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Understanding Practices around Infertility in Punjab

Introduction

Reproduction, both biological and social, is an important activity in every society usually related with structures of family and kinship. With each member of a society lies the responsibility for facilitating this cyclical process of birth and continuation of the community and family. Fertility, thus, has a very important role to play.

In India also, there is a great emphasis on fertility among men and women. However, it is fertility of a particular kind as there is a strong son preference. In fact, as Paul Hershman (1977) points out, in Punjabi kinship, the transition of a woman from her natal to her marital home begins with her becoming a wife but is cemented only upon becoming a mother, specifically mother of a son. So, along with a desire for procreation and emphasis on fertility, there are strong cultural practices and norms determined by the prevalent patriarchal system in North-West India.

In effect, infertility is a matter of grave concern, usually associated with the woman and a range of practices are employed to deal with it. With the coming in of the reproductive technologies, infertility is being addressed but alongside, social relationships are changing. This can be clearly seen in arrangements that involve 'others' such as surrogates or gamete donors in the reproduction process. Here, the solidity of the biological is being challenged and ideas of relatedness that play a fundamental role in determining relationships, specifically parenthood, are undergoing transformations (Pande 2009*a* & *b,* Ragone 1994, Thompson 2001).

On the other hand, these technologies are being used in specific cultural contexts and just as any commodity in the market is influenced by the cultural norms and practices, so are these. For example, as Susan Kahn (2000) showed in her ethnographic work on Assisted Reproductive Technologies and Techniques (ARTs) in Israel, the selection of the sperm donor is carried out keeping in mind concerns of race, religion and physical features.

Another aspect that needs to be considered in the introduction of ARTs in today's globalised market is how it permits transactions to take place among people from different parts of the world. It was quite easy for India, with its advanced medical care and specialised professionals, providing services and facilitating arrangements such as surrogacy, at

significantly cheaper rates (almost one-tenth, Sengupta, 2010) to become a preferred hub in the medical tourism world market. In India, the surrogacy business alone is estimated at $445 million (ibid) and expanding rapidly.

Keeping these various factors in mind that are influencing the exchange and use of the ARTs, it is important to undertake a detailed study of their usage in the Indian society. India is in a disadvantaged position as these technologies also possess great possibilities for exploitation especially since there are no laws that are governing their functioning. The current ART (Regulation) Bill 2010 is under discussion and it is oriented towards creating a conducive environment for medical tourism, often at the expense of vulnerable sections of India's population such as women with financial difficulties who agree to act as donors and/or surrogates (Bhangu 2010, Sama 2010).

It was with such an understanding of the situation in Indian society with regard to infertility that I decided to conduct a study of couples dealing with infertility in Punjab. Initial focus was on infertile couples engaged in surrogacy arrangements but it later developed to include the other strategies that couples dealing with infertility employed.

Choosing the Field Site

In choosing Patiala, an important reason was a desire to understand the workings of the Reproductive Technologies market in a town and not a metropolitan city. This helped in investigating the penetration of this specialized and fast growing market in the Indian society, and especially, in providing a different view from the major cities. For example, Chandigarh, just 65kms from Patiala, showed a highly evolved reproductive technology market- traces of which are only beginning to surface in Patiala.

Related with this was the concern about gaining access for conducting research work in a highly sensitive area. In this regard, Patiala, my mother’s home town proved to be an excellent choice as I was able to trace members of the medical profession through personal networks.

Another reason for focusing on Patiala, was the issue of logistics- financial and time constraints within which I had to work. Rather than spreading my research work out over a larger area, I limited myself to Patiala so that a more detailed understanding may be reached of couples dealing with infertility here.

Within Patiala also, I had to identify the various sites where I wanted to focus my field work. For their determination I returned to my research questions- To try and understand the social use of surrogacy as a technique for reproduction. More specifically, how couples arrived at and navigated through this process? And which choices led them to and facilitated the use of surrogacy as a technique of reproduction?

Very early in my fieldwork, I discovered that use of surrogacy and other emerging reproductive technologies was limited in Patiala, almost absent. In fact, there were no clinics or hospitals that dealt exclusively with the treatment of infertility. But this was not due to a shortage in cases of infertility as out of the 169 patients that visited a gynecologist I sat in with, 45 % were those directly or indirectly related to infertility (such as cases of infections, hormonal disturbances, etc.). Therefore, in dealing with infertility, a different set of practices were employed. As I focused on these alternative practices, I was guided into different field sites aided by the feedback and answers to my inquiries. And as I chose Patiala because of its non-metropolitan nature, the absence of specialised centres proved to be an important avenue for understanding the availability of the ARTs, and their interaction with the social networks and systems.

By the end of my field work, I had visited an urban civil dispensary (DK), an adjacent village civil dispensary (SL), a multi-specialty private hospital (Anand Hospital), two private clinics (Gill Maternity Nursing Home and Clinic & Aradhna Infertility Clinic) and a government hospital (Rajindra Hospital) in Patiala. Apart from these I also met with a doctor running an IVF clinic in Chandigarh (Jayati IVF Clinic). Amongst the three private clinics/hospitals and at the government hospital, I interacted with the doctors (gynecologists) and other medical personnel. I sat in with the gynecologist at the Anand Hospital (AG) as a silent observer for a week as she dealt with patients, while at the Rajindra Hospital I was granted access to speak with the patients dealing with infertility after they had met with the doctors. As a result, I also had the opportunity to observe the workings of the government and private hospitals and the differences in the medical practices.

In these sites, I was able to meet with people from various sections of the society, especially members from different class positions. The ways in which these individuals, couples and families dealt with infertility showed multiple variations which I shall elaborate upon later but it is important to add that this diversity has been critical in shaping my understanding of

the Punjabi society and its people in matters related with position of women, reproduction, kinship, and of course, infertility.

'Infertile' Couples

As discussed earlier, there is an emphasis on fertility and a desire for procreation. This leads to severe stigmatisation in cases of infertility, especially of women. But how is infertility established? This isn't a straightforward answer about absence of children because among others, there are considerations about how long the couple has been married, whether they live together or not, and more importantly, who is infertility identified with? And the answers to all of these questions vary. Even the medical domain while at the surface level defines infertility as the failure to achieve conception after one year of trying, in practice, there are multiple variations. For example, secondary infertility (couples unable to conceive after a pregnancy), cases in which conception is achieved but the woman is unable to carry the pregnancy to term and so on. In the end the identification of infertile couples was carried out by the doctors at the various sites as all couples with difficulties in conceiving and carrying a pregnancy to term. The couples and women that were visiting the gynecologists both at Rajindra and Anand Hospitals, showed a varied age range- from late teens to early forties. Most of them had been undergoing treatment for long durations, in some cases 13-14 years. But there was also a significant number of extremely young couples, married for only a few months, who were reporting infertility as their medical problem to the gynecologists.

It is interesting to note that during my stay in Patiala, the term for male infertility- 'Nipunsak' was never mentioned. The statements sometimes included the word 'problem' and in very unclear terms. At most, one lady commented, “Ho sakda hai, unha vich problem hove. Eh mainu doctor ne keha hai.” (“The problem may be in him. Thats what the doctor told me.”) This shows an interesting play of words. There is no clear accusation and yet an attempt to include within the circle of infertility blame. Even in the hospitals, the advertising posters and in the societal discourse, in translation, the word for infertility was always 'Baanchpan' (term for female infertility). As a result, infertility was viewed predominantly as a woman's problem in the social sphere. This was not a result of ignorance about male factor infertility but a reflection of the automatic associations about fertility, childbirth and childcare with women.

Dealing with Infertility

Once infertility is established, and the decision to address it has been reached, families choose between 'treatment' or adopting a range of other strategies to deal with it. The latter I shall club under the term alternative practices. The phenomena today is a combination of both, usually treatment is attempted first and if it fails, then the alternative practices are adopted.

Alternative Practices

The alternative practices, not in order of preference, include familial adoption, polygyny (a man with more than one wife) and dissolution of marriage to remarry (done by sending a wife back to her natal home). These have been around for a significant period of time and were usually adopted in cases of infertility prior to the coming in of medical practices to deal with it.

- Familial Adoption: In this, an infertile couple adopts a child born within either of their kinship networks. Concerns about relatedness are thus combated as the child is seen a part of the same family. In this, both girls and boys are adopted and there isn't a clear gender divide. However, there is a tendency to adopt more than one child if the first adopted was a girl. Sometimes these arrangements are made prior to the birth of the child, i.e., during the pregnancy while at other times, it may happen years after birth. But there is a preference of adopting children less than a year old. These arrangements may be mediated by members of the kin group or directly set-up by the couples.

  The couples giving their children up for adoption used similar ambiguous arguments as those used by the surrogates in Gujarat as reported in Amrita Pande's (2009*b*) work. Both stressed relatedness with the children and at the same time recognised that giving them away was inevitable.

  While on the one hand, the discourse emphasized relatedness with statements like, “Main jeh aapna bachcha ohna nu de vi dendi haan tan oh mera hona bund tan nahi ho javega. Vaise vi eh gair thodi ne?” (Even if I give my child away to them, the fact that he is my child will not change. Anyway, these people are not strangers. They are also family), on the other it brought up issues of duty, responsibility and concern as can be seen in the following statement- “Eh farz

di gal hai. Ehna ne hi tan mera sari umar dhyan rakhya hai. Ehna de dukh de same vich main aina nu kiddan chad davan? Bachcheyan bigair, mere bhra nu sukh kiddan milu?" (This is a matter of duty. They are the ones who have looked after me all my life. How can I leave them in their time of need? Without children, how will my brother ever find peace?).

This practice of familial adoption highlights some interesting aspects of the operation of the kin groups. But it is important to note that familial adoptions are not always to deal with infertility. Another cause may be an attempt to provide support to a family. For example: Reena, was adopted by her mother's parents because she was part of a family of seven children (five girls and two boys) and she was then brought up by her grandparents along with her maternal uncle.

- Dissolution of marriage and re-marrying: Upon failure to conceive, this practice involves extreme stigmatisation of the woman accompanied with a symbolic breaking of marital ties. This occurs by asking a woman or forcing a woman to go back to her natal home which is seen as a dissolution of the marriage and is followed by a second marriage by the man. The legal ambiguities are often unrecognised and ignored as a result of which a divorce is not applied for. In my fieldwork, I did not see this strategy in practice though it was frequently reported. It was more commonly used as a threat against women to pressurise them into achieving conception. This emphasis on fertility and its association solely with the woman is indicative of the prevalent patriarchal norms and also, the established identity of women as mothers.

- Polygyny: This practice is different from the older practice of polygyny in which it was the norm for a man to take on more than one wife. This norm has weakened and it is no longer a common practice. Instead, this is used as a strategy to deal with infertility. The impetus for entering into these marriages is a desire for progeny and to address the problem of infertility. From a legal point of view, there is no difference between the practice of dissolution of a marriage and polygyny as both involve taking on second wives. But in practice and discourse, these are viewed as two separate phenomenon. This is because

in polygynous arrangements there is an element of co-residence. The man and his wives live in the same house.

The polygynous arrangement is entered with or without the consensus of the first wife. Frequently, however, the first wife actively participates in this process. She chooses the second wife, commonly from within or through her kinship networks and while she may not participate in the wedding ceremony, she is there to receive the couple when they enter the home. By becoming a part of this arrangement, the first wife cements her position in the home. In cases of pregnancy, she is also socially recognised as a mother. However, the dynamics of the relationships between the three are not discussed.

This addressal of infertility can be seen as a form of traditional surrogacy which involves bringing in a surrogate through the institution of marriage so that the surrogate as well as the children born of this union are legitimate. This is discussed further when the commercial surrogacy arrangements are looked at.

Infertility 'Treatment'- An Intersection of the Medical and Social

Treatment for infertility may operate at various levels. It may be the village vaid, the dai, the doctor at the civil dispensary, an ayurvedic or homeopathic doctor, or a gynecologist. In India, the availability of medical treatments is across a spectrum. In fact, the definition of medical itself varies. In this study, the focus was only on the gynecologists. Despite multiplicity in treatment options, the procedures for accessing treatment for infertility are highly consistent and well established. In all cases, it is the women who are taken for a check-up first and in many cases, it is only the women who undergo treatment. Also, these women are always accompanied by someone for their visit to the gynecologist, frequently the husband, or the mother-in-law. Here, we face a contradiction. We have established that there is a prevalent structural bias against women. Infertility is predominantly associated with them and therefore, the treatment procedure begins with taking her to the doctor. As a result, the point of accessing treatment for infertility is the gynecologist. The contradiction, then, is in the absence of gender neutral infertility specialists whom these couples may approach. Because of this absence, the focus is on the woman, the concerns are about her 'baanchpan' (infertility) and for this treatment is by the 'lady's doctor'. Also, the

training of the gynecologist orients her (as it is usually a woman) towards examining the female body so that is where she usually beings her procedures of diagnosis, testing and treatment. This may be because infertility is seen as an inherent contradiction of the concerns of the gynecologist. She is the medical expert for assisting conception, monitoring pregnancies, delivering the babies and is even involved in antenatal care- in short, she is the medical manager of a woman's reproductive capability.

The medical field is thus, also facilitating the social biases. There is a growing trend of involving men in treatment of infertility and interestingly, these begin with the gynecologist. She usually arranges for testing and consultations for male factor infertility. But for such practices to continue, there must be a code of conduct that is not oriented towards profit making and this is in sharp contrast with the economic considerations and desires of many private clinics and hospitals.

Another aspect of the interaction between the gynecologist and the infertile couples is the series of choices that come up. Each of these is instrumental in shaping the course of the treatment. And it is here again, that the position of the gynecologist becomes very important. It is the type of choices that are suggested and the decisions that are made by the gynecologist that highlight the differences in the styles of medical practice. This begins with the testing and diagnosis stages and operates through treatment.

- Testing for Infertility: Beginning with testing, there are various decisions that need to be made. Who is to be tested first? When is the right time to begin testing for infertility?

  According to the doctor at Gill Nursing Home, when a couple approaches her for ‘infertility’ treatment, she begins by conducting tests on the woman and on failure to identify any cause of infertility in the woman, she asks the man to undergo testing. On the other hand, the doctor at Anand Hospital, begins by getting the husband tested first as male infertility may be determined through one test that checks for sperm count. For women, the determination of infertility is across a spectrum and requires a battery of tests and examinations

to be conducted. The other doctors at Rajindra Hospital and also at Aradhna Clinic ask both the husband and wife to be tested right at the beginning.

This testing process is not so straightforward. It offers various choices, for example, there are two tests for identifying presence of TB and between the two there is a vast difference of money but also reliability. One priced at Rs. 100 is often not conclusive while a piece test priced at Rs. 4000 offers conclusive results. Not all doctors give the couples a choice in which test they want conducted first. Most push them into getting the more expensive test directly.

The system of getting cuts for medical tests that a doctor prescribes is well established and openly acknowledged by all other than the doctors. The doctors frequently tie up with a pathology lab and ultrasound centres and a large part of their income is through these arrangements. A similar tie-up but not so openly recognised, is the doctor-medicine brand relationship, in which the doctors receive cuts by prescribing certain brands of medicines over others.

Apart from the testing for infertility, there were great variations also in the manner in which reports were presented and discussed. And here, I don't think it was a matter of ethical and unethical practices but one that is operating in a gray zone. For example: Other than the doctor at Anand Hospital, all doctors irrespective of the test results would say that there are elements of infertility in both the man and the woman. The doctor at Anand would state the matter as indicated by the tests. This may be seen as problematic in some regards as the existing structural biases against women would worsen the situation if even the doctor were to state the cause of infertility as rooted in the woman. Also, how do you proceed in treatment if the the infertile partner is not identified and treated. It is here that further complications are seen, especially when decisions about involving donors arise.

- Treatment Process and its Options: Once the cause of infertility is identified, the various causes open up a range of treatment options. While among women, infertility may be caused due to a variety of reasons, those due to infections are prevalent, among men infertility was reported as rising by the doctors.

Reasons stated for the latter included drug addictions, unhealthy lifestyles and environmental factors.

As a result, the treatment processes are made up of diverse practices. Which medicines are administered? Are there side-effects ever discussed? And most, importantly, are couples ever presented with the options that the doctors come across?

For Example: Zendol is a drug commonly administered on women with infertility but this drug is known to upset the hormone levels increasing facial hair and even changing the pitch of a woman's voice. These are permanent changes that may have long term impacts on the woman. Compared to infertility, some doctors reason that these side-effects are minor. As a result, they rarely inform the patients about these impacts. Of course, they are never presented with the alternatives. This may appear to be a small concern however, it shows the attitude of the doctors in taking decisions on behalf of the patients and the fact that they don't consider it a right of the patient to know what the medicines being prescribed are doing to her body.

- Persistent Infertility- Involving Donors and Surrogates: If infertility remains unresolved despite adopting various treatments, it usually leads to a stage where the couples exercise the alternative strategies or use assisted reproductive technologies such as Artificial Insemination (AI), Donor Insemination (DI), In-vitro Fertilisation (IVF), surrogacy and so on. The nature of the alternative practices have already been discussed. As I have already stated, there are no clinics or hospitals that deal exclusively with the treatment of infertility in Patiala. Even the sperm bank is not very old. It has been around for approximately 5-8 years and yet, it is not a collection centre. This sperm bank purchases donor samples from other centres outside Patiala.

  At the level of the discourse around relatedness, these technologies that involve participation of 'others' such as donors of sperm and egg, and surrogates in the process of reproduction pose a challenge in determination of parenthood. This is faced because of the fragmentation of biological processes

and in turn, relatedness ideas associated with different stages of reproduction such as conception, gestation and parturition.

In Patiala, techniques such as IVF and IUI are not available. During my fieldwork, I came across a number of cases of AI and DI, and a few cases of surrogacy also.

Artificial and Donor Insemination- Artificial insemination has been available in Patiala since the late 1980s. It is the process by which sperm is placed into the reproductive tract of a female for the purpose of impregnating the female without the sexual act. It is quite commonly reported and as the process of reproduction is limited to the couple, it is not associated with any stigma. It also is easier to maintain secrecy in a matter like this when no 'others' are involved.

Donor insemination, on the other hand, has been available in Patiala for the last 8-10 years, i.e., since the sperm bank has been set up. In this the sperm that is used for impregnation is not that of the husband. There was no clear trend regarding the preference for a donor between a known person, usually, a family member or an anonymous one. For anonymous donors, very little information was provided. It included the age, height, weight, eye and hair colour, and some information about medical fitness such as HIV, etc. Sometimes, the person's religion was also stated but no information about caste was ever provided. All the doctors reported being asked for a son. The couples believed that the interference of medicine in the process of reproduction would include the possibility of manipulating the sex of the child. Another request that was predominant was fairness. Couples tend to select donors who were fair. This occurred even in cases when the parents were not. The doctors discouraged couples from this and argued that “Bachcha tuhade vang dikhna chahida hai” (The child should look like you).

Other than the appearance, there were other, more serious manipulations that were occurring. A number of cases of donor insemination were presented to the women being impregnated as cases of artificial insemination. The woman believed that the child she was conceiving was that fathered by her husband while this was not the case. Sometimes, the donor was anonymous but more

frequently, the donor was a family member such as the father or brother of the infertile man. There were even cases in which distant relatives or friends were asked to act as donors. In such a scenario, claims of relatedness are more important for the intending father to establish rather than the unaware mother. It is reasoned that relatedness becomes easier when the donors are members of the family. The decision for such cases of DI/AI was usually taken by the husband and members of his family, namely, parents and siblings. This may be a result of viewing the wife/daughter-in-law as an outsider and not an established member of the family and with a desire to hide the infertility of the son. This practice was reported as normal by the doctor at Gill Maternity Clinic and as a practice that was commonly requested but not encouraged at the Aradhna clinic. The doctor at Aradhna insisted that the woman be informed as she believed it was the right of the woman to know. But the doctor at Gill Maternity Clinic, argued that if the daughters-in-law come to know about their husband's infertility, then their attitude changes and it leads to conflict in the homes.

Another concern with donor insemination is the vast discrepancy in the cost of the procedures. The sperm sample in Patiala costs Rs. 600 while in the Jayati IVF Centre in Chandigarh, it was closer to Rs. 1000. But the actual procedure of inseminating is where the cost differences lie. In Chandigarh, the procedure costs Rs. 3000, in the private clinics in Patiala it is approximately Rs. 1000-1500, and in the government hospital- Rajindra hospital, the procedure is free. This is just one example of the kind of price variations in the same market space and for the same facilities. It applies to other procedures and treatments also.

A similar case of exploitation involving donor insemination can be seen in the following example. As I have already stated, Tuberculosis (TB) is a common cause of infertility in Patiala. It creates difficulties in conception and if it occurs, then it is rare that a pregnancy may be carried to term, miscarriages are common.

While I was at Anand Hospital, a couple came reportedly undergoing infertility treatment in their hometown, Rajpura, approximately 20 kms away

from Patiala. They had come to get a second opinion. Infertility had already been identified in the husband and so the couple had opted for donor insemination. The wife had undergone two rounds of donor insemination and had failed to conceive. She was currently on her third cycle. As the doctor looked through their reports, she saw that the woman had been diagnosed with TB a year ago. When she asked the woman if her TB treatment (which lasts approximately 9-10 months) was complete, the woman said that their doctor had assured them that TB is unrelated with fertility. This manipulation of information had resulted in two painful and emotionally draining cycles of Donor Insemination (each cycle is accompanied with numerous hormonal changes and variations).

The workings of the medical and social domain intersect in all treatment styles and practices. But the operation of the economic, as this example shows us, can never be undermined. Once again, the example used here is that of a process of donor insemination, but similar reports were found in cases of artificial insemination also.

Surrogacy- Surrogacy is a term applied to a practice in which an infertile woman or couple, approach another woman to assist in the process of reproduction by carrying a pregnancy to term. This practice is frequently referred to as the ‘hiring of a womb’. Surrogacy arrangements may be of different types. In traditional surrogacy, the ova or the egg of the surrogate combines with the sperm of the intending husband and frequently, this occurs with sexual intercourse. In gestational surrogacy, the egg of the surrogate is not used and the implantation of the fertilized egg (which may be that of the intending mother or a donor) occurs through the process of in-vitro fertilization. While the sexual act is thereby removed from the process of reproduction, the participation of the surrogate’s genetic material is may or may not be. This absence or participation of the surrogate's genetic material is viewed in relation with claims of relatedness. It is on the basis of this that parenthood is established. If the genetic material of the surrogate is prevented from participating in the pregnancy and only her womb is rented then this arrangement becomes similar to any other economic transaction in which a

service is rendered and a price paid. Also, it encourages a disconnect between the surrogate and the child and similarly, between the surrogate and the 'intending' couple, thus, freeing them from any legal accountability or responsibility towards the surrogate. Such a practice allows for two occurrences- first, establishment of a relationship between the surrogate and child is prevented which in turn facilitates the claims of relatedness by the parents. And second, the easy termination of this surrogacy arrangement is made possible. These are both appealing factors for entering into surrogacy contracts.

The contrasts between these new commercial surrogacy cases and the earlier practice of polygynous arrangements are interesting. In the first, the relationship with the surrogate is an economic one, it lasts for a short duration of time and terminates at the moment of handing over the child to the couple. At the same time it is marked with an end in the relationship of the surrogate to the child. The price paid to the surrogate varies and is considered a fair transaction in exchange for renting her womb. She is not looked at as the provider of a child but as one that facilitated the process. Very often, her genetic material is prevented from participating and the process does not involve the sexual act. In contrast, in the polygynous arrangement, the relationship with the surrogate is a life-long one as she becomes a part of the family as the second wife. In place of termination of contract, the birth of a child firmly situates the second wife/surrogate in her marital home. She is looked at as the provider of the child, her genetic material is a part of the reproduction process and it involves the sexual act.

In the absence of procedures like IVF, the cases of commercial surrogacy involved the genetic material of the surrogate but conception had been achieved through artificial insemination and not, the sexual act. I came across two such cases. In the first case, the intending mother and the surrogate were best friends. They referred to each other as ‘sisters’ and continually stressed on the similarities and connections between them. Both were married and employed.

In the second case, the surrogate had been recruited by the intending mother and brought to the doctor merely for the process of artificial insemination and following check-ups. Apart from her husband, the doctor and the surrogate, no one else was aware of this arrangement. The woman had told everyone else that she was pregnant. Her name appeared as the patient name for all appointments at the doctor's clinic, tests and procedures which were in reality conducted on the surrogate. She had succeeded in completely erasing any record of the role of the surrogate as the mother of her child. The intending mother had thus legally and on record established her identity as the mother. This easy manipulation of records is truly worrisome.

In the absence of medical guidelines and laws to monitor such practices, there are many avenues of exploitation. The recruited surrogate is the most vulnerable. She may be present under threat, blackmail or even lure of money but no guarantees or avenues for protection. Even in cases with legal contracts, they are usually in English, a language foreign to the surrogates. Its explanation is provided by the medical practitioner which a surrogate has no way of verifying.

For non-traditional and not artificially inseminated cases, couples go to Chandigarh for further treatment around surrogacy.

Infertility 'Treatments' Outside Patiala- Continuities and Discontinuities

For more advanced treatments, patients visit Chandigarh. Procedures such as IVF and IUI are commonly performed. The IVF clinic that I visited here claims to be the first in Punjab offering oocyte donations and also surrogates. The doctor had recruited approximately thirty women who acted as egg donors and/or surrogates. Most of her customers were NRIs or foreigners of Indian origin living abroad. Amongst her patients, couples came from Canada, Dubai, United States of America and United Kingdom. In each surrogacy arrangement she charged approximately five and a half lakh rupees of which Rs. 2-3 lakhs was given to the surrogate and a fee of Rs. 20,000 to a lawyer for drawing up the legal documents. She worked with an interesting set of criteria in selection of surrogates while the intending couple did not have to fulfill any criteria, other than financial capability. There were a number of similarities in the criteria followed by the gynecologist here in Jayati, Chandigarh and the one in who

has been studied by Amrita Pande in her article, ‘Not an Angel, Not a Whore’. These criteria clearly feed the interest of the intending parents rather than the surrogate. They are oriented towards economic gains and expanding the reproductive tourism market even if it involves exploitation of the surrogates.

1. A woman may act as a surrogate only if she is above 21 years of age and under 35years.
2. She must have her ‘own’ children,
3. undergo thorough medical investigation so as to determine her suitability as a surrogate and by implication a healthy reproductive body/machine, and most interestingly,
4. She must provide her husband’s consent.

This is a clear manifestation of an underlying ideological belief that privileges a man with a right to a woman's sexuality and reproductive capacity. As an adult woman may not act as a surrogate without the consent of her husband, her reproductive labour is by implication the property of or under the control of her husband. She must undergo physical examinations to determine her biological and reproductive suitability but an intending couple need not undergo any examinations for assessing their suitability in becoming parents. She must have her own children so that she will not stress on relatedness with the child that she gives birth to and thus assist in making the process of transfer of child from the surrogate to the intending couple smooth.

On the other hand the emotional attachment with her children is often stressed upon to push a woman into acting as as surrogate. Some of these criteria that determine who can be a surrogate can be found in the ART (Regulation) Bill Draft 2010 also.

These new arrangement and the older practices such as familial adoption and polygyny indicate distinct variations as well as continuities. All of these strategies are ways of dealing with the stigma of infertility by realising the desire for progeny. But at the same time, the strategies are changing from life long settlements such as polygyny, and remarriages to short term ones like a surrogacy arrangement. The possibility of buying or renting a woman's reproductive labour or purchasing sperm samples are becoming a part of the social practices

as availability and awareness about these spreads. A space for contractual arrangements has thus been created in the domain of reproduction that has made reproductive capacity a saleable commodity. As a result, understanding of body are beginning to transform as the body is viewed in its fragments and manipulation of reproduction becomes possible. Thus, definitions of body and commodification take on completely new meanings as these basic assumptions in the economic (what is a saleable commodity?, what is the value of a woman acting as a surrogate?), familial (how do you understand relatedness?), and reproductive domains (the various new arrangements that have arisen) change.

Role of Kinship

An important aspect that comes into play in all these strategies both of alternative practices and those clubbed under the term 'treatment' is the role of kinship networks in facilitating these processes. Among the alternative practices, familial adoption relies solely and directly on kinship networks. Though unclear, even in polygynous arrangements and remarriages kinship has a role to play as tracing of these women who become the second wives is through this network. Usually, it is through the kinship network of the man looking for second wives but when a first wife participates in establishing a polygynous arrangement, even she makes use of her kin group to trace a woman who may become her husband's second wife. This, as discussed earlier, is the attempt of the first wife to cement her position in her marital home and also, to be able to claim rights to the children so born.

On the other end, with the emerging forms of surrogacy and infertility treatments, the importance and role of kinship networks is not seen to diminish. In selecting the doctor they intend to get treatment for infertility from, patients chose doctors that were recommended to them through their kin networks. It is important to note that kinship networks may imply distant relatives even those with whom a person has not interacted except on occasions such as marriage and death. These ties are often stressed upon in the working relationship with the doctor also. Patient stress on the points of contact with the doctor which can be seen as an attempt at normalising the discussion of an issue such as infertility with an outsider, especially since it carries a stigma with it.

In effect, the kin group continues to play a very important role in practices dealing with infertility in Punjab despite transformations in the nature of their participation.

Concluding Remarks

Here, I have attempted to present the cultural context in which the reproductive technologies are accessed in Punjab. More importantly, the practices dealing with infertility have been addressed and while doing so, the prevalent ideas around them are also discussed. Questions such as- How are these justified? Why are these processes seen as coherent practices?, have been addressed. This has been done by tracing the spectrum of choices available to the infertile couples.

While looking at these choices, various practices of the medical domain have also been addressed, especially in the manner in which they interact with the social. And also, the role of the kinship networks has also been traced out.

It is important to note that infertility is a very secretive phenomena. It is prevalent but hidden. Accessing cases of infertility require time and patience. As a result, a one month research project is able to see only certain phenomena and at perhaps, only the surface level. Only a longer study would allow us to conclude the validity of these observations.

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