Chapter 4

Gender at Play

In the site of infertility clinics gender is at play at every juncture. To capture this complex multifaceted concept in action becomes a complex task at hand as it pervades the field of infertility care and makes in roads by shaping, resisting, and supporting people’s choice. This is because what are the alternatives that exist at a given point in time and space and what is to be engineered, how, when and to what extent are determined by a wide range of structural and cultural factors. While we talk of engineering, choice, and agency in the context of becoming a parent the situation in which the so-called choices are made are in itself constrained. It is neither free choice, nor prescript and cannot exactly be categorized as a preferred choice\(^1\). Rather, this choice can be said to be closest to preferred choice in

\(^1\) An important category to understand choice in the field of having a child can well be derived from Needham’s (1960) distinction of ‘prescriptive’ and ‘preferential’ choice in reference to marriage rules. For Needham:

The term “preferential” implies that there is choice, and in the context of marriage that there is a choice between a number of persons (distinguished genealogically, for example, or categorically) who may all be married. In this situation there may be a preference for one or more persons within the range of possibilities...The term “prescriptive,” on the other hand, has quite different connotations. In this case the emphasis is on the very lack of choice: the category or type of person to be married is precisely determined, and this marriage is obligatory (1960: 8-9).

The classification that demarcates alternatives, options and choices is reproduced from Morton Klass (1966). In this classification:

**Alternatives mean,“those responses theoretically possible in a given situation; in effect, the set of responses for that situation known for all human societies. Any given cultural inventory may contain only a limited number of alternatives, and the rules of that society will determine whether option is present and whether certain alternatives involve negative sanctions.**

**Choices:** Within a specific culture, those alternatives available where option is recognized.

1a. Free choice: Where option exists and no pattern of preference can be detected in either real or ideal behaviour.

1b. Preferential Choice: Where option exists, but – all things being equal – one alternative would invariably be preferred; or where it is possible to chart the order of preference, although any choice would be acceptable and none would be met with negative sanction.

2. Prescript: Where only one response is socially acceptable, and all others receive negative sanctions. Thus, from the perspective of the culture, alternatives do not exist, and the term alternative can only be used analytically or comparatively. Prescripts may be negative or positive.

3a. Closed Prescript: Where the culture recognizes only one response as possible or conceivable. No sanctions are reported for other responses, since the existence, or at least the occurrence, of such responses is denied.
the sense that all other factors remaining the same, to resort to medical assistance for having a child is preferred over others. But, in case where the couple has economical backing and they still do not choose to take medical assistance such a choice almost cease to exist.

At the medical frontier also the focus is not to treat "his and hers'" (Greil et al 1988: 172) infertility but to offer the couple a solution. As, Dr. Rohit Gutgutia says,

*I am not here to say that the problem is with husband or the wife, how does it make any difference other than creating a rift that it is "my problem or yours". I am here to help them have a baby and that is what I do.*

With this logic in mind the doctor's recommendation is not to provide the couple with an option of not having a child, or having a child through adoption but to opt for a particular procedure. It is taken for granted that the couple is in the clinic not to correct their individual physiological impairment but to have a biological child. A prominent Mumbai based clinic in its website defines how their entire outlook towards infertility and delivering a child is different and more promising:

*We adopt a success-oriented approach towards infertility... Many infertile couples want to know - "what is the diagnosis, doctor? Why am I not getting pregnant"? Or "why did the IVF cycle not work"? However, we feel this is the wrong question - and if you ask the wrong question, you get the wrong answer!*

3b. Open Prescript: Where other responses are known but pronounced unacceptable. If and when they are made, specific negative sanctions are imposed" (Klass 1966: 953).

In following Morton Klass (1966) one can say that there is no reason whatsoever as to why these terms could not be extended to other domains in order to examine the availability of alternatives, judge the existence of choice or the lack of it. Here we make such an attempt - to use his classification and categories of 'alternatives', 'choices' (free choice/ preferential choice), and prescript (closed prescript/ open prescript) in the domain of NRGTs, which promise to throw up choices and varied alternatives for having a child. However, the nature of "value orientation", according to Parsons and Shils "may be interpreted as imposing a preference or giving a primacy to one alternative over the other in a particular type of situation" (Parsons and Shills 1962: 78-9, their italics) is reflective of the societal preferences, prescriptions and resistance. It would be fascinating to reflect at what point of time a particular society accepts certain choices and rejects other and what are the guiding principles behind it.

2 Sandeloski writes, "For them, the critical sets of options are trying to have a baby versus trying to get one; becoming a parent versus remaining without children; and, most importantly, having regrets for not pursuing a particular option versus having no regrets, even though they might remain child-free" (Sandeloski 1990b, Cited in Lorber and Bandlamudi 1993:35). In this thesis, however, we did not encounter not having a child being one of the options.
Rather than focusing on what your problem is, you should focus on the solution—which is a baby! This means that the question you should be asking is "what can we do to maximize our chances of getting pregnant?" (www.drmalpani.com)

In this context once a couple has approached the medical establishment they are not really left with an option of not opting for one procedure or the other. Hence in this context they are but forced to engineer social relations in order to justify it as normal and natural both to themselves and to others. Of the structural and cultural factors that guides and limits choice, gender is crucial. In understanding this, there can be different points of entry. Here, we primarily focus on: why and how gender plays a decisive role in directing individuals to encounter infertility as a woman’s problem, how intra-couple relationship operates and how masculinity and femininity get defined in the reproductive paradigm, how donation and sale of reproductive material is structured around gendered notion of who can give whom what and last but not the least how the functioning of the clinic runs on parameters of gender ideology and provider’s perception of gendered reproduction.

I. Women: The Socially Infertile

Medically Infertile women: The Doubly Disadvantaged

Infertility is still considered to be primarily a woman’s problem. In cases where women are medically infertile they are treated as social outcast for not being able to fulfill the desired role. Hence they become the target of covert and overt pressures both from the family and relatives. Women also themselves feel inadequate for not being able to produce a child. It is in this urge to be woman and feminine that women resort to these technologies. They often see pregnancy and childbirth as a confirmation and fulfillment of their womanhood (Bailey 2001) and glamorize the bodily changes during pregnancy. As, ST puts it,

As such we leave out any systematic focused attention on how women’s body becomes captive in the male medical gaze and the entire discourse on how the process of reproduction is turned into a mechanical affair to be performed at the direction of the physician.

At the same time, in the Indian context, it is also a “family tragedy” (Reissman 2000:129).
I sometimes think if God has made me a woman why has he made me incomplete? If I cannot give birth to a child what's the point in being a woman. Though there is no family pressure as such – my mother-in-law says, “I have married off my son to have a heir. But I don't think that I will live to see that”. But as the fault is with me I have no other option but to listen to these. People fail to look at it as a medical problem.

These women look at these procedures as something they have to resort to in order to bypass their inadequacy and come back to the normal fold of family life. It is somewhere their feeling of guilt, shame, and incompleteness as a woman that they are trying to alter by resorting to artificial means. They even justify abuses and questions by the family, friends and neighbour as normal and natural as they are the ones who have the medical impairment.

**Inherent Power Dynamics**

Infertility at times also takes a toll on the interpersonal relationship between the husband and wife. However it is difficult to gauge the inherent power dynamics. As, Dr. S. K. Goswami reflects,

*The couples are quite political in their responses when we disclose that the fault is with the husband or the wife and ask them to resort to donor procedures. When the problem is with the husband, the wife will say 'it is OK with me. It is just a medical fault'. This is almost same in case when the women are diagnosed with a problem. I don’t know how they handle it outside the clinic but in front of us they can even compete with political leaders.*

But there were certain definite patterns that emerged. In case of the wife's problem the husband seem to be considerate, neither considerate nor resistant, resistant and coercive. However, some women said that their husbands were more enthusiastic in finding about the procedure and even in getting egg donors or surrogates and also acted as the fundamental support structure.

BB: *I think people, mainly my in-laws, do talk about me at my back for not being pregnant which I come to know somehow. My unmarried sister-in-law shoots abusive remarks at me for not conceiving... My husband has taken the entire initiative in finding a donor and not agreed to the procedures only half-
heartedly. They also dislike the fact that my husband is trying to guard and support me.

This eagerness and readiness of the husband to accept donor egg is not a necessary statement of an equal, well adjusted relationship between the husband and wife. At times the husband's overt or covert wish to father a child at any cost is the reason as to why women succumb to donor programmes in spite of their uneasiness. As, SC's narration clearly points out that she had to submit to her husband's will because she is the one incapable of having a child and is already in a disadvantageous position in the marriage equation. Here, women operate from a sense of guilt, shame and obligation as they feel they are at the mercy of their husband.

SC: 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 my husband was quite keen. He said, "we at least have someone and we should not let her go at any cost". So I had to accept it. This is not accepting out of will but as you are forced to do so in this circumstance. There is no question of choice, you have nothing to choose from and there are covert or overt forces which act on you. I am still trying hard to throw the apprehension that I have. If I do not accept, my husband will think that in spite of him being so broad minded about my failure I am creating tantrum whereas I should be obliged. It is not that he has said this to me or there is severe unpleasantness among us. But when there are moments of anger, frustration, tension these issues do come in.

In these cases the husbands are broadminded enough not to desert their wives or abandon them but this situation is not devoid of subtle coercion and can hardly be said to be gender neutral. Here the men are equipped with their patriarchal control as they themselves feel that they are anyway going to a large extent to being noble and hence there cannot and should not be any space where women can voice their dissatisfaction and apprehension.

To some women, though their husbands have been quite understanding at the beginning but with each failed cycle they became irritated with the whole process resulting in frequent quarrels.
MD: Even your relationship with your husband gets strained. I can realize he has become very bitter these days and gets angry at the slightest of things. He never used to be like this. Nowadays I come to the clinic all by myself.

MD1: My relationship with my husband has deteriorated. This is bound to happen if you do not have a child. To keep a man attached to the family and to make the marriage work you need a child. Otherwise the man starts withdrawing from the family. Our sexual interaction has also become minimal. This is bound to happen if there is immense tension in this sphere of life.

To these set of respondents, their husbands’ withdrawal both from being part of the medical protocol and family life is illustrative of the fact that their failure to mother a child becomes the sole hindrance in maintaining a stable relationship. Repeated cycles of medical procedures and the lengthy medical protocols not only take a toll on individual’s health but their relationship as well.

Hence, often women’s resorting to technical assistance even for their own impairment does not necessarily emanate as a true choice but as a submission to the patriarchal fold which craft women’s identity on motherhood and revolves around her womb. Women in this study more than often resorted to treatment in order to save their marriage. This is in contrast to the findings of Bharadwaj (2006b) which state that the couples who undergo IVF through economical, emotional, physical discomfort hand in hand make a statement about the enduring well adjusted relationship between partners. Though that can be true in certain situations and for a selected few, what we find here is far from this. Rather, women often undergo the medically exhaustive procedures in dire desperation to save their marriage and from the fear of being deserted and abandoned. An entry from the field

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5 Riesmann’s (2000) study of stigma and infertility in South India also confirms this. She writes, “a child solidifies a wife’s often fragile bond with a spouse” (2000:131).
6 There is an extensive feminist literature which views women resorting to assisted procreation as driven by ‘false consciousness’ and the health implications of these ‘hazardous technologies’. For further discussion on these see Overall (1987), Corea (1985), Mies (1994), Vincent (1996), Shachar (2001), vast literature produced by FINRRAGE (Feminist International Network of Resistance to Reproductive and Gender Engineering 1984), Greer (2000). For a comprehensive understanding of various feminist positions on technology, reproductive technology and scientific knowledge see Wajcman (1991) and Beckman and Harvey (2005); for a overview on feminist ethical framework for analyzing NRTs, see Curtis (1995). Though these bring in important pointers of female subordination both in the hands of medical establishment as a result of patriarchy and/or capitalism, we feel restrictive to paint a portrayal of women as passive and victimized. We, on the other hand, try to locate how women create spaces for themselves in their negotiations. They are often dictated by the normative order but there are times when they stretch the limits to the extent possible.
notes illustrative of how women endure coercion in order to maintain the face of marriage:

Patient (Woman): Till date my husband has not accompanied me to the clinic once. He is saying that he will go and marry again. But the Doctors are saying that his “hormone” needs to be tested. I am in a situation where I can’t do anything. I live in a family of 18 members and my eldest sister-in-law taunts me. My husband also shouts and abuses me. He (Her husband) has signed the paper but will not come to the clinic. Please give me a date as early as possible. My husband is threatening to leave me and remarry. He said, “Go and get baby from wherever you can and I don’t mind from where”. I know what he is hinting at. He is precisely trying to tell me to go to other men if necessary. But I can’t do that. I am a good woman from a respectable family. Please do something, I have already gone through two cycles (IVF); he is not ready to spare any more money. I don’t have any more money to try one more pick up so I have got this friend who have preserved embryos after having two children through IVF. I have somehow managed the money for implantation. They have written that they will give the spare embryo to us and my husband has also signed.

Administrator: You are saying that he is not giving you money, threatening remarriage and is not ready to come from Assam (teaches in Assam) with you will he consent to having a child by donor embryo. Signing is one thing but if tomorrow he says that the child is not his and if he goes for DNA test it will be proved that the child is not his. Then what will you do? And strictly speaking the child will not be yours (genetically). If this couple tomorrow wants the child back what will you do?

Few of the women respondents in this study not only endured the emotional responsibility of going through this lengthy exhaustive procedures alone but at times were the ones to bear the huge cost of the treatment on their own. Women have to continue these on their own both because of their husband’s refusal to shell out money for his wife’s impairment and woman’s urge to keep this away from her husband’s knowledge for the fear of being ridiculed and abandoned. This is equally true of women who did not have an independent income and had to rely on their wedding jewelleries to pull them through the repeated treatment cycles.

XY: My father died and my brothers had to accumulate to marry me off. They gave one lakh (cash money) and considerable amount of gold jewellary (and not bronze). In spite of spending so much money they are now under pressure to save my marriage. I have sold all my gold jewellaries to meet the cost of the treatment. I don’t have a face to ask my brothers for money. But I don’t have so much money. Once you are married, you become an outsider to your parent’s family. You become far off from your brother. Their wives become much closer
and intimate to them. Today I have pleaded my brother to come with me. He runs a medicine shop and I presumed that he would understand better than me.

People like XY are alone in their battle and do not have any support structure in place whether natal family, in-laws family or husband. In certain other cases, natal home acted as a support structure in order to save their daughter’s marriage and home. Here, the natal home took it as their responsibility to shield their daughter’s interest and to make her marriage work.

MS2: My mother knows everything about it. She is the one who is paying for this entire treatment. I have sold off all my gold jewelleries for my treatment. I have not asked for money from my husband. It is my fault and I am trying to overcome it without dragging my husband into it.

There is thus no uniform trend in which either women’s subordination, their disadvantageous status or their agency can be categorized once they are identified to be the one having the medical impairment. This is also true of husband’s participation in the medical process in particular and his presence in the family life in general. To either cast women as solely victims or as conscious active agents in bringing about change is then to gloss one reality over another. It is more of a continuum where multifaceted realities coexist depending on the individual’s life situation and the time frame.

Medically Infertile Male vis-à-vis Socially Infertile Female

In the earlier section we have witnessed how for women with medical problems, their infertility status becomes their sole signifier (sometimes both for them and for others around them). This identity formation however does not restrict itself to women bearing the medical impairment but is pertinent even in cases where both the partners have medical problems or where the medical incapability resides with the male partner. This becomes most prominent if we listen to the narrations of women respondents who are undergoing infertility treatment due to their husband’s ailment. Medicalization of

We have focused on women’s narratives in cases where they were going through ‘treatment’ because of their husband’s impairment. This has been done with two purposes in mind – firstly to show that even in such case women are the ones who are considered ‘socially infertile’; secondly if women are at the receiving end even in cases of ‘male infertility’, their experience of infertility when medically the problem is with them is easily comprehensible.
infertility, no doubt, has the potential to decrease social stigma falling disproportionately on women. But, what we find in our interaction with women going through medical procedures for their husbands’ infertility is that many of them are still at the receiving end.

In the medical arena which until recently was guided by understanding of infertility as female problem there can be said to be a visible shift. But however, in the familial setting to a large extent, women are the still the ones to be stigmatized for childlessness even when the medical diagnosis speaks otherwise. Hence women, even those who are in the infertility clinic for their husband’s ailment, are ridiculed in social functions, cannot take part in rituals, are the ones to take on the burden of extra housework. This often led to social exclusion from the normal flow of life, and childlessness becomes the prime identity through which roles get sketched out (for further discussion see Widge 2000, 2002, Baker 2004). Women thus become solely responsible for the infertility irrespective of their husband suffering from the physiological and endocrinological impairment. This happens at two levels: at one level there is reluctance on part of women to disclose that their male partners are incapable of producing healthy sperm, as this to their mind will ridicule their husbands’ manhood; at the level of the family (mainly the husband’s family) there is a reluctance to accept that the medical inadequacy lies with their son.

**Silencing of Husband’s Medical Ailment**

In most cases the husbands’ medical problems have been hushed up and women by default have been identified as the deficient. It is difficult to assess whether this is a

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8 Reissman in her study of infertility in South India also confirms that women are ostracized even when the “failing is the husband’s” (2000:136). This reminds us of Schepa-Huges and Lock’s claim that “societal and cultural responses to disease create a second illness in addition to the original affliction” which they term as “double” – the “layer of stigma, rejection, fear and exclusion” (1986:137). In case of socially infertile women, it can be said following Schepa-Huges and Lock (1986) that illness is created by “social and cultural responses” where none existed.

9 It might be so that this shift is restricted to prominent infertility treatment centers, which harp on the simultaneous examination of partners and is not an universal feature of all gynecological clinics where women are still subjected to grueling diagnostic tests, corrective surgeries and fertility medication, even before their partners are called in for examinations.
conscious decision on the part of the women or their husbands have imposed it on them. As, UD says,

*I have not told anybody that the problem is with my husband – neither to my in-laws nor in my family. How could I tell someone about it? So everybody by default thinks that the problem is with me. Hence the entire blame falls on me. Everyone feels I cannot bear a child.*

In order to safeguard their husbands' self image there is a mechanism in place to portray the husband as a humane person. As, RM justifies her act of silencing:

*Both our families know that we are undergoing treatment. But I have not told my parents that he has this problem. Then they will look down upon him. He would not have any prestige in front of others and his head will go down. That is something I won’t be able to bear. Actually he is very ‘touchy’ (sensitive) by nature and if anyone asks him anything about this he would feel miserable. My in-laws do not know anything about this. But when they abuse me, my husband always supports me and asks them not to behave in such a manner.*

In most cases where the husband had a ‘problem’, there has been a rationalizing that he is otherwise a very nice person at heart. The idea that is put forth is that even if he is not a complete man he is definitely a noble human being. It is his gentleness, sensitivity, loving his wife more than other men makes it up for his shortcoming on one front. But women in this study never questioned as to why their husbands do not take the initiative to reveal that the problem is with them and not with their wives. It is also interesting that a woman often choose to keep this secret even among her natal family with whom she would share other secrets so that her husband’s image of true man does not get disturbed.

**Denial to Accept Male Infertility**

Somewhere, there is denial to accept on the part of the family members (especially husband’s family) that the problem can even stem from the male partner. This medical knowledge is not only received with skepticism but is outright rejected. Rejecting the medical diagnosis consciously or unconsciously provides family members the space to recede back to their comfortable shell by shifting the onus on the woman. As, AM, one of the respondents undergoing treatment for her husband’s ailment says,
My in-laws ... know that the problem is with my husband but still they call me barren. I cannot even attend any family functions for the fear of being interrogated. My mother-in-law abuses me even after knowing that the problem is with him. They are not ready to accept that the problem is with him and they feel my husband is covering it up for me. The burden of household work falls disproportionately on me. Even yesterday when we came to Calcutta they told my husband that leave her behind and don't bring her back.

Medical impairment hence does not necessarily in itself get translated to the experience of infertility in both the partners (Greil et al 1988). What is also at the basis of this is that a woman’s own fertility becomes immaterial and she becomes socially infertile which affects her gender performance and hence needs to be refigured. However, how much the physical infertility of the woman affects the man’s status of being socially infertile is difficult to ascertain. As even now at least in the social world women are by default infertile, if not proven otherwise. However, for men such association of infertility is not spontaneous and only gets crafted, if at all, with repeated confirmation of medical diagnosis. The process of being infertile then, though sometimes draws from the medical diagnosis it neither starts with it nor it is shaped by only medical dictum. This is as much true for the couples themselves as well those around them, who choose which medical fact to take in consideration and what to negate to build up a narrative, which satisfy their purpose.

▶ The Inherent Power Dynamics

In case of male infertility, two distinct trends have emerged. While men sometimes were reluctant to enter the medical arena but at other times they were the ones who persuaded their wives to resort to donor sperm on the logic of their incapability for biological parenthood but desire and love for children. Even in cases of male infertility, the onus of childlessness falls on women hence they are often the ones to initiate treatment (Lorber 1987, Lorber and Bandlamudi 1993). In these cases and in cases where women and men both had problem in conceiving, women thought they were the “prime beneficiaries of treatment” (Lorber and Bandlamudi 1993: 37). In these instances we see a flicker of women as manipulators of situation and an attempt to use her agency to normalize the
artificial. As KM narrates how she manipulated her husband to give consent for donor insemination in spite of his unwillingness:

My husband was apprehensive and was not eager to accept this in the first place. He said, "there are many couples who do not have child and they are okay with it. If you want we can even take a child from Mother"\textsuperscript{10}. But I was adamant. Why would I do away with my linkage with the child because he cannot have one from his own? If the problem had been with me would he have agreed to adoption? I used to cry a lot so ultimately he agreed. Anyway he had to agree sooner or later as the problem is with him.

Even when the male partner is infertile it is wrong to assume that the female partner will always have the bargaining power in the relationship. As, in these cases the presence of the man and his signature in the consent forms is mandatory. In order to preserve that the child is not claimed to be illegitimate it becomes important to have the husband’s consent. Though the wife’s consent is also mandatory, in the day-to-day working of the clinic it is the man’s consent and his knowledge of use of the third party, which is, valued more\textsuperscript{11}.

Peculiar to the narratives of women undergoing donor insemination is to look at their act as driven by duty (something they ought to do in order to save the face of the marriage and they do not have an individual position of not accepting as long their husbands are ok) and obligation. But they also look at it as a sacrificial gift to their husbands, in spite of their discomfort, for the sake of belonging and love and to make up for the injustice that is done to them by nature/ God/ uncontrollable circumstances. The respondents in

\textsuperscript{10} This refers to the orphanage of Mother Teresa that acts as one of the prominent adoption agencies in Kolkata.

\textsuperscript{11} A field note entry illustrates how women need a ‘guardian’ in order to access ‘treatment’:

Administrator to patient: (Formalities to be completed before starting IVF Cycle) Where is your husband?
Patient: He is in Bangalore.
Administrator (A): Then who will sign? We need your husband’s signature.
Patient (P): I will sign myself?
A: But who will be your guardian?
P: I, am my guardian?
A: This is not foreign, all this will not do, we have our rules to follow.
P: OK. Can my brother sign?
A: No we need your husband. We would leave it blank for the moment but when he is here we will get it signed by him.
this study thus looked at their act of undergoing treatment for their husbands' impairment either as gifts to their husbands or as gestures of love and obligation for them.

*Family relationships and the professions of love ... carry with them an assumption that one has earned great credit... The credit is normatively defined as almost unlimited – whatever the small child needs, whatever the spouse needs, will be forthcoming if at all within the realm of possibility (Simmons 1987 et al cited in Lorber 1989).

These gifts are so much part of the family *package* that often such giving are taken as normal and natural within the framework of marriage and is not even identified in terms of *donating* or *giving*. As Hochschild (1989a, cited in Lorber and Bandlamudi 1993: 40), observes “crucial to a healthy economy of gratitude is a common interpretation of reality, such that what feels like a gift to one, feels like a gift to another”. These plurality of situations in which women become part of treatment protocols make it difficult to categorize them either as a “patriarchal bargain”(Kandiyoti 1988, quoted in Lorber 1989: 31, Lorber and Bandlamudi 1993: 40) or as a spontaneous desire emanating out of free choice.

It would be hence, futile to paint a rosy picture and gloss over the internal dynamics, which crisscrosses the relationship between the partners as they make their journey through the rough terrain of technological reproduction. It would be equally pointless to assume that none of the women had agency in the sense of making a considered choice. More than often women and also men resorted to IVF treatment out of calculated choice between options that existed, because of altruism, or through coercion (Lorber 1989). In a context which is pervaded by social pressure, biological craving and technological hope IVF becomes “obligatory *rite de passage*” both as an attempt to have a child and “an attempt to reach a secondary objective as a necessary substitute, that is, protection against social stigmatization and a means to obtain social recognition” (Koch 1990: 240-241, cited in Lorber and Bandlamudi 1993: 46).

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12 For a comprehensive literature review on family support and spouse’s reaction to infertility see Boonmongkon (2002).
II. "Is Man to Father as Woman is to Mother\textsuperscript{13}?": Notions of Masculinity and Femininity

The medical procedure is only one part of the treatment carried out in the clinic. Of equal importance are those socio-cultural dealings through which gender roles, notions of unsurpassed body and the real family get crafted. Once couples take on this journey their cultural ideas around notions of gender, identity, and body come face to face with the medical knowledge and what results from such encounters become a forming process in itself. As it is through these interactions and everyday dealings that otherwise implicit notions of gender, masculinity, femininity surfaces and become explicit. This becomes prominent while men and women are diagnosed with a particular impairment and through their negotiation with it. Hence we find that the shortcoming in case of husband is hushed up either by the couple or denied by their immediate family members.

Gendered Image of Medically Infertile Men

In everyday life people are not always explicitly aware of gender (Riley 1988, cited in Bailey 2001:116) but are reminded of it when certain actions, gestures, or state of affairs invite positive or negative reactions. Such is the case with infertility as it hits at the basic expectation that women and men have for themselves (Becker 1994) in order to fulfill the gender roles ascribed to them and the gendered knowledge that they have been socialized into. This blow not only destabilized their understanding of normal life and life course but also assumptions about body. The reaction both by a male respondent who was diagnosed with less sperm count and that by a female respondent who was undergoing treatment for her husband's sperm deformity bring in an association between reduced/deformed sperm and notions of masculine, fit and sexually active man. As, BM, a male respondent diagnosed with low sperm count or MS2, a female respondent undergoing IUI with donor sperm narrates.

\textsuperscript{13} Through this phrasing Cussins, articulates "performance of masculinity" in clinics and threats to gendered identity of men and women (1996: 19).
BM: After a battery of tests were performed they detected my sperm count was low and we were advised to resort to donor. Initially the diagnosis in itself was a shock in the sense that a man with a normal physique, working capability, and sexual drive like mine will have such a problem.

MS2: Initially it came to me as a shock to accept the fact that my husband would have such a problem. You can't even imagine if you look at him. He is such a well-built man having a huge physique. Moreover, I never had any problem in having sex.

Knowing one is azoospermic or one's husband has morphologically distorted sperm brought in cultural construction of a male image with "reduced fertility and atrophied sexuality" (Lundin 2001: 141). The information regarding low sperm count and bad quality semen somehow made them lesser men and contradicted their hitherto image of being normal and complete. Hence, often this diagnosis was difficult for them to digest. Men often did not separate their ability to reproduce from the ability to be sexually active. In case of men who were sexually active without any external manifestation of their medical problem of their fertility were shocked at the diagnosis that their sperm count was low, or nil or were deformed, or not active. For them it is difficult to equate that their otherwise normal masculine body with its manliness and prowess is unable to produce sperms that can fertilize a woman. When men's sperm fall short of normal medical standard both their sexuality and masculinity were threatened and their gendered image collapsed.

Women also while talking about their husband's problem found it difficult to fathom how an able masculine body with sexual ability is suddenly diagnosed as distorted, below normal and less masculine. It becomes clear that symbolic connotation of sperm moves beyond medicalized reproductive substance and sexual competency becomes an indicator of one's manhood. Even when sexual performance is normal, the diagnosis of imperfection of otherwise unknown sperm quantity, quality and morphology had serious repercussion on self-identity of masculinity. While impotence has always been equated with reduced strength, power and capability, this medical identification furthers such

14Similar to respondents in this thesis, Brian, a respondent in Mary Claire Mason's (1993) study on male infertility confided that his parents could not believe that their "big healthy son" (1993:120) can be infertile.
association not only with impotency but also with the medical normalcy of sperm capable of fertilizing an egg\textsuperscript{15}. This interconnectedness of sexual performance and that of gender role has been added on to reproductive performance and gendered construction of manhood.

This acceptance thus becomes a difficult encounter between one's own self image and the image brought in through medical examination. Such confrontation is so strong at times that it leads to denial of the medically established report as useless. As one trainee doctor observes,

\textit{It is very difficult for men to accept donor sperm. They would go for a second marriage without even realizing that the problem is with them...the initial reaction is generally an instant no. But once they go back and are asked to think over it, and are repeatedly told about it they finally resort to it because there is no other option for them.}

In order to preserve the self image utmost secrecy is often desired even among the couple – where the husband does not want his wife to know that she is inseminated with donor sperm. Or the other way round i.e. the wife does not want her husband to know that donor sperm had been used as she feels this will hurt her husband's self ego and manhood (Gupta 2000, Bharadwaj 2003). This kind of requests either stem from the fact that the husband/ wife\textsuperscript{16} does not want to disclose their inadequacies to their partner or fear that such revelation can either threaten their marriage or can invite negative sanction for the use of donor gametes. The notions of masculinity and self image are so much rooted in reproductive potentiality of one's semen and sexual performance that “two patients, both men committed suicide after being told they would never be able to have children of their own. The second, even accepted a donor's semen for the wife but still killed himself” (Biswas 2002:54). This makes us pause and think how normative ideas about gender, identity, masculinity and manhood are being negotiated in the entire process of infertility

\textsuperscript{15}Even the fact that court can give a divorce when the man is impotent, becomes a glaring pointer that this failing gets equated to role failing both as a man and a husband.

\textsuperscript{16}Throughout the thesis in most cases, except a few, I have used the words husband/wife because all my respondents were married and they referred each other as my husband or wife and not as partners. Hence even being conscious of the heteronormative bias that these terms often bring in I have used them as more appropriate for the present study.
treatment and how gender performances and threats to masculinity become a threat to
gender identity.

The Performance Pressure

The man who has to go through tests and produce sperm on demand or accept donor sperm after being diagnosed with low sperm potential is further faced with a challenge which derogates his already “fragile sense of manhood” (Lorber Bandlamudi 1993: 33). IUI with donor sperm brings us to a domain where women are no longer the only object of male medical gaze but the men also become captivated under its scrutiny. As we hear MD speaking for her husband, we find the image of a man emerging who has to perform under medical gaze and prove his competence in making a baby:

When I did not conceive (the baby did not come in my stomach) we went to a doctor in Tarakeshwar only...then after a gap we consulted a doctor in Hajra (Calcutta). He also asked my husband to go for semen analysis. But what happened he failed to give sample. This is something that is happening from the past few years. He is OK during intercourse, he also has erection and fluid comes out. But whenever he is asked to give semen in the clinic he cannot. Last time what happened is that I even slept with him in the collection room but then also he could not give it. It is so embarrassing. I have left treatment after that. It is very difficult to go through treatment in this way.

The performance pressure which MD talks about becomes a critical point of enquiry given the fact that the man is thrust in a clinical setting which till date has been dominated by women. Both in cultural birthing practices and in institutional delivery the role of the man has been delegated to the backstage which in this case of assisted reproduction suddenly got altered. Moreover, such alteration takes place not only on a regular basis but also for one particular clinical necessity that is to fill a lab container with his sperm sample in a room which is marked as ‘Collection Room’. Though definitely men in most cases are not subjected to internal gynecological examination and invasive technologies and harmful hormonal medicines, but what MD is talking about is

17 Medical gaze and reproductive performance of female patients have been studied in detail. However, medical gaze on male patients still remain an area to be critically looked into. For an understanding of male infertility as a “silenced phenomena” in the infertility clinics and sperm donation as a “private act”, see Helen Goldberg, http://www.ku.dk/satsning/pdf/the_secret_sperm.pdf.
the social display associated with sperm production. With the lab container in hand the
moment the man enters the collection room sometimes alone but also with his wife it
becomes quite clear to everybody around what is happening in that room.

This disquiet erupts as not only reproduction but sexual intercourse is dragged from the
intimacy of private sphere to that of medical gaze in a clinical set up. When a man gives
his sperm sample for medical scrutiny he is not only under the medical gaze but also gaze
of others. His entry and exit from the ‘Collection Room’ with a lab container stunts his
masculine image which was otherwise strong, competent till this date. Inadequate sperm
thus not only destroys the image of a potential father but also calls into question his own
self-identity as a true man. Here the image of the man does not emerge as the one who
has the power to penetrate but as one who is left at the mercy of the medical
establishment to be assisted in the construction of his identity of being a man. Hence men
often weave a shield of silence in order to keep their integrity which they have been
socialized to keep intact by not sharing their innermost panic when their power is called
into question. Hence though men were present in case of IUI with donated sperm mainly
because they were needed to sign on the informed consent forms before donor
insemination but were reluctant to talk about these issues. Even when men did talk they
just bypassed their crestfallen condition on being diagnosed ‘one with the problem’. They
also justified that they have long enough adjusted to it and to them donated sperm was
nothing more than a medical substance like blood. Through these mechanisms men often
reconstruct their image of logical, reasonable, self-composed human being.

Gendered Image of Infertile Women

The linkage between sexuality and reproductive identity shapes differently for men and
women. While men equated “virility with potency” women equated their femininity to
nurturance and being able to mother a child and care for it in the womb as “infertility
strikes at the essence of what is culturally defined as femaleness” (Meacher, cited in
Morgan 1985:225). Just as bad quality semen not only destroy the man’s role as a

18 This refers to medical as well as social infertility.
potential father but also bangs on the way he identifies himself as strong and physically fit; woman’s inability to conceive a child or hold it gets translated in terms of not being able to “have anyone to love who is a part” (Lundin 2000:147). For women, reproductive incapability gets directly translated to motherhood. Women claim to feel lesser women, less feminine but nowhere their sexuality become an intermediary factor between their gender identity and reproductive performance.

For the women in the study, this medical information challenged their knowledge of self which till date was taken to be feminine and womanly. Referring to their body as having “no good eggs”, “unable to produce any more egg” or “too old”, dehumanized their body as distorted and torn out. Being a mother is equated to the experience of carrying a life in one’s body for nine months (“tile tile baro hache amar sarire”) and this becomes the most important signifier in one’s feeling of fulfilling the womanly role she is bestowed with. A consistent theme in reference to motherhood has been visualization of the pregnant body which they believed to be a “confirmation” to womanliness (Bailey 2001:116). This visibility of pregnancy even through egg donation or sperm donation, as the case may be, did not hinder the fulfillment of the gender role and helped them in accomplishing their desired status. Being pregnant does not only confirm the woman’s contribution to childbirth but also affirms her husband’s manhood and “manifestation of his fertility” (Mahwoold 2000:136).

The desexualization of their bodies in their narration of conception and pregnancy, unlike men, portrayed them as existing for the child who can give them a final touch of womanhood. In order to achieve this desired role which has been disrupted, they see their

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19. Motherhood is still the stated primary role for women. Inability to perform this role has been negatively sanctioned through terms like “barren”. However, terms like “non-father” do not exist as a social category (Rich 1997, cited in Hardy and Makuch 2002: 273). Paxon (2006) in her ethnographic work at an Athens IVF clinic observes, “the ideologies of motherhood” which proclaims mothering to be “woman’s moral achievement” normalizes the use of the artificial technologies as a kind of “spiritual kin work” (2006:481). This notion is so deep seated, that women who do not mother a child (voluntarily childlessness) are often stereotyped as either selfish or are taken for granted that they are infertile (Letherby 2002). Toulemon (1996) shows that very few people remain voluntarily childless.

20. Following similar logic an egg donor thus becomes more feminine and fertile through taking in ovulation drugs which are synthetic chemical residues made from urinal excretion of menopausal and pregnant women - other women’s substance of fertility (Konrad 1998). Thus their capacity to superovulate makes them “superfeminine” (Konrad 1998: 650).
journey through infertility clinics as a struggle, a fight against odds of nature. Using these
technologies\textsuperscript{21} to become pregnant and to confirm to the role of motherhood is thus based
on the idea that gender is performative (Butler 1990). The identity one assumes is based
on such performances in front of an audience who has a normative script written and
drawn for such dramaturgical representations (Goffman 1963). Hence to them, pregnancy
becomes an achievement not only in having a child but also in reinstating their
womanliness\textsuperscript{22}. The desire to overcome the "inherited identities" and achieve the "desired
identities" (Dubar 1991, cited in Tain and Robertson 2002: 393) makes women endure
anything that come in their way.

III. Paternity and Maternity: A Gendered Script

The notion of "paternity and maternity are constructed within a specific theory of
procreation, a theory in which paternity is defined as the primary generative role. What
the man contributes is... seminal\textsuperscript{23} – the creative seed that contains and confers identity.
Maternity, in contrast, is defined not as conferring identity but as giving birth and

\textsuperscript{21}These "disciplinary technologies" (Sawicki 1991: 193) perform the task of normalizing woman's role
fulfillment as mother and further reinforces gendered images of womanhood and femininity. This is carried
out by "producing new forms of motherhood, by attaching women to their identities as mothers...by
inciting desire, attaching individual to specific identities, and addressing real needs" (Sawicki 1991: 194-
95). By creating "new subjects" – "infertile, surrogate and genetically impaired mothers, mothers whose
bodies are not fit for pregnancy (either biologically or socially), mothers who are psychologically unfit for
fertility treatments, mothers whose wombs are hostile environments to fetuses, mothers who are deemed
'negligent' for not choosing to undergo tests..."(1991:194) it normalizes and naturalizes motherhood and
for that matter fatherhood as well.

\textsuperscript{22}This is because as Goffman writes, bodily signs which depart from the "ordinary and natural" are
disgracing. It reduces the person from a "whole and usual person to a tainted, discounted one" (1963:3).
\textsuperscript{23}We will see towards the end of this chapter that this notion of men as the seminal contributor is also
grounded in the understanding that sperm is the active partner in the process of fertilization and nucleus is
the master molecule conferring genetic material hence identity. This hypothesis erroneously equates
menstrual blood with seminal fluid goes to the extent of devising a theory of procreation in which male is
the sole creator of future offspring while women only performs the nurturing role. As Aristotle writes, "by
definition the male is that which is able to generate in another ... the female is that which is able to
generate in itself and out of which comes into being the offspring previously existing in the generator" (GA
716.a.20-23, cited in Tuana 1988). Women hence assume the secondary position as they contribute material
to the fetus but the soul, form and movement come from the man which is superior substance as it is
'divine' and purified. "For the female, is as it were, a mutilated male, and the menstrual fluids are semen,
only not pure; for there is only one thing they have not in them, the principle of soul" (GA 737.a.27-29,
cited in Tuana 1988). Aristotle echoes Aeschylus' Apollo, "[t]he woman you call the mother of the child/ is
not the parent, just a nurse to the seed./the new-sown seed that grows and swells inside her./ The man is the
nurture, a task that can be shared by several women” (Collier and Delaney 1992: 303, Delaney 1986). This has its roots in sexualization of biological facts which projects the nucleus as the head of the family and the sole contributor of genetic material whereas the cytoplasm as merely performing the nutritive role. The sperm, it is said, contributes in making of the nucleus. Hence paternity is significant as it confers genetic material and consequently identity. Here bodies are seen as passive vehicles through which active genes are transmitted from father to the child. Hence, “maternal inheritance” is identical with “cytoplasmic inheritance” and “paternal inheritance” with the nucleus\(^24\). The latter is perceived as the “masculine ruler of the cell, the stable yet dynamic inheritance from former generations, the unmoved mover, the mind of the cell” (Beldecos et al 1988:68).

In the arena of assisted procreation this gendered script of maternity and paternity gets manifested both in the texts and in the daily working of the clinic. Thus the ART guidelines and practitioners alike prescribe a mandate in which paternity supercedes maternity. The texts sometimes become the ultimate reference point in these contexts. But also at times the providers go out of their way in perpetuating their personal beliefs.

The Mandate

In this hierarchical ordering of paternity and maternity, the ICMR guidelines ascribe the heterosexual married couples’ desire to parent a child as the fundamental one. The guideline, comes out clear with its inherent preference for a hetero-normative family to be in the best interest of the child in the article 3.16.4:

\[\text{There is no legal bar on an unmarried woman going for AID. A child born to a single woman through AID would be deemed legitimate. However, AID should normally be performed only on a married woman and that, too, with the written consent of her husband, as a two-parent family would always be better for the}\]

\(^24\) As, Beldecos et al views,

In this cellular version of the Aristotelian cosmos, the nucleus is the efficient cause (as Aristotle posited the sperm to be) while the cytoplasm (like Aristotle’s conception of the female substrate) is merely the material cause. The nuclear DNA is the essence of domination and control. Macromolecule as machomolecule. (1988:70, quoted in Martin 1992: 122)… Among all the constituents of living organisms, the genetic material has a privileged position. It occupies the summit of the pyramid and decided the properties of the organism. The other constituents are charged with the execution of the decision (1976:224, cited in Beldecos et al 1988: 68).
child than a single parent one, and the child's interests must outweigh all other interests.

No doubt cursorily, single women's desire of motherhood is mentioned but it is perceived not to be in the best interest of the child. Though, woman's natural desire for children is the bedrock on which these technologies are marketed, the naturalness of the

25 Section 3.16.6 of the ICMR draft guidelines 2002, “General Comment on the Responsibilities of the ART Clinic: Reproduction Rights of Gays, Lesbian and Single mothers”, talks at length about homosexual couples and single women gaining access to infertility clinics:

All along society has been used to the concept of childbirth occurring within the bonds of bisexual wedlock. Gays and lesbians in the West have assumed the right to marriage and some gays have even gone to the extent of seeking out a woman who would donate her oocyte for in vitro fertilization, and a surrogate mother who would carry the transferred IVF embryo pregnancy to term on behalf of the gay couple. Similarly, lesbians and women preferring to be single parents have sought and succeeded in getting ART clinics to artificially inseminate them to bear a child. Gays, lesbians and single mothers are gaining ground to get social approval of their sexual preferences around the world. The days are not far off when they would make demands on ART clinics in countries such as ours as their Western counterparts have done.

Recognizing the sexual liberties of the gays, lesbians and single parenthood has also raised moral dilemmas. The moral and ethical responsibilities and the legal rights of third parties in ARTs, such as semen donors, oocyte and embryo donors, and surrogate mothers, are a cause of much concern to our present society....

The question is how does an ART clinic respond as a part of society to such situations? Medically, there is no great technology involved. How would our society treat babies born out of wedlock? One must remember that India is a country where the cults of 'hijras' or eunuchs have been socially accepted for centuries. Can our country also absorb the new types of parents mentioned above? Obviously, there will be regional and individual differences. In such a situation it is considered wise not to make any one of the possibilities illegal but set up appropriate counseling facilities to ensure that there is least suffering on the part of those directly involved.

This entire section seemed to have vanished from the final document where we find a fleeting reference to single women but hardly any concrete discussion about lesbian or gay men willing to start family through the use of these technologies. This removal of the entire section becomes sociologically significant as it becomes indicative of the process through which a particular culture identifies, acknowledges, negates or normalizes emergence of 'new' social identities. This is not to say that homosexuality as a sexual preference is new but the political presence of this socio political identity group is. The draft document makes an attempt to normalize this social fact on grounds of both universalistic acceptances of these identity groups in other parts of the world and particularistic culture traits of India, which have been tolerant enough to absorb other non-mainstream identity groups. The final draft has reduced it to a mere appendage and has silenced any discussion about lesbians and homosexuals to have the probability or the potential to be able to parent a child. The committee members' individual biases and their personal belief systems might be the reason which has induced or reinforced an understanding that kinship is quintessentially heterosexual. This implicit framework on which the guidelines operates often leads to professional belief that it is illegal to give access to these technologies to unmarried woman (Harvard Law Society 1985).

26 It does not, however, negate outright single women's (it does not mention single men) access to ART; but rather states in article 3.5.2

There would be no bar to the use of ART by a single woman who wishes to have a child, and no ART clinic may refuse to offer its services to the above, provided other criteria mentioned in this document are satisfied. The child thus born will have all the legal rights on the woman or the man.
desire is only authenticated within the hetero-normative framework\textsuperscript{27} of marriage where there is a identifiable 'father' through whom identity can be stressed. To be otherwise is "not only a violation of the ideal of biological fatherhood but also a denial of the nuclear family (the two parent family in ICMR's language) itself and the sexual union that is thought to be the basis upon which conjugal love, therefore family love, is built" (Shore 1992: 301). It is these married heterosexual couples that the guidelines wish to assist in making parents rather than all those who approach the clinic irrespective of their marital status and sexual preference. Thus though we might assume that anyone who accesses the clinic do have a right to engineer family values, we find such agency is vested on a certain section of the population both by the medico-legal documents and by the practitioners' own interpretation of it.

The Practice

As much as the existing guidelines, the practitioners themselves believe that the society traces the lineage of the child through the father and not through the mother. It is the actual genetic link or the assumed one (in case of donor where the social father is assumed to have the genetic link) which is emphasized by the practice of ascribing the child with the father's name thus marking his belonging to a particular kin group. Even in cultures where practice of using both the parental surname is in use, the social significance of the father's surname surpasses that of the mother (Mahowald 2000). In this idea of kinship structuring thus there are different definite gender based roles ascribed to men and women. Though the medical professionals in a joint venture with the treatment seekers more than often take up the process of engineering, they also draw the line as to what extent such tampering could or should be done, much like the prescribed guidelines.

\textsuperscript{27} The hetero-normative framework refers to the inherent bias which accepts the heterosexual unit as the default setting. Hence it treats single women or women and men having different sexual aspiration (homosexuality) as deviance. It does not acknowledge that single or homosexual units can also be the family setting in which a child is raised.
To the providers thus, conception taking place with donor sperms was definitely different in nature from that done from oocyte donors or through surrogates. In their opinion this feeling is not restricted to the guidelines or the medical community but shared as well by the treatment seekers themselves. Dr B. N. Chakravarty, the Director of IRM and also instrumental in formulating the ICMR Guidelines for ARTs thus opines that the idea of using sperms only from anonymous donors and not from known relative operates within the existing framework and is guided mostly by “social and religious factors.”

According to him,

If you observe Bengali kinship terminological pattern it will become self explanatory that though cultural practices do tolerate two/three women in the mothering role but it cannot provide space for two men being probable fathers. Thus we have 'masima' (mother's sister), jathima (father's elder brother's wife), kakima (father's younger brother's wife), mamima (mother's brother's wife), didima (mother's mother) but we have one baba (father) and others are kaka (father's younger brother), jatha (father's elder brother) and so on. We prefix or suffix ma (mother) to a variety of relations but we do not suffix father in the same way. As father provides the social identity and obligation and rights gets transferred through him having more than one father has the potential to disrupt family relationships.

This attempt to intervene in the process of reproduction and in turn in the making of relationships thus does not question the structured gender role assigned to each member of the society. Hence Schneider (1992) is right in pointing out that the basic cultural roles do not transform with ARTs, but what changes is, who will execute the role of the father and the mother. This is not to deny ARTs, however put the egg donor in a role formerly associated with father as she only contributes genetic material. The dichotomy of sex which is often assessed through one's contribution in the framework of procreation also gets blurred along with dichotomies between nature and culture (Sedlenieks 1999). This makes Oakley comment, “[g]ender becomes as useless as sex” (Oakley 1997: 52) as gender which is defined on the potential parenting role changes.

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28 Co-mothering by two women or multiple mothering by a group of women is mentioned as an ideal feature in Vedas, epics and the puranas. The Rig Veda (ca. 1500 BC) also mentions multiple mothering in regard to Agni, who is described as “child of two mothers” (dvimatri) and occasionally as “child of three mothers” (the three world) (Vanita 2005).
Sexual Connotation of Sperm Donation

Right from the days of donor insemination and even today secrecy is often emphasized to protect men. The aim is to guard the donor against paternity claims and to shield the infertile husband from presumed feelings of emasculation. Hence while we find there is preference by a significant chunk of medical fraternity to have relative or known people as surrogates and egg donors there is a strict negation of accepting a known sperm donor. Though part of this is attributed to medical criteria and the reason that there is a system in place as long as sperm donation is concerned. But part of this also stems from the cultural understanding of fatherhood and the gendered assumption of who can be father and who all can become mothers or like mothers.

The root of this apprehension lies in the understanding that if the person who has technically fathered the child is in constant vicinity it can cause emotional turmoil and disturbance in the family. While the same can be said about family members being egg donors or surrogates, this is often rationalized and naturalized as being part of existing culture in which mothering has often been shared by various women. Moreover, the man who has fathered the child is also thought to be a potential threat not only for the resultant child but also the mother. This though has not been mentioned in clear cut terms in this study but has been touched upon by Dr. Gutgutia,

The husband without asking me got a neighbour living in the same flat for being the donor. I threw them out of the chamber. I told the husband, "Are you mad? Have you thought what impact it will have on your wife when the man would roam around in the same surrounding? What if tomorrow he not only claims the child but make advances towards your wife"?

The objection to entertain known donors can be explained as a mechanism in place to keep the identity of the donor a secret as part of the standard clinical practice. However, such an explanation does not suffice here. But this insistence draws our attention to the

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29 Dr. B.N. Chakravarty also brings in medical reason for their resistance to use sperm donors as family members. According to him, "mixing of blood between close relatives as happens in consanguineous marriage and among Muslims also result to congenital abnormality hence close breeding is not advisable".
30 Aditya Bharadwaj (2003) mentions this explicitly through his field data from IVF clinics.
intertwined notions of gender and sexuality which dictate who can donate what and to whom. The process of selecting a donor which is otherwise a medical procedure thus gets invested with social categories and a gendered process far from being a neutral clinical one. This way of looking at donor selection both by Dr. B.N. Chakraparty and by Dr. Ghutghutia seems to echo Haines while she speaks about “issues of gender in gamete donation” (1993: 85) in the context of Warnock Report. Haines argues that woman-to-woman egg donation is perceived as asexual in contrast to man to woman semen donation which is often burdened with sexual imageries. A female third party according to Haines is not seen as invasive and threatening to the existing family unit as introduction of the semen is (1992, 1993). This “dubious sexual connotations” and “inappropriate sexuality” (Bharadwaj 2003: 1873) identified by Haines (1993) is exemplified in the physicians’ apprehension. They resonate each other irrespective of their considerable difference, both in age and association with the field of assisted conception.

The drawing of sexual connotation and looking at sperm as not only medical dehumanized genetic material in this context is contradictory and surprising given the fact that in all other spheres of assisted conception the sole aim is to do the contrary i.e. build a narrative in which eggs and sperms are nothing more that medical substances devoid of humanness and merely assisting the process of conception. This highlights the deep-rooted fear regarding the stereotypical notion of aggressive male sexuality. This untamed masculinity is thought to be so threatening that an otherwise medical substance like sperm which has been often compared to blood donation becomes ribbed with sexual connotations if the donor is known or from the family. Moreover, the fear stems from the patriarchal understanding that the man who gives his semen by default can also buy off the access to woman’s sexuality. This becomes threatening in the patriarchal strictures where the possession of the woman along with her reproductive and sexual capabilities lies only to her husband.
IV. Gendered Understanding of Commercialization

Commercial transactions in egg and sperm and hiring of one’s womb have strings of gendered overtone attached to it. Commercial transactions in sperm donation have not been met with intense criticism and eruption of ethical furor that egg donation and especially surrogacy has been subjected to. This is because there are significant differences between selling of sperms and selling of eggs or contract pregnancy. The difference stems both in the way the process of donation is executed and the normative framework in which it takes place. While male substance can be easily detachable and can be potent outside the male body, woman’s egg has to be extracted from woman’s body through a painful medical process thus subjecting the woman’s body in the hands of the medical professional. Thus while selling of sperms no doubt leads to commodification of his reproductive substance, it does not necessarily amounts to control over his body by others.

A 1993 analysis estimated that oocyte donors spend 56 hours in the medical setting, undergoing interviews, counseling, and medical procedures related to the process. According to this analysis which is based on Western context a man receives $25 for sperm donation which is presumed to be completed in an hour’s time. In this estimation egg donor should at least need $1400. In 2000 it is estimated that sperm donor gets $60 to $75, hence the egg donor should get $5360-$4200 (cited in Ethics Committee Report of ASRM 2000). In Indian context according to rough estimates sperm donor gets something around Rs. 300 to Rs.1000; whereas payment to the egg donor varies from 10000 to 40000 and above. The rigorous disparagement against commodification of body parts and reproductive processes in case of commercial egg donation and surrogacy in contrast to sperm donation stems as much from the amount of money involved, the probability of exploitation of vulnerable women as well as the gendered

\[\text{\footnotesize 31 In Indian context there is no standardization of payment. Neither it is calculated on the basis of certain fixed criteria but depends totally on the vulnerability of the donor and the paying capacity of the recipient. The same is true of surrogacy where the surrogate can earn something in between 1.5 lakh to that of 5 lakh rupees and even more on exceptional circumstances.}\]
conceptualization of woman as altruistic, care-giver, nurturer in opposition to men who are self-seeking and geared at fulfilling their own self interest.

**Commercial Surrogacy: Gender Norm/s Unsettled**

In a context where gender norms dictate social action and cultural norms portray women as someone who “give and are given away”, women selling their reproductive material or renting their womb are seen as a probable threat to the normative order. This becomes all the more true in case of women in the context of reproduction who are seen as “archetypal altruists” (Raymond 1990: 8). As, Harrison (1983) points out:

> Many philosophers and theologists although decrying gender inequality, still unconsciously assume that women’s lives should express a different moral norm than men’s, that women should exemplify moral purity and self sacrifice, whereas men may live by the more minimal rational standards of moral obligation...perfection and self-sacrifice are never taken to be a day-to-day moral requirement for any moral agent except, it would seem, a pregnant woman (Harrison 1983, cited in Raymond 1990: 8).

This “supererogatory morality” stems from the dualistic standards, which prevails in our societies where “perhaps most, of the voluntary sacrifices on behalf of human well-being are made by women, but the assumption of a special obligation to self-giving or sacrifice...is male generated ideology” (Harrison 1983, cited in Raymond 1990: 8). Hence the very idea of women entering the market and involved in commercial deals and transaction guided by self interest threatens the edifice of the structured patriarchal order. This is not then just a moralistic hue and cry over commodification of body and body parts but is the gendered expression of the moral standards crafted by the patriarchal structure in which women are portrayed in the “discourse of maternalism” which in turn bases itself on the “discourse of dedication and devotion” (Raymond 1990: 8).

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32. This bears all the hallmarks of what Stan Cohen calls “moral panic” - “a condition, episode, person or group of persons [emerging] to become identified as a threat to societal value or interests” (1972:9, cited in Morgan 1985:222).

33. For a discussion on various positions regarding commodification of women in general and contractual surrogacy in particular see Ciccarelli and Beckman (2005).
The market as a public sphere is characterized by attributes that are in direct contrast with the private domestic life. Both these sphere exist in “mutual presupposition and exclusion and the nature of each is determined by what it excludes” (Poole 1983, cited in Morgan 1985: 230). But what have happened are not “a simple exclusion of women, but a constitution of femininity through that exclusion... Femininity has been constructed through exclusion, as a necessary ‘complement’ to maleness” (Lloyd 1983, cited in Poole 1983, cited in Morgan 1985: 230). The condemnation of surrogacy is intertwined with the concern that with surrogacy women are capable of reproducing without the need of “patriarchal genetics” (Morgan 1985: 231). The “most fundamental threat to male hegemony and the construction of patriarchy” (Morgan 1985: 231) occurs in case of surrogacy as not only women enter the labour market (which they have been doing since quite some time) but they are no more bearing children only for their husband or husband’s family but anyone who pays for it outside the monogamous family unit.

This becomes clear if we pay a critical look to the moral distinction between commercial surrogacy as abhorrent and altruistic surrogacy as gift-giving which tends from gender norms and assumptions of men and women and their relationship with family and market (Anleu 1992). Commercial surrogacy is seen to be deviant because it seems to unsettle gender norms of motherhood. It thrives on the selfless act of profiteering and therefore relocates her from the private space of family to that of the market place. Hence there is limited choice but to project that the act of egg donation or surrogacy (Ragoné 1996) is immersed in women’s quintessential love for children and their fellow feeling and willingness to help other women. Hence recent media photograph of a surrogate is depicted to have a satisfying smile on her face for being able to help a foreign couple to have the child (Ananda Bazaar Patrika, March 26, 2007). At the same time her act of renting her womb is justified because she used it as a “noble way of earning money for the treatment of her only child suffering from critical heart ailment” (Ananda Bazaar Patrika, March 26, 2007)\textsuperscript{34}.

\textsuperscript{34} Ragoné’s (1996) also reports similar findings from her study on surrogates. She writes, “not one of the surrogates I interviewed spent the money she earned on herself alone; the majority spend it on their children – as a contribution to their college education funds, for example – while others spend it on home improvement, gifts for their husbands, a family vacation, or simply to pay off ‘family debts’”(1996:355).
If egg donors or surrogate attempt to project a professional commercial enterprise devoid of familial values they are met with skepticism both by the medical establishment and the recipient couples. Hence the general assumption is that this “should not be reduced to transaction based on give and take” (Bhattacharya 2007). It becomes difficult for them to accept professional donors and surrogates, as it leads to disjuncture between women’s traditional female roles as wives, mothers and care givers and their image as sellers endowed with rational profiteering and business tactics. Moreover, if a surrogate denies to give the child to the recipient after giving birth she becomes “doubly deviant” “first, for entering [into] contractual relations and, second for reneging on those obligations” (Anleu 1992:32) In contrast altruistic surrogacy seem to reconfirm women’s traditional gender role and preserve tenants of womanhood.

Altruistic Donation: A Prescriptive Choice

While commercial surrogacy and selling of donor egg is shunned, the same act is glamorized when it happens within the family circle dictated by altruistic motives\(^35\). However, when a woman \textit{decides} to donate egg or become a surrogate for someone in the family it would be wrong to presume that her act is solely an individual choice and dictated by altruistic motive without any compulsion. Given the fact that in most circumstances a woman is completely absorbed and integrated in the family and committed to the expectations of the family members, she rarely has any choice in not complying and is subjected to a situation which can be best be seen as an “open prescript”\(^36\) (Klass 1966: 953). Though in a family setting there might not be direct exploitation of the poor by the rich (there might be instances where a poor family member is much more vulnerable) or commercialization of body parts and reproductive

\(^35\) Cannell writes in this regard, “the symbol of the pure surrogate who creates a child for love was pitted against the symbol of the wicked surrogate who prostitutes her maternity” (1990:683). This binary opposition stems from the understanding that the former, the altruistic surrogacy, does not involve transaction of money and hence is considered pure. Kaplan (1994) in her analysis of media narratives of surrogacy supports this binary opposition. She claims media either projects the surrogate as operating from the ultimate principle of sisterhood and ready to offer ’gift of life’; or negative image of surrogates who are renting womb for financial benefits and are engaged in “commercial trading in flesh” (Kaplan 1994).

\(^36\) The role of the egg donor or the surrogate can be compared to those of Durkheim’s widows or soldiers (1966, reprinted 1972) who are so observed in the social organization that their individual interest cease to exist, to an extent, that they are ready to sacrifice their life and commit ‘altruistic’ suicide.
potential but familial obligations does not leave out much space for free will. Hence in most cases where the sister or the brother’s wife said that they would not be able to donate eggs or become surrogate their entire relationship and family ties got shaken. This becomes clear-cut in BL’s narration:

I have already gone through 2 IVF cycles with my own eggs. But when all of them failed the doctor asked me to use a donor. So then I asked my youngest sister. She spoke to her husband and then they came to meet the doctor. When the doctor spoke to them he told them both about the pros and the cons of the procedure... So the doctor asked them to think and decide. But my sister and her husband only picked up the negative points and hesitated. They even came for the blood tests but just before pick up they said they do not want to continue. I am very emotional and this broke my heart and I did not request them anymore... if I have offered them money (around Rs. 50,000) then they would have agreed. Actually my youngest sister’s husband is a little weird and back dated. Since then my relation with them has been cold.

As Mauss (1954, reprinted 1974) believes gift giving at the cultural level is prescriptive and is used to maintain the group solidarity this is true even of family situations where the move by the woman is not spontaneous but a mechanism through which that family bondage and stability is reinforced. In such a situation though women make an apparent choice, they do so under circumstances they are not free to change. In such situation to deny the needy the care, the nurturance, and the reproductive support is to draw ostracism, ridicule and be labeled as selfish and self centered and as a glaring pointer of diminished family commitments. Donation hence is a,

\[M\]ore momentous event for the male. He is more likely to be questioned whether he wishes to make the sacrifice. If he does make the sacrifice, he reacts more dramatically – either with regret or with a great boost in the self-picture. The female appears to take donation more for granted, neither reacting as negatively nor as likely to perceive the act to be an extraordinary one on her part, as an act that proves her greater worth as her person. Perhaps donation seems to the female to be a simple extension of her usual family obligations, while for male it is an unusual type of gift. In our society the traditional female role is one in which altruism and sacrifice within the family is expected (Simmons et al 1987: 188-89, cited in Lorber 1989: 28)\(^{37}\).

This also leads us to the fundamental question of whether women themselves do have control over their bodies, reproductive processes and reproductive materials. In a set up where she is always expected to make herself available for other's benefit either as part of the given norms of family functioning or is coerced to do so, it is worth asking how much altruistic is altruistic donation? This is brought up by BL, while she speaks of her brother going out of his way to help her:

> My brother is keen that if any help can be done by his wife. She was pregnant just three months after marriage. But my brother got it aborted because he wants that I have baby before them. He has even offered that if she can give egg for us. He has said, “I would not tell her (his wife) but somehow manage to make her come and give eggs without her knowing”.

With BL’s proud proclamation of her brother’s intent and willingness to help her, we are forced to encounter how gender constructions are rooted in patriarchal control of women’s bodies. The fact that her brother’s wife had to undergo abortion neither for medical reasons nor out of her own choice make us pause and re-look at the entire abortion debate in a new light. The brother’s wife not only lacks control in deciding whether to have a child or not, but also over her own body and reproductive materials. She is being drawn into a conspiracy in which she has to give her eggs without her knowledge and consent. This ridicules the notion of informed consent which is so fundamental to questions of medical ethics and an integral part of the field of assisted procreation.

When we talk about informed consent and informed decision the question arise who under what circumstance has the correct information, and access to knowledge in order to make an informed decision and consent to it. It also raises question as to in a country like India where more often than not the family is idealized as an harmonious and well adjusted unit in which every member is ready to help; to be an egg donor or a surrogate, far from emanating from personal choice can be a result of familial obligation and patriarchal control. In this narration by BL there is an inherent tacit understanding that her brother’s wife might not be an active self willing collaborator in her conception and pregnancy and hence is drawn into it through deceit and cover up plans. As and when
BL’s brother commits to such an act, deep down he as well as BL herself are guided by the belief and internal socialization that it is the husband who has unquestioned control over his wife’s body and her reproductive potential and the highest authority and access to use it in case of any crisis.

It also becomes clear that the medical fraternity themselves often submit to such understanding. Hence we find that IRM informed consent forms make it mandatory for the egg donor and surrogate to have the signature of their husband, in spite of the fact that ICMR guidelines do not make it a compulsory requirement. This is so inherent an understanding of the patriarchal fold that women who come on their own for being donor are looked down with suspicion and are subjected to grueling interrogation as to their whereabouts and social standing. In contrast, the sperm donor need not seek his wife’s permission even when he is married. The fact that unmarried men are allowed to donate

38 A conversation in this regard between the doctor and the prospective egg donor is reproduced from my field notes:

Doctor to Donor: We would need your husband’s consent for you to donate egg.
Donor: My husband is not with me. He lives in a different place for business purpose. My parents can give the consent.

Doctor: We would need your husband to give consent. He is away and you might be doing this at his back. Parents do not matter anymore after you are married. Who earns the living for you? Who arranges for your food and clothing? Through whom is your children identified – is it your parents or husband? So if tomorrow your husband comes and questions us, we will be at fault. May be they (recipient couples) are giving you a lot of money and hence you have agreed.
Recipient’s husband: But she is my wife’s sister.

Doctor: So what? May be you have enough money and you are coaxing her into it, everything is possible. Tell me frankly is she your wife’s real sister? I don’t think so.
Recipient’s husband: No actually she is distantly related.

Doctor to donor: Where do you stay? Do you stay with your in-laws?
Donor: No I stay with my parents. And I can’t answer to all your queries. It is as if you are trying to grill me by asking me all personal questions. There is some problem that is why I am staying with my parents.

Doctor: That I have realized at the first instance. Tell me frankly has your husband left you?
Donor: No he has not left me.

Doctor: See either he has to come here and sign here in front of us or take the form and get it signed by him in front of a first class magistrate, a rotary counsellor or municipal officer with their official seal and in that case if anyone else signs for your husband we are not going to take responsibility for that.

Recipient’s husband: Ok we will try and get the husband. But please don’t tell him that there are certain complications because then they might withdraw from the process.

Doctor: I have to tell everything both the pros and cons. I cannot tell them that there would be no complications. After that if they decide not to do it, they won’t. But this is no religious place (baba ’r than) that we will intoxicate her and make her do even if she is not willing.
sperm in comparison to women for whom “proven fertility” (ICMR 2005)\textsuperscript{39} becomes a marker stems not only from medical but social reasons as well. The notion of proven fertility is being equated with being married, totally denying that women might be in sexual relationship before marriage and can even choose to give birth when single.

Hence it will be wrong to assume and frame the experience of donation only through the narrow predetermined lens of domination in case of commercial donation and altruism and benevolence in case of non-commercial donation. To do so would be to paint a reality in which there “can only be one natural woman (the reproductive woman), one natural mother (the genetic mother), one natural family (the nuclear, private family), and one way to be a surrogate (a “cow”)” (Goslinga-Roy 2000: 124). These rigid and unitary representations of human life naturalize and normalize only one set of predisposition as normal and natural and shuts up all other avenues to act. This “reified, privatized, and biologized notion of the body and personhood... strang[e]s the existential richness and complexity of being embodied at specific intersections of historical biographies and social geographies” (Goslinga-Roy 2000: 124).

V. Posthumous Conception: Gender Issues at Stake

In order to thrash out posthumous conception in case of man and woman as sociologically different, two cases of posthumous conceptions\textsuperscript{40} have been considered. The procedure involving cryopreserved embryo of a woman who has passed away is reproduced from my field notes; the case of posthumous conception with donor sperm, was brought to my notice by Dr. S.K. Goswami and Dr. Sanghamitra Ghosh, of IRM.

\textsuperscript{39} There are instances where young unmarried girls are selling their eggs for earning money. It is not to say that I personally are weighing giving of eggs by young girls vis-à-vis women who have ‘proven fertility’. But this is a point I am making in order to bring in the gender dimension of egg donation.

\textsuperscript{40} Until now, our focus has been on conception taking place with donor eggs and sperms but we would like to discuss two cases where though gametes from the recipient couple were used they open up a plethora of issues about relationship, maternity, paternity and parenthood in general. Methodologically these two cases are different in the sense that the communication did not take place with the respective respondents.
The following entry in my field notes is expounding:

Case I: A couple was undergoing IVF. During the course of the treatment the wife died. This happened after the eggs were picked up and embryos were cryopreserved. The husband has come over after a year with his new wife. They want to have a baby from this frozen embryo. As 15 embryos were preserved they have also got a relative who has been advised IVF with donor egg. As she is unable to find a donor she would also use these frozen embryos to have a baby.

In this regard, there was a furor of discussion among staffs that day which I also reproduce from my field diary, as it becomes an important arena to locate some of the crucial issues:

Staff 1: The husband mainly wants to have a child from the frozen embryos (with his first wife's egg), as then he would be entitled to claim the property of his first wife through the child. This is definitely a negative thought but that is what struck me when I heard it.

Staff 2: But it can be such that this is his way of preserving the memory of his first wife.

Staff 1: In that case he would not have married for the second time.

Staff 2: They have also got a relative.

Staff 1: It is as if the first wife is like a duck/hen who has laid eggs and others have come to buy it.

Case II: The woman was going for IUI with husband's sperm. They had gone through two cycles of insemination but both of them failed and they decided to cryopreserve the sperm. After some time the lady came back informing that her husband has passed away but she is more than willing to have a child through his sperm. We tried to counsel her making clear the consequences of such conception in a society like ours. But her in-laws also came in and said that let her proceed with this. Look at her, unlike the last two times this time she conceived. Later they said they would tell the family that her husband died when she was pregnant.41

This particular incidence is also reported in the newspaper as a landmark event. Further this technological success is being worded in the language of Hindu cosmological belief system as the widowed mother is quoted to say “Rohit (her husband) has come back to me as my son” (Pratidin, May 10, 2008). However, in our country the legal standing of posthumous conception is not clear. With the focus to legitimize childbirth in case of posthumous conception through AIH, the article 3.16.5 of ICMR guidelines state that Though the Indian Evidence Act, 1872, says that a child born within 280 days after dissolution of marriage (by death or divorce) is a legitimate child since that is considered to be the gestation period, it is pertinent to note that this Act was enacted as far back as 1872 when one could not
These two cases of posthumous conception (though in the first case conception literally have not taken place during the field work) bring us to a host of new thoughts on issues of gender and kinship. Though posthumous birth is something, which is certainly not new to us, but in this case posthumous conception has been possible only after semen was frozen and used for artificial insemination even after the death of the concerned person. The use of the frozen embryo in the first case brings in the probability where the resultant child will have a deceased genetic mother and a gestation mother as well. The use of the frozen embryo for the conception of another woman, on the other hand, poses ethical and legal question as to who has control over deciding the fate of the embryo.

In this latter case the resulting child will not only involve four parents but one of them would be deceased. There is little precedent as to how the decision regarding whether to use the gamete of the deceased should be used. Does the husband in this case have the authority not only to use the embryo to have a child for himself and his new wife but also give it to someone else. In the former case the conception by the second wife posthumously has been interpreted as a gesture to preserve the biogenetic connectivity by bypassing death. But it is perceived also as a means of utilizing the child in order to inherit wife’s natal property. In the second case the attempt is to ameliorate the grief of a widow, a family, and the wider society by making “bad deaths” to some extent “good” (Simpson 2001: 11).

In both these cases, the dissociation of reproductive material from the person and its potential of being able to mediate relationship across time and space demands
renegotiation with one’s understanding of kinship and gender. In case of posthumous conception, the idea is of a man who is absent but whose presence both as a father and husband is made visible through the use of the biogenetic substance (Simpson 2001, Strathern 1993). Gametes which was once just a biogenetic substance becomes the focus of new meaning, possibilities and relations laden with gender connotations even after they are disembodied. It thus can be said following Simpson (2001), Strathern (1988) both of whom in turn takes cue from Marriott (1976b) and establishes that sperm as the “dividual” entity having rich potential to mediate new form of social relationship. The act of posthumous conception also widens the parameter of making relationships, as the conceived child is the realization of the intent of the dead to become a parent and a repository of her/his memory.

However, in case where the egg is used posthumously not by a surrogate but by the second wife as in this case the social presence of the woman as the mother and the wife is not the logical outcome even when the biogenetic substance is present. The child’s birth as a result of the desire to preserve the memory of the deceased also gets questioned by Staff 2, unlike in the case of the posthumous conception through use of sperm in the second case. Hence the use of biogenetic substance has the budding possibility of creating (or not creating for that matter) relationships of different nature depending on the context in which it is employed. In this sense, the articulation of desire on part of the dead is seen as the natural responsibility of the partner emerging not from formal consent but from the strength of conjugal life that they have lead. Hence though the providers were not willing to become active collaborators in this process of making a relation visible, they had to consent to the use of the biogenetic substance both by the wife of the

44 This applies in case of egg as well. However, the focus is on sperm as the sperm has an existence in cryopreserved state unlike egg which cannot be cryopreserved.

45 “They [dividual persons] must also give out from themselves particles of their own coded substances – essences, residues or other active influences – that may then reproduce in others something of the nature of persons in whom they have originated” (Marriott 1976b: 111). It is in this discourse that persons not only contain substance but it is the substance, which is redolent with the potential future person. However, in this study the respondents did not specifically mention that they view these substance stored in liquid nitrogen as one’s relative. This is in contrast to Konrad (1998) who suggests that these biogenetic substances are the microcosm of kinship as long before procreation takes place they have figured into the kinship narrative.

46 As of now, egg cannot be cryopreserved for future use but embryo created and cryopreserved can be used posthumously after the death of the woman.
deceased or by the husband even in case where he has moved in to another marriage. One may assume that merging of substance that takes place through marriage and subsequent sexual intercourse bestows one with the power over the shared body. It is as if marriage gives legitimacy to the claim of bodily substance. However, the question arises when the husband has moved into a different marriage does the power still exist and would this be similar in case while the woman moves on to a different marriage. However, if we consider the technicalities of consent in the legal framework we find that consent of the deceased becomes mandatory in using any of his/her body parts\textsuperscript{47} (ICMR 2005).

VI. Genetic vs. Gestational Tie: Gendered Aspect

In this study it was not possible to draw a direct correlation between sex segregated view of ‘what is thought to be the building block in making parent’ as most of the respondents were women. However, women did speak about their understanding of the fundamental component in making ‘nijer santan’ and also often quoted their difference of opinion with their husbands regarding this. Most women felt that to them holding the child for nine months was most important in bonding with the child. They felt if disjuncture occurred at that level it would be quite difficult for them to accept, as they would be totally “cut off” from the experience of childbirth and pregnancy. This view, however, was predominant in case of women who were medically \textit{fit} to carry the pregnancy to term. Those women to whom surrogacy was the only option of having a child however did not necessarily give importance to gestational component over genetics. In their ranking, most women felt that though they would have resorted to any of the techniques as and when suggested by the physician in due course of time they felt that accepting egg donor was easiest, followed by accepting sperm donor and to take help of a surrogate was the most difficult compromise that had to be made. Some women also felt that they

\textsuperscript{47} This dichotomy in common understanding and in the legal framework stems from the fact that though socio-ethical concern is to fulfill the desire of the dead person and her/his partner the bioethical concern is that such desire need to be translated in medico-legal consent to be valid (Jennings 1998, cited in Simpson 2001). This is because while people are bound by law and customs but they are importantly bond by shared substance be it food, nurturance, care which gives them the authority to fulfill wish, desire and intent on behalf of the person they feel related to (Simpson 2001).
would like to nurse a child in their own hand and it did not matter to them whether the child was biologically theirs or not. But they felt that their husbands were reluctant to have an adopted child in most cases, as they themselves were not at fault. As, CS, articulated her concern:

\[I \text{ have not thought of adoption, as my husband would not agree. You are doing research just find it out if whatever I am telling you matches with your research findings or not. In case where the man is active he will never agree to adoption. He will tell am I not man enough to father my child? Am I unable to produce one that I will adopt? Am I disabled? (akhsam). So there is no question of adoption.}\]

Or as MS2 puts it,

\[I \text{ have thought of adoption a couple of times. But have not gathered the strength to tell my husband. He may feel bad. I do not want to add tension to his life. I do not mind adopting, as I will at least have the pleasure of rearing a child. But may be my husband will say what's the need? There are so many children in the family. But even if we adopt we will have someone to call our own and also a support for older life.}\]

However, some women felt that their husbands were eager to have an adopted child. But they felt totally repugnant to the idea of rearing an “unwanted” child of “unknown blood”. While their husbands were eager to have the child they felt it was their decision which was upheld because they are the ones who would nurture the child in the long run. We hence could not arrive at a direct answer to the question that “do women who desire to be mothers have as much interest in genetic ties to their children as men do” (Mahowald 2000:127)? In, most cases genetic tie is taken as synonymous to biological tie. However this is only true in case of men. Women are biologically related in three distinct ways: genetic, gestation and lactation. Women though definitely placed biologically relatedness in any of these three ways as different and intrinsic to that being related through social bonds of adoption. However, which of these three would count as the most important criteria is dependent on the individual circumstances. Clear cut gender differences in attitude towards genetic tie was not evident in this study as Mahowald (2000) observed where women were more flexible to let go genetic component as the grounding factor of kinship. However, what was significant in this study was that
gestation was given primary importance over and above genetics by women and even by men regarding their wife’s contribution in making the child. It was justified in terms of the existing compelling demand to perform the prescribed gender role.

VII. “Science is Politics by other Means”\textsuperscript{48}/Science as a Gendered Manuscript

The “sexist bias” (Tuana 1988: 36) and attribution of cultural normative properties is as much true of the social world as well as the world of reproductive biology and other disciplines which claim to be value free because of their scientific pursuit\textsuperscript{49}. This is done by culturally attributing “extra-physical properties... to those bodies (men, women) – active or passive; independent or dependent; primary or secondary...and the same properties that are ascribed to the whole are then attributed to the subcategories of, or processes associated with these bodies (sperm, egg, cell)” (Keller 1995:33).

This attribution of cultural properties to so called scientific processes and entities of reproductive biology is made clear by Dr. Sudarshan Ghosh-Dastidar in his articulation of what he calls “intrinsic evolutionary biology of human reproduction”. This is what he had to offer:

The oocyte or what is commonly called the egg after being released resides in the fallopian tube in a static position. Sperm cells migrate around the reproductive tract and finally one of the most viable sperm cells penetrates the egg and fertilizes it. However, women’s reproductive system is so designed that it chooses the most viable and potent spermatozoa among million of them and this is a natural selection process in place to rule out sub-fertile sperms... This process inherent to reproductive biology also gets translated in the behaviour of male and female. Thus female are more receptive and resilient and they initiate to choose the best male in order to ensure that biologically stronger offspring is born. Biologically the reproductive system is so designed so as to protect the uterus and the oocytes in a much more guarded way compared to the male

\textsuperscript{48} Latour in Visualization and Social Reproduction has deduced this inference (cited in Moore and Clarke 1995:291).

\textsuperscript{49} Though, anthropology has long been interested in medicine and technology, till 1990s their emphasis has been to study “folk beliefs” and “alternative” systems rather than Western Biomedicine. The latter was considered “off limits” as it was thought to be based on “rational” discourse and hence beyond critical analysis (Casper and Koenig 1996: 525).
gamete which is innumerable and easily exposed to the outside world so as to preserve the former. This is to ensure the continuity of species, as it is the female species that has the capability to give birth.

Dr. Ghosh Dastidar’s imagery of the sperm and the egg and the process of fertilization are rooted in embryological and reproductive theories of the 1980s which does not necessarily cast the egg and sperm as strictly passive and active entities but neither is free from the sexist bias which pervades the field of reproductive biology from the days of Aristotle. Whereas he talks about sperms making the journey and fertilizing the ova, he

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50 From 1980s onwards there has been a stark shift in the technical understanding of fertilization which was highlighted by Gerald and Helen Schatten:

The classic account, current for centuries, has emphasized the sperm’s performance and relegated to the egg the supporting role of Sleeping Beauty.... The egg is central to this drama, to be sure, but it is as passive as the Grimm brothers’ princess. Now, it is becoming clear that the egg is not merely a large yolk-filled sphere into which the sperm burrows to endow new life. Rather, recent research suggests the almost heretical view that sperm and egg are mutually active partners’ (1983:29, cited in Beldecos et al 1988: 66).

In “the sperm sage”, sperm is portrayed as heroic victor and the egg as passive prize awarded to him (Beldecos et al 1988). These are manifestation of the myths of the heroic quest by Odyssey or Aeneid where the hero faces every challenge on his path and survives through them only to receive an award the egg. Since 1980 there has been new account of sperm egg interaction and in which egg is more of an active partner. This new research or interpretation of the old investigation showed that rather than sperm burrowing the egg, the egg “directs the growth of microvilli - small finger - like projections of the cell surface - to clasp the sperm and slowly draw it into the cell” (Beldecos et al 1988: 65). The new ‘revisionist’ accounts though has made a conscious shift in attributing the egg and sperm equal partner in the process of fertilization they often tend to reinforce old imagery. These new accounts though give the egg a much more active role they does not subvert the hierarchical gender stereotype. Rather they perpetuate an image of “women as dangerous” and aggressive threat... female fatale who victimizes men” (Martin 1991: 489-500). As such far from subverting the gender stereotype they often tend to reinforce old imagery. Even literature on foetal health problem, places sperm at the center of the discourse as “the littlest ones... victimized by reproductive toxins, somehow without involving their male makers as responsible agents” (Daniels 1997: 579).

51 The sexist bias in embryological and reproductive theories can be traced from the days of Aristotle in which women’s inferior status has been rooted in biological explanation. The central premise of Aristotle’s theorization bases itself on the theses that heat being the fundamental principle in perfection of animals, “that which has by nature a smaller portion of heat is weaker” (GA 726.b.33, cited in Tuana 1988: 36). This is the reason that he bestows for women’s defect in both structuration and functioning compared to men. His thesis of ‘defect in heat’ is also closely tied to the theory of reproduction. In this understanding male semen is scarce and is unlike blood because of the ‘right’ heat that it receives in male bodies which conceots blood to semen with ultimate perfection. However, in female this process is not complete hence female semen which he equates with menstruation is abundant and resembles blood which has not being ‘cooked’ till perfection and has not been purified. Due to this imperfection and lack of purity, Aristotle perceives that the female semen is devoid of reproductive potential and is ‘impotent’, “It is plain the female does not contribute semen to the generation of the offspring. For if she had semen she would not have...
makes a conscious effort to attribute the ovum having a definite purpose of selecting and screening the most viable sperm. Thus we find in the narrative of the practicing clinicians and embryologists construction of biological facts in such a way that provides space both for passivity and active agency vested in the ovum. However, it is interesting that to him, this biological structuration and what he calls "the mechanism of evolutionary biology" is the grounding factor for creation of feminine and masculine roles. This "cultural ideas about passive females and heroic male" are thus further imposed on the "personalities of gametes" (Martin 1991: 500)\footnote{In this scientific construct loaded with cultural meanings the sperm cell has been depicted as "active, "forceful", and "self-propelled". With these aggressive "maleness" the sperm is capable to "burrow through the egg coat" and "penetrate" the egg and "activate[s] the developmental program". The egg cell on the other hand is depicted in passive language that is "transported", "swept", "assaulted" and "penetrated" and fertilized by the sperm (Martin 1991:489-490). The ovum is portrayed as the one waiting in the darkness of fallopian tube to be conquered, won over, rescued and made worthy as otherwise it will degenerate and will be wasted (Martin 1991). Female reproductive processes have been consistently painted in negative light (Martin 1991). Sperm production is seen as an active process as it continues from puberty to senescence (Martin 1991) while egg production is seen as passive, 'inferior' wasteful as it is completed at birth. Though men also 'waste' almost one trillion sperm for every baby produced, this is not seen to be wasteful (Martin 1991). This biological construction becomes the basis on which the edifice of gender roles gets erected. In the same way egg and sperm have been cast with gender imageries so are clitoris and penis. Moore and Clarke in their analysis of Clitoral Conventions and transgression through analysis of anatomical texts from 1900 to 1991 show that clitoris (if it was at all mentioned and not totally omitted) was illustrated in passive terms and was designated no importance while penis was viewed as active and dynamic (1995: 266).}\footnote{He opines that this new concept gave fixity and rigidity to biological constructs which were fluid and transformable prior to 18\textsuperscript{th} century (Laqueur 1986). Laqueur points out, "for two millennia the organ that by the early nineteenth had become virtually a synecdoche for women had no name of its own" (1986:2). However, once this happened femininity started to become treated as revolving around their ovary as Laqueur cites French physician who says, "it is only because of the ovary that woman is what she is" (Laqueur 1986: 27). Once there was visibility of ova and women's sole existence was based on her ovary and womb, the next logical deduction was to paint a picture of passive ova and active sperm (Martin 1991, Konrad 1998) on which was erected the 'superstructure' of passive femininity and active masculinity. Carrying forward this argument of gendered images in science, Petchesky (1994) infers that in the obstetrical imagining and visual culture, the foetus is not only "already a baby" but also a "baby man...an autonomous, atomized mini-space hero"(1994: 407).} Here the provider is closer to Laqueur (1986)\footnote{He opines that this new concept gave fixity and rigidity to biological constructs which were fluid and transformable prior to 18\textsuperscript{th} century (Laqueur 1986). Laqueur points out, "for two millennia the organ that by the early nineteenth had become virtually a synecdoche for women had no name of its own" (1986:2). However, once this happened femininity started to become treated as revolving around their ovary as Laqueur cites French physician who says, "it is only because of the ovary that woman is what she is" (Laqueur 1986: 27). Once there was visibility of ova and women's sole existence was based on her ovary and womb, the next logical deduction was to paint a picture of passive ova and active sperm (Martin 1991, Konrad 1998) on which was erected the 'superstructure' of passive femininity and active masculinity. Carrying forward this argument of gendered images in science, Petchesky (1994) infers that in the obstetrical imagining and visual culture, the foetus is not only "already a baby" but also a "baby man...an autonomous, atomized mini-space hero"(1994: 407).} who traces that the two-sex model based on aggressive sperm and passive ova in turn forms the basis of notions of masculinity and femininity. This inherent link between biology being the ground for social construction which has been debased over and over again in the theoretical formulations once more gets deeply embedded in the provider's understanding of biology and emergence of social roles. Dr. Ghosh-Dastidar almost echoes McClung who using a "courtship" analogy stated that the "egg is able to attract menstrual fluid; but, as it is, because she has the latter she has not the former" (GA 727.a 27-30 cited in Tuana 1988: 36).
that form of spermatozoon which will produce an individual of the sex most desirable to the welfare of the species” (1901, cited in Beldecos et al 1988: 63). Dr. Ghosh-Dastidar further develops his argument on the same basic principle of an explicit ‘gender-laden’ correlation of the germ cell emitting same characteristic as that of the man or woman54. These imageries and illustrations are imbibed with notion of active maleness and passive femaleness. This highlights not only gender but sex in itself is a social construct rather than being untenable and fixed (Gilbert 1985, cited in Beldecos et al 1988). The defense of the tenet of male supremacy become a case in study of how gender/science (Keller 1995) system shapes the objective scientific understanding and that these biases continued to be ingrained in the “fabric of science” (Tuana 1988: 57) as late as twenty-first century. Scientific facts thus far from being true are crafted in patriarchal mode (Martin 1991) and are “culturally impregnated55” (Lundin 2000: 143).

In this sense the term “genetic engineering (like ‘reproductive technology’) is a masculine metaphor appropriating the role of procreation to technology” (Bedecos et al 1988:69). The entire field of assisted reproductive technologies is laden with gender metaphors and operates within a gender normative framework. Thus though we speak of engineering of family values and relationships, such enterprises are not built in vaccuum but use the dominant gender ideology as the building block. This is evident at all levels be it treatment seekers, their family members, medical practitioners, guideline makers or scientific theorization. This makes Haraway claim, “genetic engineering ... is a science fiction expression suggesting the triumph of the phallogocentric lust to recreate the world without the intermediary of fleshy women’s bodies”(1984, cited in Beldecos et al 1988:69).

54 Similar to Dr. Ghosh-Dastidar, McClung opines, “the ovum determines which sort of sperm shall be allowed entrance into the egg substance. In this we see the extension, to its ultimate limit, of the well-known role of selection on the part of the female organism. The ovum is thus placed in a delicate adjustment with regard to the surrounding conditions and reacts in a way to best subserve the interests of the species. To it come two forms spermatozoa from which selection is made in response to environmental necessities. Adverse conditions demand a preponderance of males, unusually favourable conditions induce an excess of females, while normal environments apportion an approximately equal representation of the sexes” (McClung 1902: 76, cited in Beldecos et al 1988: 63).

55 However, by re-looking at the gynecological and specialized texts Lundin opines it is “difficult to find a gender determined way of thinking about reproduction” though it seems to exist “in elusive ways” in doctor-patient interaction (Lundin 2000).