\(^{41}\) but Dr. Goswami (referred to as Parthada due to familiarity with the clinic over the years) said this is not preferred as this is almost like a father-daughter relationship and fusing of their egg and sperm is repulsive\(^{42}\). It is

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\(^{40}\) In case of IUI with donor sperms, the sperm donors are anonymous and semen samples are obtained from sperm banks; unlike donor eggs or surrogacy where respondents know the egg donors and surrogates. This makes IVF with donor egg/surrogates and IUI with donor sperm significantly different from each other not only in terms of technical sophistication but the cultural story that it is capable of drawing. Whereas in case of egg donor or surrogate the sole responsibility of finding a donor/surrogate rests on the recipient couple and the clinic does not take an active role other than specifying medical and often social criteria as to who should be the appropriate donor; in case of sperm donation the responsibility resides with the clinic. This difference at present is only true for the Clinics in Calcutta where the fieldwork was carried out. There are, however, egg donor programmes in practice which use unknown donors e.g. where the clinic runs an Egg Donor program in which anonymous donors are enlisted. In IRM, Egg Sharing Programme was in place but has been stopped. My personal conversation revealed that both Egg donor Programme and Donor Sharing Programme are standard feature of most clinics in Mumbai. In this case the egg donors are also anonymous like sperm donors.

\(^{41}\) This question of violating the taboo by mixing of sperm and egg in an unusual relationship is also highlighted by Andrews (1985) in his commentary on “When Baby’s Mother is also Grandma-and Sister”. He, however, specifically refer to the case where the daughter’s egg is mixed with the stepfather’s sperm. The Ethics Committee of American Society of Reproductive Medicine though supports family members being donors and surrogates it bars donation from brother to sister or vice versa and father to daughter’s husband or mother to son’s wife. For an exhaustive list of ‘Potential Intra-familial Collaborative Reproductive Arrangements among First Degree Relatives”, see Ethics Committee of American Society of Reproductive Medicine Report (2003).

\(^{42}\) Dr. Goswami considers social nature of the source of the biological material as significant. Here he echoes Dr. Srinivas, the respondent of Bharadwaj’s study (2003: 1874).
better to get the egg from someone with whom I have joking relationship (iarkir samparka) like my sister or my brother's wife. So I approached three of my brothers' wives but two of them were over 40 years of age and my youngest sister—in-law came forward to donate.

RM brings in an important point to this discussion, through this anecdotal reference and hints on the provider's preference of appropriate egg donor. The adjective appropriate clarifies that a donor is taken as apt, if she can contribute without fundamentally inviting threat to the existing order of meaning. Hence the notion of apt is founded on the providers' assumption of the construction of kinship ties and in their understanding of the extent of technological intrusion as desirable. To put it simply, the question is to what extent should science mess around with social categories and the normative structure in place. For RM asking her niece to be the donor does not bring in any sense of traversing the boundary. This might be so, because in her mind the contribution of egg for a medical reason in a medical set up acquires an asexual connotation. Quite interestingly the doctor who has been in the field for more that two decades and has been regularly handling human gametes as depersonified, asexual, and extracorporeal medical substances suddenly finds using niece's egg as problematic. In his perception to fertilize sperm and egg of the uncle and the niece who fall in genre of father-daughter relationship would be crossing boundaries of existing social parameters. Suddenly in this apprehension, the doctor leaves his professional identity and look at the probable fertilization of the egg and the sperm in terms of a sexual union of two people who are otherwise prohibited to have such relationship. The doctor's prescription\(^3\) to bring in people of joking relationship rather than a niece also points towards society's concern with what is of fundamentally polluting and what can be accepted given a particular context of crisis. Though it is the doctors who while counseling often stress on the asexual nature of sperm, by comparing it with blood,\(^4\) when it comes to particular cases like these they refuse to see sperm and egg just as a medical substance per se.

\(^3\) Frances Price (1993, cited in Floyd 1995: 1068) also documents the clinicians' response in "thought and praxis" regarding questions like "should egg donors be anonymous", "restricting treatment to heterosexual couples". Price claims these decisions are fraught with "moral and ethical ambiguities of clinical practice" and an "unrelenting tendency for such debates to be resolved in favour of the social norm".

\(^4\) My field notes entry reveal this conversation between the doctors and patients:

Doctor to Patient: if you get blood donor, kidney donor why won't you get an egg donor? You are looking at wrong place. If you give a small advertisement in newspaper or women's magazine like Women's Era you will get a donor.
Genetic essentialism

We also find how in case of egg donors though the clinic do not have the scope to handle social categories as they do while matching sperm but they try to diffuse their notion of genetic essentialism\(^45\) and good gene vis-à-vis bad ones. This becomes quite clear in Mrs. Bannerjee’s articulation. Mrs. Bannerjee is with IRM for the last 18 years in the capacity of Administrative In-charge of the IVF unit:

*In case of donor egg / surrogacy cases, the ‘party’ gets their own donor/surrogate. Sometimes it’s their sisters or brothers’ wives but they also get their maidservants and others of that class. For, e.g. someone recently got a rickshawalla’s wife. Now when they come here they do not generally tell us very clearly that it is a professional donor. But we get to know by their appearance, body language that they are not their relatives or friends. When they get these people they do not try to realize that there is 50% chance that the child will inherit the donor’s characteristics. They are so head bend to have a baby that they do not bother at that point. But I do not know how they handle once the child is born.*

In case of donor egg then where the clinic do not or cannot participate actively in crafting kinship ties in terms of class, caste, religion, ethnicity they do so in a more subtle way and through avenues that are available to them. In doing so they not only support relatives to be more appropriate only because they belong to the same genetic pool but also because that give them the chance to operate within given social parameter where mingling of bodily substance occurs if and when *sameness* is guaranteed at a certain basic level. There is also a strong overtone to the providers’ preaching that the *rickshawallas* gene is inherently bad as it is coming from the lower rung of the population. This in a way talks of good genes belonging to a certain class of people and developing subtly the concept of genetic capital which like economic and social resources will have the potential to determine individual’s social locale and standing in the near future.

\(^45\) "Genetic essentialism asserts that our genes and our DNA are the essence, the core, the most important constituent part of who we are as human beings; therefore, genes should overpower any other factor when defining biological parenthood. Genetic essentialism reduces human beings to the contents of our cells" (Bender 2003). This geneticization is no more limited to laboratories but leads to the definition of “normative personhood” in the daily social practices (Rapp *et al* 2001:17).
Strategies used to Normalize the Compromises/the Transgression/ the Artificial

There are different strategies in place, to naturalize and normalize the disjuncture that has taken place through the introduction of third party and to delineate the commissioning couple the role of the real parent. In this process, both recipient couples and the providers play a role in their different capacities to sketch out multi-pronged strategies. The providers, in order to play a supporting role in their projection of assisted procreation as normal and the departure as insignificant and inconsequential often draw from the existing guidelines. These strategizations also include devising mechanisms to gloss over the compromises that had to be made, both in using assisted reproductive techniques in general, and the preferred choice of going about it. Thus when preference of "going the family way" cannot be achieved the component of fondness and altruism is highlighted in case of commercial transaction. It also goes to the extent of down playing/obliterating the contribution of the donor and surrogate, highlighting the biological connectivity, and then building up a narrative in which the act of intervention is silenced. In this process certain metaphors of medicine, gift and analogy are in use, in order to sketch out a reality which is normal and desired.

Love that Matters: Inherent Altruism in Commercial Transaction

In this field of assisted third party conception, as we have witnessed, the preference is on seeking the assistance to a large extent from the family especially in cases of egg donors and surrogacy. This urge is so strong that even in cases where commercial transaction had to be in place (for e.g. all the surrogacy arrangements in the study were commercial) there is an insistence to gloss over the disjuncture and paint the reality in terms of love, affection, fellow feeling and altruism. This is done by stressing and highlighting the fragile personal relatedness with the surrogate and their desire to help the commissioning women. To them, the surrogates took this up, as they were in dire need of money, but

46 This strategization can be compared to Mary Douglas's understanding of elimination of dirt. As Douglas, views "dirt offends against order. Eliminating it is not a negative movement but a positive effort to organize the environment...making it conform to an idea" (1966, reprinted 1980: 2). Such comparison is not far fetched, as the aim of the couples is exactly the same i.e., to wipe away the abnormality ("which offends order") and to "re-order" the environment (ibid.).
they were not solely driven by economic interest. The respondent stressed either the fondness of the surrogate towards them or their aspiration to help someone as significant in their decision-making. It is as if this fondness, this relationship guided by fellow feeling would paint over the otherwise commercial transaction and make it humane. As if, devoid of this humanness, the process of childbirth will be incomplete. In these narratives, though the genetic contribution is given much more importance in deciding the attachment with the child and often the surrogate is referred to as “she will just carry our baby for us”, but still it is felt that if the transaction is driven strictly by money that will affect the child. In limiting the surrogate’s role to that of a carrier however does not correspond to looking at the surrogates only as “breeders”, “human incubators” or “vessel” (Roberts 1998:6). By stressing the surrogates fondness and willingness to help the mechanistic assumption of just a “carrier” or “lending” of womb or baby “machine” (Roberts 1998:6) is corroborated with her personhood.

It is interesting how two otherwise distinct binary opposites have been clubbed together in the field of ARTs – machine and person, commodity and gift, biology and social giving rise to what Strathern (1996) and Haraway (1997) called hybrid. By doing so, on the one hand there is an urge to stress on the humanness of childbirth to fit it in the normative social order driven by family values of love, affection, and continuity but only to the limit where it does not jeopardize the recipient’s relationship with the child. Hence there is also a simultaneous mechanism at place. This perceives the surrogate in terms of just being a carrier, baby machine which then justifies the severance of ties between the surrogate and the resultant child and also with the commissioning couple, as machine is not something with which one can be related in kinship terms.

► Down Playing/ Obliterating the Contribution of the Donors/ Surrogates

Once the recipient couples have accepted third party intrusion through internal negotiation, doctor’s advice and in most cases through approval of husband, not only the donor, but also her donation takes a peripheral seat. It reaches a level where there is an attempt to totally obliterate the existence of the inclusion of the external object in the
intimate process of procreation. Once the donation is made and the donor has left the clinical site and the recipient woman has again become the focus of medical gaze, both the donor and her donation loses significance in being a quintessential component of reproduction. Thus, though in the initial stage recipients talk of being concerned about the donors' health because both the women have become related by sharing of their bodily substance, such sharing does not have the potential to create an enduring relationship. The recipient becomes weary of keeping in touch with the donor once the child is born. It is here we come across instances where sharing of substance does not necessarily mediate relationships, but rather severe them. In this process, certain components of medical knowledge are sustained, incorporated and then evolved while others are erased depending on the individual and her/his context.

**Recipients’ Perception about Donor’s Substance**

*I am not bothered about where the egg is coming from...*

In case of IVF with donor egg, both the commissioning woman who would gestate the child for nine months and the egg donor who would give her eggs, have the biological potential of being the mother. However, the role of the lady who contributed egg is made custodial through a strategic process in place. The comments like “it will be my child” and “why should I”, “we are taking so much pain to show the outside world the child is ours” hint at the fact that certain biogenetic factors of birth are obliterated from the conception stories. This is where notions of “systematic misrecognition” (Das 1995: 219) and “collective bad faith” (Bourdieu 1990: 178) come into play in order to systematize this denial and creation of “practical kinship” as opposed to the “official one” (Bourdieu 1990: 168, also see Bharadwaj 2003) ⁴⁷. The submission to the use of anything *artificial* is to be conscious of the fact that the child is rooted through artificial means. The entire endeavour is just the opposite, i.e., to project to oneself and to the world outside that they,

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⁴⁷ Bourdieu proclaims “endless examples can be given of this sort of collective bad faith” (1990:178) as the task of “representational kinship” (ibid.: 169) is to cover “up the shame before it is unveiled” or before the family’s “symbolic capital” (ibid.: 169-170) is devalued. Veena Das takes on this conceptualization and through this analyzes how national honour and practical kinship is maintained. She nevertheless feels, “the term bad faith is not felicitous in this context; I would have preferred a term such as systematic misrecognition” (1995: 219). Bharadwaj (2003) in turn uses these concepts in his analysis of adoption as a disused option in India.
like others, have had a natural progression from marriage to childbirth. Hence, saying that it does not really matter where the egg has come from minimizes the donor's contribution. The claim of the recipient is further secured and sealed by highlighting recipient and donor's mutual obligation of being "close to each other" and that the donor already has "a child of her own and have decided to have no more". By saying this, the recipient not only justifies her claim to motherhood but also at the same time obliterates any remote chance of the egg donor's claim to motherhood either at present, or in the near, or distant future.

Donors' Notion of their Own Reproductive Material

It is interesting how donors play down their own contribution as having any potential to create a link. Even if they are aware that they would contribute for the 50% of the genetic make up of the child, they look at it as an insignificant contribution compared to holding the child for nine months (Ragoné 1996)\(^48\). They see their role to end with giving off egg. As one commercial donor, unwilling to give her name said,

\begin{quote}
I already have a child. It is not a big deal for me to give my egg and go away. Though no doubt it is painful. But some couple would have a child out of it. It is always a great feeling to help another woman. A woman can only understand another woman's pain. It is not that I am doing it only for money. I am a Master's degree holder, and my husband is in a government job. It is not that I am in serious dearth of money. I just happened to see this advertisement in the local daily and thought that I have heard of blood donation, kidney donation but what is this? So I just enquired and found out. It sounded interesting so here I am. May be I will do some fancy shopping with this money or will buy something for my son? But through my act I will be able to bring a smile in someone's face.
\end{quote}

In this articulation she makes her reproductive substance "exterriorized, extracorporeal body parts" (Konrad 1998: 645). It is difficult for her to construct or imagine a kinship relation evoking out of her contribution, because her donation does not change her course

\(^{48}\) A surrogate narrates, in Proceedings from the Seminar Life After ART – Developing Families', Australia (2001), "I haven't formed any motherly bond... I feel the surrogate needs to have it right in her mind from the start, and in my mind from the start I wasn't having a baby for me, it was for them... I also feel surrogates need to be prepared to be 'left' so as to speak once the child comes along" (2001: 33). Respondents in Ragoné's (1996) study who acted as surrogates de-emphasized their "biological link to the child" by focusing on the folk theory of procreation which gives primacy to paternity.

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of life significantly, but have the potential to change another woman’s life. At the same
time, however, making parts of themselves into substance of others is more than just an
act geared at medical assistance but is looked as “bringing a smile in someone’s face” 49.
Egg and other the genetic material thus, becomes abstract entities without any potential of
creating relationship and just an altruistic act for an anonymous woman for the sake of
fellow feeling.

Highlighting the Prevailing Biological and Social Connectivity

Genetic and Gestational Contribution of the Mother and Desire of the Father

MG, who is just 23 years old, housewife and is undergoing procedure with donor sperm
said,

*I wanted a child from him so I was a bit resistant to this idea. He said, “What
will I do if I cannot give you a child. But if we go for this (procedure) the child
will be in your womb. Won’t you be able to forget all these and love the child?
Nobody will know about it and the child will be ours”. My husband loves
children very much. So now I have accepted it. Only last night I was asking my
husband won’t the child get my characteristics? In that case people will say that
the child is like the mother.*

In MG’s articulation her concern about both the cultural metaphor of blood and the
scientific metaphor of genetic make up, are expressed in the same breadth. Her
assumption about physical resemblance and blood flow emanates from both, Western
Biomedical and Bengali cultural model of reproduction and pregnancy, which do not
seem to be in contradiction to each other. According to MG, who speaks on behalf of her
husband, gestation along with the genetic contribution of the wife is the primary factor
which will make the baby their own in spite of third party intervention. He sees his
contribution in making the baby both in his desire for children and also through his wife’s
contribution with whom he shares his own body. In this sense they not only negate the
donor sperm as a biogenetic substance having the potential to confer relationship,
descent, belonging, transfer of property and family line; they also stress the biological
contribution of the mother and the emotional, desire of the father as substantial in

49 Interview with an egg donor.
mediating relationship. Thus, while sharing of substance with the husband gets translated in a wider set of rights and obligation, the substance from an external body (donor’s body) is not.

In these narrations the sperm ceases to have an independent existence once it is inseminated and it gets assimilated in the flesh and blood of the recipient woman. This understanding of the process of conception and pregnancy brings into question the age long supremacy of the sperm over the passive egg. Not only the sperm here is seen just as an intermediary in making the child happen who would then draw on the flesh, blood and genetic pool of the mother but even the sperm assumes an asexual ahumane medical identity. Hence, the source of the sperm neither gives any specific identity to the child nor does a conception through third party have the probability of hinging any polluting effect on the child. It is justified that the polluting substance i.e., sperm will be purified through the assimilation in her body and hence the resultant child will be hers.

The conception story henceforth to be told, will obliterate any third party connection and ground itself on the genetic and gestational contribution of the recipient woman and will route the baby to the recipient’s husband, his family and their kin network. In this narration, what makes up for the lack of her husband’s genetic contribution is his emotional urge to have a child and his general love for children. This emotional contribution is seen as an important substance because it mediates itself in the making of the baby. Hence, while for MG her biological contribution involving both biogenetic and gestation matters, for her husband his desire and emotional urge are enough to make a baby, which they can call their own.

**Importance of Gestation vis-à-vis Genetic Component**

It would be wrong to assume that genetic component is most important ingredient for making up parent and the necessary and sufficient condition for kinship relationships. In cases where genetic linkage has to be compromised with, due to medical reason the remaining biological connectivity is highlighted as the sole and primary component for
making up the child one's own. Hence in case of IVF arrangements with egg donor, the
genetic contribution from the donor is sidelined and the gestational contribution of the
commissioning mother and genetic contribution of her husband gain prominence. While
there is pervading importance of genetic contribution in the understanding of medical
discourse in conferring kinship, respondents using donor egg look at their gestating
contribution as establishing connectedness. Thus, they concur their gestational role with
the significant biological contribution in shaping the child. MD flags this issue in clear-
cut terms:

In this case as I will gestate, the child will be mine. This is something I can do
and this is crucial. To hold the child for nine months is something, which is the
crucial. If medically I would have a problem in that and could have a child
through my egg I would have valued it. But to me at present that the egg is not
mine does not imbibe any feeling – I am thinking everything is mine, as the child
will grow in me, with my flesh and blood.

The fact that the child will grow inside her, nourished by her blood and flesh, will make
the child totally hers and the contribution by the donor would cease to have any
independent identity or existence. She, thus, brings back the theoretical understanding of
Bengali Kinship by anthropologists and in doing so she rejects completely the biomedical
dictates which credits genetic material to be the sole substance responsible for building
relationship. In down playing the genetic contribution, she unconsciously falls back to
the understanding of Smritis and Sanhitas, which does not envision egg as an entity
contributing to childbirth. What gets valued is the uterine blood, which is said to shape

50 Similar responses are also reported by Becker (1994) in his study of 236 persons in San Francisco who
were either undergoing treatment for infertility or have completed the procedure. As one of the respondents
named Sandra, who had a child from her sister’s egg says, “a few month ago I was going through a hard
time and questioning the baby we are having. One of the things ken [her husband] said to try to pull me out
of that sadness was, ‘this baby is going to be more yours than it is your sister. Your life force and your
blood is going to be the central thing.... your sister... was [just] a DNA model. The rest is going to be you’.
So I have ... adopted that philosophy and have said it other people, like an affirmation to myself, to try and
convince myself that I believe that” (1994:399). This is also documented by Hans O. Tiefel (1985) in his
commentary on a particular case where Sally Morgan, a 46 year old divorcee used her daughter’s egg and
her present husband’s sperm to have a child. Here Tiefel writes “the child-to-be will be half hers (referring
to the daughter) genetically speaking, but this is considered irrelevant....the parties seem to have
contradictory value judgments about genetic derivation” (Tiefel 1985:31).

51 However, there is a consciousness that if she could have contributed by giving eggs then she would not
have devalued it.
the child in Bengali cultural understanding of procreation and childbirth\textsuperscript{52}. Hence "my blood and flesh" as the necessary and significant component in making a child gets importance and genetic non-contribution becomes unimportant.

This becomes all the more apparent, clear and explicit in MS's narration:

\begin{quote}
I think wherever the egg might have come from it's the bonding with the child in the womb and later on when I breastfeed her and bring up the child that is most important in shaping up the child ... I think the child will imbibe my values and it will depend how I raise the child both in my womb and in this world. A child is like a white paper and you can write whatever you want to write on it. In a fertile soil it is up to you whether you will grow a flower plant or a weed.
\end{quote}

Her claim to motherhood stems from her gestational role, the sharing of blood and nutrition, which will contribute flesh and bone to the embryo. Moreover the focus is on nurturance, sharing of bodily substance and body fluid which will not stop at birth but would be a life a long process – through feeding of breast milk and then through sharing of food, residence and emotions. Thus respondents, stress not only their immediate biological contribution but also both their future biological and social contribution in making the child. The recipients accentuate not only the environment that they will provide the child in the womb but also the social environment where the child will develop as a human being. It is both the biological environment and the social, which is valued as playing the crucial role in shaping the embryo to a baby at birth to that of a grown up human being\textsuperscript{53}.

Here then, we get a case where there has been a blending of the folk model of conception and pregnancy with which the respondents have grown up with and the received knowledge from the medical establishment which they confront at a particular time of crisis. This narrative gives an essence of having a mixed nature\textsuperscript{54} which draws on both

\textsuperscript{52} It seems egg enters the discourse of childbirth in Bengali understanding through Western biomedical discourse, which tries to contradict and obliterate the folk understanding.

\textsuperscript{53} These strategizing move a step further in case of procedures with embryo adoption where the child will have no genetic connection with both the recipient couples.

\textsuperscript{54} Chaudhury and Varma (2002) in their study of "Perception of Health and Medicine among Plantation Labourers in Jalpaiguri" district quite effectively showed that often in certain realms "modern and the indigenous coexisted perhaps ambiguously, either negating or supplementing each other giving rise to an
but fuse it in a way which becomes unique to their medical and social circumstance and which supports them in believing that the external intrusion is insignificant, peripheral and perhaps comparable to the series of medicines that they have been subjected to.

**Genetic Contribution as the Fundamental**

In case of gestational surrogacy, where gestational role cannot be carried on by the commissioning mother what is essentially stressed on is the genetic aspect of making a child. The blood and shared bodily substance of gestation which has been attributed significant contribution in making relationship in case of procedures with egg donation is accorded mere “custodial” role (rather than “relational”) (Thompson 2001: 177) in case of gestational surrogacy. As RM1 puts it,

*I have 14 embryos cryopreserved and I have no dearth of money. So I have decided when the doctor will transfer the embryo to the surrogate, I will also ask to transfer the embryo in my uterus as well so that we do not rule out any chance. Between us whoever gets pregnant I will have the baby in the end. I know the surrogate we have contacted.*

In this quest for having the child the recipient couples themselves who have long been associated with the treatment protocol are the one who often suggest using a surrogate

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55 As one commissioning mother in Ragoné’s (1996) study put forth, “Ann is my baby; she was conceived in my heart before Lisa’s [the surrogate’s] body” (1996:359). By claiming this she experiences “pseudopregnancy”, the state of pregnancy by proxy and also becomes the one to be “emotionally pregnant” whereas the surrogate is said to be “physically pregnant” (1996: 360). A study in UK among 29 sub/infertile women (Akker 2000) also confirms that the women who could use their own genetic materials tended to believe genetic link was important.

56 Thompson (2001) labels certain acts as “relational” in the sense that it implicates kinship and sustain parental claim; whereas the same conduct of giving or sharing a particular substance becomes “custodial” because it does not get translated into the fabric of kinship.

57 This statement by RM reminds us of Strauss’s analysis of hospital as a place where negotiation results in provisional order thus dismissing “the stereotypical image of the physician dictating therapy protocols"
in order to speed up the process. To these recipient couples this assistance in the process of reproduction does not evoke the kind of resistance or shock that even the medical fraternity often expects. After going through different treatment protocols they are at the verge of considering every option through which they would have a child. They are also ready to suggest the doctor to split the embryos between the surrogate and recipients. This to their mind maximizes the chance of pregnancy. As in both the cases they visualize the child to be only theirs, the commissioning women do not get bothered with the surrogacy contract in place. In case of surrogacy, the visibility of pregnancy is preserved through a narration in which no body comes to know about the surrogate and hence the recipient becomes the mother of the child in the three sense of the term – genetic, gestational and social.

Different Metaphors in Use

The Metaphor of Medicine

Strategization not only includes highlighting and obliterating certain biological and cultural components of reproduction and pregnancy but also looking at the process of assistance in a particular way which helps in "strategic naturalization" (Thompson 2001: 175). This is done through use of metaphoric language which assists in normalizing the birth story. This is most prominently evident in the use of medicine metaphor while talking about donor sperm in most cases both by the recipients and the providers. This is a strategic move in order to convince oneself to think of the sperm as
medical substance. The sperm, in this conceptualization, is as much external and alien as regular dosage of hormonal drugs, series of injection that the woman is subjected to. It is assumed to have neither sexual nor reproductive potential and is not a microcosm of someone’s identity and historicity. The same sperm which was problematized at the initiation of treatment is normalized so as to carry out with the process of intervention.

As, AS puts it,

*When the doctor told us that we have to resort to donor sperm I was not keen. But my husband told me “why don’t you think it as a medicine, like people take blood from blood bank. Moreover, the child will be related to you”. I thought this is a better logic and you definitely need a child to give a complete picture to your marriage... I do not think about issues like whose sperm is used, how the child will look and so on.*

To her though having her husband’s biogenetic substance for conception is significantly important, but once she has convinced herself she prefers to obliterate this fact from her thought process and is comfortable in comparing this with a injectable drug which will merely assist the process of reproduction.

The Metaphor of Gift

A gift in anthropological language is a condition for creating a bond but in the genre of ARTs gifts “appears as the mediator between an abstract relation – the process of manipulating biogenetic substance in the laboratory of a reproductive clinic – and a concrete relation – the process of making kinship” (Bestard 2004: 256). In this act the donor as a person looses its identity and only eggs or sperms with certain genetic traits become important. This alienation of biogenetic substance becomes profound in case of sperm donor where the semen sample with specific vial numbers and certain principle genetic attributes in the sterility of sperm banks and incubators of infertility clinic replaces the person, his locale, his identity as part of a family, kin group.

Gametes as reproductive substances represent not only genes but also altruism, service, money. As such, the biogenetic substance of the donor becomes inappropriate for
creating bond or to transform into symbols of relatedness (Bestard 2004). Thus, with the birth of the child the surrogate, and in many cases the egg donor, become just like an assisting hand in the making of the baby. Her role in this process can at best be matched with the doctor or at worst the chemical cultural media, in which the embryo grows in vitro. Hence the contribution of the donors and surrogates are worded in the language of gift giving. The inherent notion is that, if an outsider gets involved in the process of procreation and issues of money come into play in an arena otherwise characterized by sharing and giving, the institution of marriage and family will crumble down. Both among the recipients and the medical fraternity to some extent, thus there is a skewed preference to think and justify to themselves and others that the motivation is altruistic. This is an effort to bring back bodily substance from the competitive, calculative realm of commodities to that of humane realm of exchange of gifts.

Nature as the Model for Scientific Engineering

RN, who is a 37 years nursing Staff from Bankura and has been suggested surrogacy after repeated failure of earlier IVF cycles takes the initiative to normalize and naturalize the arrangement of surrogacy taking clue from the natural surrounding:

This is so common in nature. Cuckoo’s egg gets hatched in crows nest. It is only among us – the humans that it is new. I am mentally prepared and I do not think there is anything unnatural in this.

In this analogy science is seen not at loggerhead with nature or trying to bypass it but merely trying to replicate it in case of human beings. In such an endeavour technologies

\[61\text{ However, there are others who preferred commercial or unknown donors and surrogates because in such cases not only will it be easier to build on the story of conception but total severance with the donor or the surrogate will be prompt and straightforward. As a respondent pointed out:}]

A friend of mine has agreed that her wife can be the donor. But he said he wouldn’t take any money. Now if they had taken money I would have instantly agreed. Now that he has said he won’t take any money I am undecided. As, in that case, whenever I see them I will be reminded of the obligation. It is very difficult to live with that. Moreover, I am working in bank and this friend of mine is in business so it might be so that he is looking forward for financial support through issuing of loans. In case they take money I can always put down his request but if he does not, I will have to succumb to his demands. It is not that I will not remember their sacrifice and not be by their side through thick and thin. But if I don’t pay them I will have to live at their mercy and always have to fulfill their demand, however irrational they might be. I would have preferred totally unknown donor whom you pay, get the service and then she goes her way and we go ours.
not only assist nature (Strathern 1992a & b, Franklin 1995a)\textsuperscript{62} but is in itself natural. In this analogy the tacit understanding put forth is that they are not resorting to anything artificial, or something, which disrupts their existence as normal human being. But it is projected as normal as nature itself, where nurturance is differentiated from the origin of the eggs. To the respondent, hence, using a surrogate was not strange or unnatural, as nature has been doing it all along. She legitimizes her deviance by asserting its inevitability and immemorial existence in nature.

\textbf{Act of Silencing}

We have so far projected ARTs as a more preferred option than adoption as it has the potential to gloss over and glue the rupture caused by infertility and hence is instrumental in making parents. However, this is not to claim that once the respondents have decided to use ARTs over adoption they do not take an active initiative so that the inside story of conception is sealed and secured throughout life. This is because though threats posed by adoption are manifold compared to ARTs but the latter do have the potential to undo the story of normal natural parenthood if it becomes public. Hence, there is a constant process in place\textsuperscript{63} to shield away this disruption both from one’s memory and the

\textsuperscript{62} Later in her thesis, Sarah Franklin (2006a), nevertheless, opines that given the fact one cycle of IVF includes a total control and taming of women’s reproductive biology, it “involves a wholesale takeover of the entire business of a single cycle, and ... is not so much [about] assisting as replacing it” (2006a: 549). Therefore technology according to her “could not only assist but replace, the concepive process...” (2006a: 552-553).

\textsuperscript{63} RM, a respondent who has undergone numerous cycles of IUIs and IVFs and is now undergoing IVF with a surrogate, talks of the way she would handle the situation,

I have told her [the surrogate] that after the child is born, “you can come and stay but you cannot say to anyone or the child that it is your kid.” But I know that once the baby is delivered she will not take the pain to come to see the child leaving behind her own children. She has told her family that she has got a job in Calcutta. As she is a divorcee if anyone comes to know about this, it would bring her bad name. She would never like to be identified as a bad woman or bad mother. We have told her that in the initial months she would stay with us. She would tell my family that she has also come for treatment in the clinic. As she has no one else to stay with in Calcutta she is staying with me. But after sometime when pregnancy will be visible then we will shift somewhere else and rent a place and would live there. My husband will make sure that no relatives or friend comes to meet the surrogate or me during that time.

This is not a unique case but is common even in other countries and other continents as well. This is exemplified from the presentation of a person born as a result of surrogacy arrangement in ‘Proceedings from Seminar Life After ART – Developing Families’, Australia (2001). Imelda’s in her presentation of her birth history as a surrogate child narrates, “the whole event had to be shrouded in secrecy and deceit. My
memory of the community and society. This act of silencing is the next act in place once relationships have been built and unbuilt and parents have been made. If this act of invisibilization does not operate in a well-coordinated fashion it poses the threat to the entire endeavor and investment that has gone into the making of parents. As a final step to mend the rupture that has taken place, and to reestablish normalcy thus an active effort is made.  

The disruption of normative order is seen to be acceptable, and worth transgressing as long as it is kept invisible from public eye. In order to preserve the fundamental cultural symbol of birth, other socio-biological categories can be played with. Such tampering, however, should happen silently without posing any significant threat to the larger social order. Quite obviously, hence, most respondents felt that they would keep this a family secret to themselves and this is the best way to go about it. However, what made them

mum faked a pregnancy, and my surrogate mother, after carrying me for nine months, mourning my loss with the tale of a still born child" (2001: 19).

Research in America also suggests that people involved is assisted procreation highlight those components of conception process which correspond to the ‘normal’ family ideology and disclose and ignore those which are “incongruous with traditional family or kinship ideology” (Ragoné 1994, cited in Akker 2000: 1850). Ciccarelli and Beckman (2005: 34) also confirm that couples use “various cognitive dissonance reduction strategies” to resolve the ambiguities associated with surrogate parenthood. Blyth (1995, cited in Akker 2000), in his study on Britain however negates this point and comments that “couples attempt to achieve ‘normality’ were not accompanied by strategies [which] deny differences”. Akker (2001) reaffirms Blyth’s findings that surrogacy practices are generally disclosed and does not result in cognitive dissonance or denial in case of UK. As such respondents of the present study seem to be closer to Ragoné’s documentation rather than that of Blyth or Akker’s.

Eric Hirsch (1993, cited in Floyd 1995: 1068) in his study of 12 married couples also comes to similar conclusion, “While accepting these technologies could ‘improve on’ nature, these couples could only accept that ‘improvement’ if the changes to ‘nature’ did not violate normative social principles”. Bloomfield and Vurdubakis thus opines that ARTs are merely doing “boundary repair work” as they no doubt “constitute interventions in the natural order, it is important that they are none the less seen to remain true to the underlying principles of that order” (1995: 538).

There are a growing number of couples worldwide, who are adopting open approach regarding use of donor insemination. They believe that keeping a secret from their children is inimical to the parent/child relationship. By borrowing the notion of “genealogical bewilderment” which is commonly used in case of adoption studies McWhinnie (2000: 17) states with regard to her study of 54 families who have a child through IVF and DI that secrecy can be distressing for children born out of ARTs as they often become unsure of themselves and their identity. These studies in the field of sharing information especially in regard to donor insemination offspring (for further discussion see Daniels and Thorn 2001, for a view on disclosure by infertility educators see Johnston 1995) view that the entire language of ‘telling the child about his/her donor conception’ has the inherent potential to separate the child from the parents as it creates an ‘us’ and ‘them’ situation. They believe that the thrust should be on sharing of information rather than on concepts like ‘telling’, ‘secrecy’ and openness as these terms polarize issues and what they propose is ‘family building approach’. The “yes-donor programs” or “identity release programs”(Orenstein 1995) support revealing of identity of donors to their offspring including phone no. and residential address.
act the way they did have varied reasons. While for some there was no stated reason for such secrecy and it was thought to be the obvious and the only way of going about it; there were others who rationalized their action in clear-cut terms. Often such rationalization gave us an idea of people’s perception of who they are close to in terms of being related but also how they make boundaries as to who they can reveal their life stories and to what extent.

MB who is a Doctorate, and was teaching in a college but presently left job to take care of her mother-in-law said,

*I have not told anyone in the family. What is there to tell?*

But another respondent MD, explained why they have chosen not to reveal it to too many people:

*We have not disclosed it to too many people. Everyone does not have a similar mindset and they would not be able to take it in the right spirit. I have not told my mother-in-law. She is from the earlier generation and would not be able to fathom the idea and will misunderstand. We have not also told friends and relatives. May be they will make out some different meaning. We have specifically not told those people who have a habit of bringing out the negative points and start a debate (litte biporit habe). Like a colleague of my husband whom he told about going for a test-tube baby told that the life span of test-tube children are less, there is no surety, why are you spending so much on it?*

In this case the decision not to disclose has been on the one hand guided with the belief that mother-in-law belonging to earlier generation will not be in a position to fathom scientific intervention. Her traditional value system might confront and contradict the value system represented by science and technology. This binary opposition between traditional and modern, culture and science, has been played on in order to rationalize

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However, in a Proceedings from Seminar Life After ART – Developing Families’, Australia (2001) where a person born from surrogate relationship speak for herself says, “Contrary to what the experts might say – I don’t believe it’s paramount the child be told. If I had a choice, maybe I wouldn’t want to know” (2001: 20). In a study on ‘quality of parenting’ and ‘psychological consequence for children’ in the ‘families created by NRTs’ among 41 families created by IVF and 45 families created by DI and where the age of the children ranged from four to eight years, Golombok *et al* (1995) inferred that all the parents kept the method of conception secret from the children.
non-disclosure. However, on the other hand the binary of old vis-à-vis new generation does not often translate itself in strict opposition. Even, in case of friends and colleagues women/men/couples often choose to tell only those from whom they expect to have unconditional support rather than those who might question their decision. It seems as women and men go through this procedure they make a conscious effort as to believe in a narrative of triumph of these technologies and there is an attempt to shut down avenues through which such narratives have the remotest threat of getting disturbed. This is a mechanism in place through which women and men make a deliberate effort in order to construct a narrative of science so as to make their “dreams come true” 67. In doing so they draw from varied sources - medical establishment, media, other couples/men/women coming for treatment and build up a model which supports their purpose 68.

The fact that there is so much secrecy and silence around these issues become an important pointer about the attitude and acceptance of these technologies within the larger society. There is an inherent fear among the users of these technologies that these medical interventions will not be taken by the family and friends in the right spirit. While this perception can be taken as general perception of larger society which is still to grasp the changing contours of human reproduction; but at the same time one need to be conscious as to what extent this is just the perception of the respondents and one will find a different picture if the larger society is taken in consideration. This act of silencing hint at the fact that treatment-seekers are often themselves not at ease with these procedures. Inherently, they also find these technologies repulsive, artificial, and unnatural and hence fear similar response from the larger society. Intrinsic to this silent mode of operating is then a sense of guilt, and shame, for being the one to resort to third party conception and also to cover up to the outside world their own perception of inadequacy and shortcoming. It is this sense of denial and a reluctance to ponder and discuss about this

67 Brochure of a Delhi Infertility clinic
68 Constant endless negotiation as part of individuals’ existence becomes well documented in Bourdieu’s analysis of ‘social space and symbolic power’, where he writes, “they may, for example, manipulate genealogy, just as we, for similar reasons, manipulate the texts of the ‘founding fathers’ of our discipline” (1989: 21). This is the most typical strategy of “construction” which aims at “retrospectively reconstructing a past fitted to the needs of the present” (1989:21).
rupture once that has been mended by technical assistance, which leads to non-disclosure. The narrative of birthing that they present to the outside world is the one that they themselves come to believe in order to obliterate any memory that has the remotest potential of calling into question their achieved parenthood.

**Medical Establishment as a Collaborator**

The engagement with ART especially with donor gametes or surrogacy cannot be kept in the realm of the secret without the support of the medical establishment which plays hand in hand with the recipients to construct these narratives. Hence, in this context it is also important to understand medical establishment’s perception of patients’ attitude, their own understanding as to ‘what should be done’, and their role as a collaborator in keeping this secret. This becomes mandatory as doctors and other associated clinical staffs do not necessarily limit their role in diagnosing and facilitating conception and pregnancy but also act in advisory capacity on matters which fall outside the medical purview. It is in these suggestions, the doctor emerges as a social being with her/his own sets of judgment, beliefs and ideas of society and social relation. These ideas and thoughts contribute in a significant way to the direction that the users choose to take. The providers also being the one in direct communication with the users on a day-to-day basis and over a considerable time span are the best suited to provide insights into the way individuals handle this process of intervention.

- **Providers’ on Patients’ Attitude**

Mrs. Bannerjee, the Administrative In-charge and Counselor of the IVF unit, proclaims that she has witnessed change in peoples’ attitude both towards “treatment and in telling others”.

> Earlier people used to come as if they have committed a crime. Nowadays they are opening up much more. Some would come for our gathering⁶⁹ and also ask

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⁶⁹ Here she refers to the Get Together of IVF babies which takes place on the last Sunday of January every year. There one can witness the proud proclamation of both the parents and the child, the latter claiming on
for certificate that the child is a test-tube baby which they proclaim will help them procure admission in the renowned schools. They feel that this is hi-fi thing and by having a test-tube they are special in a way.

The clinicians who have been in the field for more than a decade identified considerable change in attitude towards treatment and disclosure. They felt that earlier, not being able to conceive was seen not only as a breach to the normal life functioning but also as a “crime”. However, now people look at this as a medical problem which needs treatment and assistance. Medicalization of infertility in this sense has lessened the stigma associated with but has simultaneously created a normative order in which, failing to resort to treatment is seen as deviant. It is also interesting that few people do take pride in having test tube baby. This pride surfaces from being able to bypass nature, bypass their “years of infertility” but more so at the prized possession of a baby who is not only a product of sexual intercourse but also a triumph of science. As in the achievement of the scientific progress this unnamed couple and their child also had a role to play and a part and parcel of the highly elite scientific endeavor.

A few of the clinicians and staff of the clinic felt that some people are reluctant to disclose that they are going for test-tube baby; not because they think it to be inherently stigmatizing but rather they fear that such a disclosure would be read by others as test-tube baby with donor gametes. Dr. Goswami, who heads the IVF unit and is with the IRM from the time of its inception said,

*They want to keep it a secret... in most cases the couple themselves does not disclose even if they are having an IVF child with their own gametes. They are apprehensive that if anyone comes to know that the child is an IVF baby they might as well assume that the procedure involved someone else’s sperm.*

This myth which is perceived to pervade the common understanding is also the reason behind non-disclosure. The moment there is an external agent in place in the process of conception, the entire process become shrouded in silence, as people not only fear ridicule and critical comments but also they themselves do not want to be reminded of the stage, ‘I am a Test-Tube baby’. However, all the couples in the Get Together communicated that they had IVF with their own gametes.
their medical inadequacies. Hence, there is still a significant chunk of the population who would not hesitate to sever ties even with the clinical staff with whom they have developed long association and personal relationship. They do so, as they presume these might intervene and contradict the narrative that they have constructed so efficiently and painstakingly. Mrs. Bannerjee points out her experience of contacting couples for the Annual Get Together,

*This year when we started sending off invitation letters for the 13th Annual Get Together, I got a call the other day from a man, accusing me furiously. He said, “I asked you not to send any correspondence from your clinic. We have not told anyone about this. Now what will happen if anyone comes to know about it? Neither do I want to have any further communication with you on this and nor want to attend your celebration”.*

Women, especially those, who come to the clinic for a considerable time period on their own develops a unique relationship with the clinical staff if not the doctors *per se* who are comparatively inaccessible. In the realm of sophisticated birth techniques the doctor - patient relationship is no longer based on a one to one basis. The patient has to interact and depend on the cooperation of a large number of medical and non-medical personnel who work together as a team (Stacey 1992). This relationship with the counselor, administrative in-charge, nurse, ‘*masis*’ (as *ayeas* are commonly known as), receptionists often go beyond formal exchange of information or instruction. It is in this conversation that the patients are no longer identified by their file numbers but gain a human identity. There is a also a sense of belonging to the clinic that develops due to the long association to the extent of calling the doctors often by their name and prefixing a ‘*dada*’ or ‘*didi*’ as required. The clinic also showcases these patients as part and parcel of the clinic and tries to make avenues by giving reduction or by allowing them to see the doctor out of turn or in similar other ways to show their concern and support. However, these acquaintances that are built over years, often do not get translated in long-term relationship, and get severed the moment the child is born. This is because the association then poses threat to

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70 This often includes discussion of family problems, the pain of traveling so far, the trauma of failure in each cycle to that of exchange of recipes, discussion on recent films and political state of affairs. During the last phase of my field visit there was political disturbance on issues related to SEZ in Singur and Nandigram. These issues became important topic of discussion.
the normalcy of the triad that has been established with the birth of the child and any remotest contact to anything artificial jeopardizes that normalcy.

- Providers' Take on Disclosure: A long Way for Openness

The clinician and staff themselves also feel that our society is not in a state where openness on this issue can be practiced. They feel that with openness there is a fear of disrupting not only the commissioning family but also the family of donors and surrogates. Hence clinicians as social agents believe that this restoration of normalcy is something that needs to be carried out within the silence of laboratories and operation theatre under medical gaze which then can be significantly obliterated from memory. As Dr. Goswami puts it:

*We take infertility treatment as the treatment of the couple. Hence we generally ask them to come together. Though philosophically what two people know is not a secret anymore but we treat the couple as a unit. If a lot many people come to know, later on, it becomes complicated.*

Thus, like most of the respondents undergoing treatment in this study, the professionals involved in providing the service visualize disclosure as threatening. The culture of secrecy has been so comforting that the thought of sharing information seems disastrous. As Dr. Baidyanath Chakravarty, Director of IRM, who has been associated with this field for more than three decades draws an East–West dichotomy with regard to disclosure,

*As much transparency* as is acceptably possible should be maintained but not beyond it. Disclosure may be appropriate in case of Western society where children through ARTs are also being born to single parents or unmarried couples. But in our society if the child comes to know that the person whom he

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71 The woman must be told that donor sperm is being used or the husband might be told about use of donor egg but the identity of the donor to the child should not be revealed.

72 As a research fellow in IRM opines, “Tomorrow the donor does not want an 18-year-old coming up to him saying that he is his father. In the West, when they made it mandatory that the identity of the donor be disclosed to the child, the semen donation decreased substantially. The donor is either doing it on humanitarian or commercial ground but they do not want headache in his life”. This is also supported by Bob Simpson in his analysis of 'Viking baby invasion' (2000: 4). In UK, donation of sperm reduced drastically as the donors “who are usually young and single at the time of donating”, do not want to be traced later on. The dearth of sperm became so acute that Dr. Richard Fleming, fertility specialist at Glasgow Royal Infirmary, imported sperm from the Cryos sperm bank in Denmark. (ibid.).
knew to be his father is not related to him he would be totally devastated. Moreover if she/he comes to know of who her/his real father is (meaning sperm donor) and goes and tracks him, the family of the donor will also crumble down. So we do not encourage disclosure but rather tell the couple to keep it among themselves. We do not want two families to get disrupted. The attempt is to create happiness in the lives of women and not to unsettle families.

- **Medical Establishment as the Partner**

Medical establishment becomes the collaborator in this act of silencing due to two fold reasons: the clients' (patients') demand on non-disclosure and their own perception that it is important to keep it a secret in order to preserve the sanctity of marriage and parenthood. Hence, when providers are requested not to disclose they comply with it. They do not even hesitate to issue false certificate, as they believe that they are not only acting in the best interest of their patient in particular but also the society at large. Dr. Goswami mentions the ways in which they become active collaborator to the scripted narrative of birthing.

They would even request us to issue the discharge certificate as normal pregnancy delivery. Some days back two families who have not told each other that they are pursuing treatment met at the clinic. After that both the families came to me requesting that I should not disclose to the other family their modalities of treatment and make it sound they are undergoing something minor.

By asking the doctor to issue certificate for normal delivery and requests for non-disclosure, the doctor is also drawn in the story of conception and pregnancy that the couples' wish to tell the world. Though Bharadwaj looks at it as “clinician” being “drawn into the lie” (2003: 1872), I think by doing so he somehow justifies the fact that the true kinship is the one that is rooted in biogenetic tie. What I find in this quest of couple's being selective of what medical, genetic and biological substance they would take up in making their kinship stories is far from just lying, rather an attempt to create a space of normalcy for them. The active support by the providers in this quest is not an arbitrary agreement to patients demand. Rather this act of silencing is deep structured and is rooted both in the providers' psyche and in the medico-legal document which to an extent guides their action in the day-to-day working. Moreover, interestingly what is engineered by the users (who have the remotest possibility to have access to the guideline) is at times
strikingly similar to the textual version of engineering, i.e., the guidelines. It is these glaring similarities (and at times diametrical opposites) which need to be taken into consideration and hence one cannot but draw from the guidelines in the present discussion.

Systematic Support: The Guidelines

The legal domain being an integral part of culture, and often, reflecting the dominant normative order and the "collective consciousness" of its members, becomes a "conceptual map of categorical inclusions and exclusions" (Delaney 2000: 489) of what is to be accepted and rejected in a particular society, and how boundaries are to be drawn. In the Indian context, as of now, there is no existing law regarding Assisted Reproductive Technologies. There are two main regulatory frameworks that deal with ARTs – The Ethical Guidelines for Biomedical Research on Human Subjects (also known as ICMR Code issued by ICMR in 2000) and The National Guidelines for Accreditation, Supervision and Regulation of ART clinics in India which was finally published in 2005 after the draft appeared in 2002. These medico-legal documents, like guidelines, by laying out the map for attributing parenthood to some (the commissioning couple) and disowning others (donors and surrogates) from the claim and

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73 An account of the worldwide legislation (Cohen et al 2001) focuses on the fact that in India there is no such law on AID or IVF; nor do we find here a body of experts to supervise the ethics of business or to certify the institutions. A few states have passed laws requiring clinics offering infertility services to register themselves, but there is no establishment to monitor the quality of services provided.

74 According to Sangeeta Udgaonkar, an advocate, both ICMR Code and ART regulation "are binding on all registered medical practitioners" (2006). However, the medical practitioners themselves said that the guideline has no legal binding and is not enforceable in the court of law. They also shared that ART Bill has been formulated and has been introduced in the Parliament. Once the bill gets passed it will have a legal status.

75 Court cases between the surrogate mother and the commissioning couples, among divorcing recipient couples over donor embryos and similar others have also become important texts to understand parenthood, motherhood and fatherhood. However, such court cases have been kept outside the purview of the present study, as I did not encounter any such court cases (other than some fleeting anecdotal reference by some respondents) in the course of my fieldwork. For a better understanding of 'legal aspect of parental rights' in assisted conception through an analysis of court cases see Ciccarelli and Ciccarelli (2005). For an analysis of a court case between Anna Johnson vs. Mark Calvert, the former being the gestational surrogate who refused to give away the child born from the embryo of the Calverts which pose the question can "genes alone should be the determining factor in defining parental rights and relationships", see Grayson (1998:526).
silencing their contribution play a significant role in conceptualization of family and kinship.  

- Legitimizing the birth

Attributing parenthood to a particular individual or couple over others is based on the way the birth of the child is legitimized both legally and socially. As a medico-legal document (in the absence of any other legal structure), the guidelines become the basis on which legitimacy is achieved. Article 3.12.1 states:

*A child born through ART shall be presumed to be the legitimate child of the couple having been born within wedlock and with the consent of both the spouses. Therefore the child shall have a legal right to parental support, inheritance, and all other privileges of a child born to a couple through sexual intercourse.*

It is important to pay a closer look at the language used by ICMR, which claims that the child should be presumed to be legitimate. In this utterance what is kept unsaid is an understanding that the child need not necessarily be legitimate and there should be a conscious concrete mechanism in place to confirm her/his status. There is a related presumption that the child born through third party conception has to acquire the rights and obligation which are by default bestowed on a child born through intercourse. This language of ICMR follows the same line of thought of the Warnock Committee which states that the child born through AID should be treated as the legitimate child of its mother and her husband (Warnock 1984, cited in Cannell 1990). Reverie (1985) pointed out that in this directive lies the assumption that the child born through intercourse is the real child whereas the child born through AID in actuality is not legitimate but has to be treated as such. Thus, while we have seen that Bengali Hindu cultural conceptualization does not necessarily give an unquestioned precedence to genetic/blood ties in making

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76 In treating the text as an anthropological data and a cultural artifact to understand the structural and normative values we do not attribute to the text an autonomous entity but look at it as representing the voice of the dominant forces which mediates 'doing kinship' by guiding, dictating and opposing some choice over other.
relationship, the medico-legal documents place significant importance to genetic parents and child born through sexual intercourse. Through terms like ‘presumed’ and ‘should be treated’ the attempt, apparently, is to gloss over the ‘real’ facts and normalize the otherwise ‘repugnant’ introduction of a donor within a conjugal relationship.

It becomes clear that the primary thrust of the guideline is to protect the child and the commissioning couple from “unwarranted harsh situation” (ICMR 2005) that might come into play. The fundamental legal issue in this case is that of attributing parenthood amidst a number of persons who has the potential to become father/mother. In order to keep the face of the marriage intact and naturalize and normalize childbirth through medical intervention the guideline takes an extra step. The guideline does provide a helping hand in making parent; however, it does so within the larger normative order.

77 This dynamics of providing assistance to the intended parents in spite of the underlying assumption, which gives skewed preference to genetic parentage, became apparent when, in 2003, Amit Banerjee became the first single man in India to have a child. The baby was “created in a lab out of Amit’s sperm and an unknown donor’s egg and nurtured for nine months in a stranger’s womb” (Banerje 2005). Though Mr. Banerjee claimed that “biologically the child is mine”, but still he would have to “legally adopt his own son” (Banerje 2005). The media reporting undoubtedly created a narrative in which the child is referred to as Amit’s ‘own son’; however, as there are no provision for single men in the guideline as of now and no definite law concerning ART, the child can be claimed by, apart from Mr. Banerjee, both the surrogate and the egg donor. The legal status of the child born out of three people is that of an orphan and the Juvenile Welfare Board would need to appoint a guardian for the child (Udgaonkar 2006) and Mr. Banerjee would have to adopt the child. According to the lawyer,

Where a child is created by a medical procedure initiated by a consenting couple with the intention of becoming parents, it is the couple who are the lawful parents of the resulting child. Such a view would give effect to the intention of all the parties, the couple, the sperm and oocyte donors, the surrogate mother and her husband and to the intention of the ART clinic as well (Udgaonkar 2006).

This view is in accordance with case of Buzzanca vs. Buzzanca In this case the court was required to determine “who was the parent” among five possibilities (intending couple, egg donor, sperm donor and surrogate). At the stage of appeal it also considered a sixth possibility i.e. the husband of the surrogate. Applying the old established principles of family law, the California Court of Appeal held the intending couple to be lawful parents despite the fact that they had not contributed any genetic material, nor had the wife given birth. The court said, “just as a husband is deemed to be the lawful father of a child unrelated to him when his wife gives birth after a artificial insemination, so should a husband and wife be deemed the lawful parents of a child after a surrogate bears a biologically unrelated child on their behalf. In each instance, a child is procreated because a medical procedure was initiated and consented to by intended parents” (cited in Udgaonkar 2006). Woodhouse (1995: 2500), taking example of the biblical story of Solomon’s judgment, (where the ‘real’ mother gave up her claim when Solomon threatened to slice the child into two pieces to end the dispute) argues that a mother (parents as such) can be identified by her bonding and selfless and often irrational acting in the best interest of the child. This notion of ‘bondage’, she believes need to be ‘harnessed’ by lawmakers and “parental power should be ‘earned’, not absolute, and evaluated from a ‘functional’ rather than a purely biological standpoint” (ibid.: 2501). However, Bartlett (1988: 303) cautions us “the best interests of the child is a highly contingent social construction...what is best for our children are as much the result of political and social judgments about what kind of society we prefer as they are conclusions based upon neutral or scientific data about what is ‘best’ for children”.

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The assistance provided to the process of making parent thus never goes to the extent of questioning fundamental societal ethos and institutions like marriage and family. Rather the sole aim is to preserve these institutions by normalizing the divergence that often occurs in the process of seeking and delivering assistance. By preserving the sanctity of marriage, which is seen to be under potential threat with the introduction of third party conception, and by legitimizing such birth, the ICMR guideline plays a crucial role in attributing parenthood to those who have intended to become parents.

- Denying Parenthood

The act of silencing is a multi-thronged policy. To complement the 'legitimization of birth' and attributing of parenthood to a specific individual or couple it becomes mandatory that there should be a process in place to deny parental rights and obligations to certain others. This is basically achieved both by severing rights of parentage from the genetic parents and also denying right to the resultant child to know the personal identity of the donor and the surrogate. Another significant step in order to portray the naturalness of the child born through ARTs is to restrict 'relatives and friends to act either as sperm /egg donor'.

78 In order to legitimize the birth of the child and also to preserve the well defined boundaries of the institution of marriage which has been transgressed by the introduction of a third party, the guideline states “ART used for married woman with the consent of the husband does not amount to adultery on part of the wife or the donor. AID without the husband’s consent, however, can be a ground for divorce or judicial deprevation”. Adultery is defined as an offence under Section 497 of Indian penal code (IPC) which perceives a consensual sexual union between a man, married or unmarried, and a married woman without the consent or connivance of her husband as an offence of adultery – thus it is based on “husband’s ‘right’ to fidelity of his wife and his wife as a property” (Sama 2006). Saheli, a women’s organization in its critique of ICMR Code (2000) and draft guideline (ICMR 2002) has opposed “such woman focused notion of adultery” (Saheli 2002). Also see, Laxmi Murthy and Vani Subhramanian (2007).

79 However, ICMR guidelines pronounce that the child should be given an access to the information regarding the donor at 18 years of age because ultimately she/he is her/his ‘real’ biological parents (ICMR 2005). O’Donovan (2002) argues that the English cultural and legal discourse much more strongly uphold the idea of ‘real’ mother (can also apply to the father) as the one who have genetic connection compared to its French or American counterpart. However, ICMR guidelines seem to borrow this cultural concept of realness and apply it in the Indian context.

80 In contrast to ICMR, the Ethics Committee of American Society of Reproductive Medicine however opines that there is nothing unethical per se with seeking familial donor or surrogate both intragenerational and intergenerational (2003).
Articles 3.5.1 and 3.5.5, respectively, state:

A third party donor of sperm or oocytes must be informed that the offspring will not know his/her identity.

And,

A third-party donor and a surrogate mother must relinquish in writing all parental rights concerning the offspring and vice versa.

These two articles truncate the relationship between the donor and the child as it is assumed to intrude into the social triad that has been created comprising the child and his/her intending or commissioning parents. The position of the donors becomes similar to that of the birth parents relinquishing their rights of parentage by giving their child for adoption. There is an internal dialectics in place — on the one hand, there is the tendency of the guidelines to default to a genetic essentialism or biological essentialism when trying to unravel the complicated mess of parenthood created by ARTs; on the other hand, there is also the utmost desire that normal functioning of the intending couple and their engineered facts should be kept a secret. Caught between these two diametrically opposite tendencies the guidelines often reflect contradiction and unease to assist a particular relationship at the cost of the other.

This contradiction becomes all the more complicated when there is a disjunction between biological and genetic parents as in case of surrogacy. Article 3.5.4 brings out this confusion quite clearly:

A surrogate mother carrying a child biologically unrelated to her must register as a patient in her own name. While registering she must mention that she is a surrogate mother and provide all the necessary information about the genetic parents such as names, addresses, etc. She must not use/register in the name of the person for whom she is carrying the child, as this would pose legal issues, particularly in the untoward event of maternal death. The birth certificate shall be in the name of the genetic parents. The surrogate mother would also be entitled to a monetary compensation from the couple for agreeing to act as a surrogate; the exact value of this compensation should be decided by discussion.

However, the use of the word ‘parental right’ in case of donors implies that they are the ones who have the rights to parentage by default in their capacity of being the genetic contributor.
between the couple and the proposed surrogate mother. An oocyte donor cannot act as a surrogate mother for the couple to whom the oocyte is donated.

In the opening line of the article we locate that though the surrogate is definitely biologically related to the child this association is totally denied. By using the phrase ‘biologically unrelated’ in place of ‘genetically unrelated’ what the ICMR guideline does is to sideline the biological nurturance which is instrumental in having a child. By doing this it falls into the trap of genetic essentialism and reduces the surrogate to just a carrier without giving any credibility to her biological contribution. It also reflects that genetic parentage is so important that they are the ones treated as the ‘real parents.’ The surrogate is made to register in her own name not because she is the one delivering the child but to stay clear from any responsibilities which might be bestowed in case of certain unavoidable circumstances. In surrogacy, the urge to disconnect the gestational mother from the child is so high that not only is she referred to as just a carrier but “legal lie” (Cannell 1990: 673) takes place in which the genetic parents becomes visible in the birth certificate as the parents. This ‘lie’ is legalized as it “is near enough to a natural family to justify a legal lie, but far enough away from being really natural to need a lie” (Cannell 1990: 673).

In case of surrogacy such a “legal lie” (Cannell 1990: 673) becomes mandatory. In justifying the recipient as the mother it also becomes important to divide the gestational role and the genetic role in such cases where both donor egg and surrogacy have to be used. By not allowing the same person to donate egg and become the surrogate for the same commissioning couple the guideline takes on the ethos of capitalist production. By splitting the process of production it makes sure that none of the two women in their capacity of egg donor and surrogate are in a position to demand the baby as their own. Hence, this document provides legal justification to the commissioning couples in their quest to have a child through artificial means and then normalize and naturalize it. This

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82 We can find a parallel of this 'legal lie' in Warnock Committee Report which stated that “husband of the woman receiving treatment [AID] shall be allowed to register himself as the child’s father on the birth certificate” (Warnock Committee 1984: 23-26, cited in Cannell 1990:673). At the turn of 2005, when ICMR guidelines were drafted, the sperm donor had to relinquish all his rights at the time of donation and the woman and her husband were considered to be the real parents as long as the husband had consented to the procedure.
article then defends the intending parents' act of silencing and treats surrogates (even donors) as mere appendages whose services have been bought or compensated\(^{83}\).

Another concrete move of the ICMR guidelines in making sure of eliminating even the remotest chance of disclosure and in safeguarding the family unit can be seen in the directives regarding prohibition of known donors\(^{84}\). The ICMR guidelines have come out strongly in prohibition of using relatives, friend and known people as sperm and egg donors. While using anonymous sperm from sperm banks has been a universal institutional practice throughout the world, the prohibition regarding egg donor is peculiar to ICMR guideline. Articles 3.5.13 and 3.5.14, respectively, state:

\begin{quote}
Use of sperm donated by a relative or a known friend of either the wife or the husband shall not be permitted. It will be the responsibility of the ART clinic to obtain sperm from appropriate banks; neither the clinic nor the couple shall have the right to know the donor identity and address, but both the clinic and the couple, however, shall have the right to have the fullest possible information from the semen bank.
\end{quote}

And,

\begin{quote}
What has been said above under 3.5.13 would be true of oocyte donation.
\end{quote}

This much-debated\(^{85}\) move by ICMR can as well be read in anthropological term. This is an attempt to keep third party conception as much as possible to the backdrop. Involving

\(^{83}\) The article 3.10.1 states:

A child born through surrogacy must be adopted by the genetic (biological) parents unless they can establish through genetic (DNA) fingerprinting … that the child is theirs. In this article, quite contrary to the earlier one, the surrogate is treated as the ‘real’ mother as it is the commissioning couple who have to adopt the child, given they are not the genetic parents. From these two articles (3.10.1 and 3.5.4) related to surrogacy what emerges is a struggle to pinpoint the grounding factor of making a parent, which has been the essence of anthropological theorizing on kinship. Implicit in these articles is also a grading of various components contributing towards making a baby of which genetic contribution is seen to be the primary one followed by gestation and nurturance.

\(^{84}\) The ICMR guidelines prohibit use of family members as sperm and egg donors. While the prohibition in case of former is followed by providers and recipients to a large extent; the prohibition in case of the latter is not adhered to. This is because the providers feel that family members are better suited for the role of egg donors as it requires long-term commitment on part of the donors.

\(^{85}\) Professional criticism has questioned this move by ICMR, as it is believed to justify and promote commercial practice in body, body parts and reproductive processes. There has also been concern raised about the vested interests of the members of the drafting committee most of whom are themselves practitioners of fertility treatment (Saheli 2002, Sama 2006, Udgaonkar 2006). To Dr. Rohit Gutgutia of
family members as egg donors has the potential to jeopardize the existing family relationship as the act of donation places the donor, recipient and the child in new complex web of social relationship, which is not in line with the existing one. It is this fear (that a close interaction between the recipient and donor after the child is born can be detrimental to the normal functioning of family) which can be seen as instrumental in bringing out this directive against all professional criticism and lengthy debates on the Draft 2002 guidelines.\textsuperscript{86} It is interesting that, while in Euro-American countries non-commercial or altruistic egg donation and surrogacy (Cannel 1990, Raymond 1990) have been much more readily accepted, in case of India unknown commercial egg donors and surrogates have been preferred. Though the guidelines often follow the footsteps of the Warnock Committee report in most of its directions on do’s and don’ts, in the case of promoting commercial egg donation and commercial surrogacy it makes a unique point.

This is apparently in contradiction to the so-called Indian-ness which strives on its family values and image of family as a harmonious unit based on care and help for each other. In this context seeking such a private service from the market outside the family seems to go against the prevalent norm of family functioning. But a closer look gives the idea that the guideline, far from being a document that has no conviction in family ideals, is much too cautious to prevent and preserve the family. It takes every possible step to keep the triad out of bound from even the remotest possibility of being threatened either through introduction of a known third party within conjugal relationship or by creating

Genomee, this effort to restrict family members from becoming donors is an attempt to build a nexus between the medical establishment and the donor market as reproductive materials are in high demand: ICMR [guidelines] has been drafted by people with their vested interest. Hence you see so much specification on the infrastructure of the clinic, space allocation – waiting area, sterile space/ non sterile space but you find gaps regarding how many embryos to be implanted, prohibition of procuring of surrogates and donors. They drafted the guideline in a way so that their practice is not affected.

\textsuperscript{86} Article 3.10.6 of the draft guideline states that "no relative or a person known may act as a surrogate" thus leaving space for only commercial surrogacy. However, the present guideline has come with an amendment and the revised 3.10.6 states:

A relative, a known person, as well as person unknown to the couple may act as surrogate mother for the couple. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.

\textsuperscript{87} Warnock Committee report sharply criticizes commercial surrogacy as it: involves a third party, uses human organ i.e., the uterus for profit, distorts the mother and child relationship and is degrading for the resultant child (Warnock 1984, cited in Shore 1992).
possibilities of the child confronting the truth through family network. Even by allowing only related surrogacy among people of the same generation it strictly resists any chance of altering the unilateral descent and complicating and threatening the existing social relationship. Throughout the document what is predominant is undeniably an anxiousness to help the couple in having a child artificially and then normalizing the artificial but only to the extent that it does not mess around with the existing social relationships and the broader family values.

III. The Grounding Factor of Kinship: Gene/Gestation or Nurturance?

In this discourse of ART then, the sole aim thus with which the couple enters the infertility clinic is to have a biological child of their own. In the course of the treatment however, they realize that given their medical conditionalities it might not be possible to have a child with whom both the parents would have biological connection. As in the present study biological connection with the child to that of respondents or their partners have been severed in one way or the other. Once the respondents realize that there is a potential to encounter such rupture their ideas of what is essential and grounding factor in making a parent takes on a new trajectory. As we have seen, that though the biological connectedness is still valued and desired, which of the biological connection they would emphasize or make salient depend on the specific situation or rather procedure they are undergoing. It is made quite clear that it is neither the genetic contribution through one’s egg nor the gestational contribution of nurturance in one’s womb nor the biogenetic transmission through sperm that is taken as the fundamental grounding factor for kinship in itself.

There are different strategies in place to delineate who the actual mother or father is, and thus, what is taken as the fundamental grounding factor in one context looses its value in the other. It offers certain flexibility to the concept of both biology and social, and questions the age long thought that kinship is grounded in biological facts of nature and

88 There has been an instance when a woman named Radha Patel has gestated an embryo made out of her daughter’s egg and her son-in-law’s sperm which attracted considerable media attention (Roy 2004).
hence, is fixed and unchangeable. Not only facts of nature get tampered in the process of
ARTs but also what is natural, biological are even called into question. This questioning
though lies at the core of the new kinship studies, we find lay men and women along with
the clinician, the counselors, the donors, and surrogates doing the same in their everyday
encounter. Though biological essentialism and what constitutes biological ties assumes
new look both in case of fatherhood and motherhood it is the latter no doubt which
questions genetic essentialism to its core by separating genetic, gestational component of
motherhood. It is hence of immense sociological interest to unearth the processes through
which somebody becomes a mother and the other person’s role gets defined as being just
providing assistance. However, when, how and why certain substances become
“relational” in contrast to “custodial” is a dynamic and ambivalent process (Thompson
2001: 189). As we go through narration of different recipient’s responses we find the aim
is to justify their claim to parenthood. However what ingredients make up that claim
varies in content and essence in each of the cases depending on the situational context,
procedure used, the relationship with donor and their the interaction with the clinic, and
their medico-legal protocols.

Thus, we see the definition of having a child of one’s own in the initiation of treatment
takes steep departure and both the biology and the social get reconstituted in their own
light. While genetic contribution of the father through semen has been both strong
biological and cultural edifice in transferring family line and belonging, the moment the
semen comes from an external source, such connection between facts of biology and
kinship gets altered. In cultural construct the child as the desire of the women has
preceded over the man’s desire for child – however in this genre of technical assistance to
reproduction suddenly it is the man’s desire to father a child and his emotional
attachment makes up for his lack of biogenetic contribution.

In documentation of Bengali kinship and early texts on conception and pregnancy we
hardly encounter the existence and significance of mother’s genetic material in the sense
of egg; but it is her uterine blood which is of importance. But in the narratives of women
where genetic contribution of the commissioning father is missing suddenly women’s
genetic contribution becomes the grounding factor of relatedness along with gestation. Here the mother not only plays her prescribed role of supplying the uterine blood but takes on the role of the father as well. She is no more the vehicle through which her husband’s blood is passed on, but she also becomes the source of genetic material in absence of her husband’s contribution. The semen of the donor becomes a medicalized object which when inseminated in the woman’s body looses any of its humanness and get converted into the women’s bodily substance. The way ties are then built or severed in these sites of assistance reproduction gives us a glimpse of kinship, identity, conception and pregnancy but an apparent sense of human agency in doing kinship within the parameter of the normative order.

The Procreative Intent as the Fundamental Component

In the clinical setting it is ultimately the "procreative intent" (Thompson 2001: 191) that guides all parties concerned – the recipient couples who want to have a child of their own, the doctor who wants to assist the couples to have a baby of their own, and the donor who give their gametes with the intent that somebody would have a child out of it. However it is only the intent and effort of the commissioning couple that has the potential to get translated in future kinship network with its corresponding rights and obligation. There are wide ranges of ingredients that make and determine which of the sharing and giving will in the long run mediate relationship. These ingredients or what Thompson calls "resources" are varied. "Biology and nature are resources; so are wide range of legal, socioeconomic and familial factors that make up procreative intent, such as who is paying for treatment, who owns the gametes and embryos, who is providing the sperm, and who is projected to have future financial and nuclear family responsibility for the child" (2001: 190).

89 Marilyn Strathern (1995) calls this "dispersed kinship". She infers that being "constituted in dispersed conception; it includes those who ‘produce’ the child with assistance as well as those who assist. As a consequence, there thus exists a field of procreators whose relationship to one another and to the product of conception is contained in the act of conception itself and not in the family as such" (1995:352).
What becomes momentous and critical is that parenthood gets crafted along the line of intent, desire and effort invested in parenting a child. It could be said “in the \ldots\text{determination of motherhood (and also fatherhood), intentionality apparently overrides gestation, and sometimes genetic as well}” (Mahowald 2000: 129). Just as to MS2, the fact that she is “trying for this child so long, \ldots\text{taking so much pain to continue treatment all these years...spending so much money}” makes her emphatically claim “it is my child”. It is this yearning and craving for a child which is the crucial substance, having the potential to implicate kin relations. It is this inherent desire to have a child of one’s own which give them the power and the authority to erase certain facts and reinforce certain others; and to create a narrative so that they can fall back to the rhythm of normal life. In doing so their claim to parenthood is established as unique and exclusive.

In these narratives, women and men in their quest for a biological child draw various scripts of the biology and the social in making and unmaking relationship. In doing so they construct a rich narrative of how boundaries get drawn, how and when certain bodily substances become the grounding of kinship, where, when and how sharing of bodily substances severe relationships than mediating it. It will however, be wrong to think that such agency is not influenced, shaped and to an extent backed by the medical establishment who also plays a supporting role not in making babies but making relationships as well. The assistance then provided to the process of engineering favours in most cases the intending parents and their quest for making a child. Therefore, in this endeavour, having a baby becomes a collaborative effort and seems to satisfy not only the commissioning couple but physicians and donors as well. The guidelines become the guardian to foresee that there are no aberrations of the normative order and “the nation’s common-denominator definition of what is acceptable ‘natural’ and ‘good for the family’” (Cannell 1990: 667) is not compromised at the cost of engineering.

\footnote{The desire to have a child as the sole criterion of relatedness is termed by Ragoné as “mythic conception” and “conception in the heart” (1996: 359-60) as it is the commissioning mother/couples’ desire to have a child that has made the artificial arrangement possible.}
However, what we arrive at is, that it will be fallacious to assume that ‘biogenetic substance is fixed and permanent’ (Schneider 1968, reprinted 1980). Not only genes here are sufficient to create a bond but also they are suppressed and played down in order to create a biological bond based on gestation, nurturance and intent. The child is attributed not only to the biogenetic substance that the child draws on but the recipient woman’s/man’s desire to have the child, the pain undergone both physical, mental, economical, and experience of the pregnancy – all of these inculcate the feeling of belonging. Sharing the substance with the child is thus not a fixed, permanent process outside the purview of human intervention but it is an active, dynamic, conscious process galvanized and given due significance in case of the receiver but sidelined and suppressed in case of donor. The relationship between the parent and the child thus depends on a complex system of negotiations, their aim at “strategic naturalizing” (Thompson 2001: 175) and “systematic misrecognition” (Das 1995) and recognition of certain facts of nature and culture in which both are modified and tampered with. Thus kinship “not [as] a form of being but [as] a form of doing (Schneider 1984: 13) was never truer than it is in the context of infertility clinics.