

Assisted Reproductive Technologies and its Gender Implications with Special Reference to the Middle Class in Guwahati, Assam

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Abstract:- *An examination of women's health from a feminist perspective is crucial in the understanding of gender relations in a society. The expansion of medical technologies has ushered in wide scale medical intervention in the area of reproduction, particularly in assisting reproduction with the use of technologies. It is imperative to examine the relationship between reproductive technologies and women as the relationship is mediated by gender and other axes of power like class caste religion sexuality etc. The need to address this issue arises from the fact that the development, consolidation and proliferation of ARTs as a distinct group of procedures is posited as designed to assist conception by circumventing and correcting infertility and propelled by the understanding that infertile women would do anything to be pregnant and become 'whole'. Coupled with it is the fact that the nexus between the global capital and the patriarchal social order has laid a fertile ground for the proliferation of ARTs by creating a trans-national market for it. Thus complicating choices for women and making it further difficult to challenge patriarchal norms of motherhood and care. The paper attempts to examine this nexus by looking into the reproductive choices made by middle class men and women with regard to their decisions to avail ARTs and to determine if such choices lead to emancipation or further coercion.*

Keywords:- *Gender, Infertility, Middle class, Motherhood, Reproductive Technology.*

Recent years have seen the expansion of medical profession and medical technology into new areas of women's health. Such a development has not gone unnoticed by feminist who view these expansions with suspicion and not without reason. Feminism has historically provided the major challenge to normative conceptions about health and the body, reciprocally the issue of health has been a crucial vehicle for the development of feminist theory dating back to at least the eighteenth century (Annandale, 2009). As Ellen Lewin and Virginia Olesen explains that an examination of health is revealing of such elements of culture and society which has a direct bearing on the construction of gender and its consequences for women, men and the larger social order (Lewin, 1985). The statement although made twenty years earlier in the context of western societies, yet it is to a large extent applicable even today for South Asian particularly Indian society. An examination of women's health from a feminist perspective is therefore crucial in the understanding of gender relations in a society.

In India the concern for women's health has seen a sharp rise particularly after the International community acknowledged it as an area of major concern for development. The programme of Action adopted by 176 countries in the UN Cairo Conference in 1994 saw for the first time, the reproductive and sexual health and rights of women become a central element in an international agreement on population and development (Mathur, 2008). Although Women's health became an area of concern, reproduction as a site of enquiry within the social sciences had emerged late as historically it had always remained within the domain of biological sciences. The rise of the International Women's movement and within that the women's health movement coterminous with the growth and transformation in Medical Anthropological research was crucial in the rekindling of social scientists' and feminists' interest in women's reproductive health and in destabilising the notion of reproduction as purely biological and familial (Rapp, 2001).

The foray that technology has made into reproductive processes of humans has succeeded in multiplying this research interest manifold particularly in the field of Assisted Reproductive Technologies, which has itself proliferated by leaps and bounds. However, 'technologically assisted reproduction is not a new phenomenon. Yet, the development and consolidation of ARTs as a distinct group of procedures designed to assist conception by correcting or circumventing infertility is relatively recent' (Marwah & Sarojini N, 2011). The notion of correcting infertility with the use of ARTs has serious social implications particularly for women of traditionally inclined developing countries like India. On one hand the present globalised world has augmented the proliferation of Assisted Reproductive Technologies it has also at the same time managed to further entrench the idea of women's self realisation through motherhood, an idea central to the perpetuation of patriarchy. Incidentally globalisation has also led to the emergence of a burgeoning middle class exerting power and influence in socio-economic as well as cultural terms, although not in a homogenous manner (Ganguly-

Scrase & Scrase, 2009). It is this class that also holds the potential as consumers of Assisted Reproductive Technologies.

The present paper is an attempt to examine the reproductive choices made by middle class women and men with regard to their decision to avail the New Reproductive Technologies and to know if such choices really lead to women's emancipation. Through an examination of the proliferation of New Reproductive Technologies, and taking into account the unmistakable nexus between global capital and the patriarchal social order, the paper contends that although liberating in essence such technologies complicate choices for women by making it further difficult to challenge patriarchal norms of motherhood and care.

The paper uses the theoretical concept of Stratified Reproduction, a term that 'implicitly acknowledges both the sexual politics and the political economy of reproduction' (Agigian, 2007). Demystifying motherhood as political and socially constructed as opposed to being 'natural' and private is aimed at by adopting a stratified reproduction analysis.

The paper locates the problem in the context of Guwahati, which is an emerging metropolitan 'small town' turned 'city' in the State of Assam. The proliferation of fertility clinics in the city and the increasing footfalls in them, the presence of an upwardly mobile and increasingly bloating middle class and at the same time a society that is traditionally rooted and patriarchally compliant, provides a picture where the problem outlined above comes into sharp focus.

I. NEW REPRODUCTIVE TECHNOLOGIES: BOON OR BANE

Use of technology for purposes of reproduction initially started within the field of veterinary sciences as a measure that could not only save time but also improve food and milk production. With the expansion of the medical profession into new areas of women's health, reproductive technologies began to emerge as a solution for increasing chances of conception among women previously considered infertile, to enable them to carry a pregnancy to term. Assisted Reproductive Technologies is the term used to denote various procedures ranging from relatively simple intrauterine insemination to variants of in-vitro fertilisation and embryo transfer (IVF-ET) more commonly known as 'test-tube baby technology' (Corea, 1985). In the seventies when the technology was first used and the first test-tube baby, Louise Brown was born through the IVF technology in 1978, it was widely publicized by the media. The fact that Louise Brown has grown like any other normal child and later given birth herself at the age of 28 was the subject of many television shows in the West. However, there were resistances particularly from the religious orthodoxy who condemned it as a travesty against God. Some sociologists, biologists, feminists and philosophers too were alarmed and suspicious of the New Reproductive Technologies and considered IVF, embryo freezing, egg donation and other new developments in infertility treatment harmful and threatening to women's right to control their reproduction. Gena Corea, member of the Feminist International Network Resisting Reproductive and Genetic Engineering (FINRRAGE), said that 'the issue is not fertility. The issue is the exploitation of women'. (Corea, 1985). Most feminists whether liberal, radical or otherwise along with women health advocates have focussed on the impact of ART on women's lives, the construction of infertility and the commodification of humans through purchase and sale of human gametes, embryos and rent-a-womb surrogacy arrangements. The techniques of coercion inherent within the patriarchal system which play on women's lives when it comes to desiring children is also an underlying current in feminists discussions on the ART (Rowland, 1992) (Corea, 1985). In the West, where these technologies were initially developed, the debates surrounding the ARTs traversed the philosophical and ethical realm and were rooted in socio-cultural, political, economic and epidemiological settings, very unlike that in the Asian countries. As Imrana Qadeer points out 'While the focus of the debate there is within the human rights frame with a focus on the individual's right to reproduce, the entry of these technologies in India is justified on the basis of increasing need due to high infertility' (Qadeer, 2010). The pervasive and grave consequence of infertility in the traditional social context of developing societies is often presented as a case in favour of ARTs. As stated by Abdallah S. Daar, Zara Merali "Infertility in developing countries extends beyond the loss of human potential and *unrealized self*. The experience of infertility causes harsh, poignant and unique difficulties: economic hardship, social stigma and blame, social isolation and alienation, guilt, fear, loss of social status, helplessness and, in some cases, violence" (Daar & Merali, 2001) (emphasis added). The emotional and psychological harms associated with infertility given the WHO definition of health as overall well being is upheld to posit infertility as a substantive public health problem. Such a view summarily overlooks the social construction of infertility and the premium placed on fertility, which has serious repercussions for women's well being in many other aspects of life. The need to address the issue of social construction of infertility while at the same time addressing the issue as a public health concern is pertinent. The stigmatisation inherent with infertility also needs to be condemned by disengaging such an understanding with that of what it means to be a woman.

II. PROBLEM OF INFERTILITY AND WOMEN

Infertility and the problems resulting from it being a non- life threatening condition has not received due attention in India medically until the recent times. Although not life threatening infertility is still a life crisis, where the losses are invisible and the consequences are manifold. Infertility has been estimated to affect roughly 80 million adults of reproductive age globally (Nachtigall, 2006). In India, primary and secondary infertility figures, as given in WHO studies, are 3% and 8%, respectively (Rutstein & Shah, 2004). According to the NFHS 3 Data for 2005- 2006¹, primary infertility rate among currently married women aged 20-49 and married for above 5 years is 1.85%, whereas 2 percent of currently married women age 45-49 have never given birth (National Family Health Survey (NFHS-3), 2005–06: India: Volume I., 2007). The figures show a much higher level of secondary infertility as compared to primary infertility in India as is the characteristics of most developing countries.

Again, as in many developing countries, infertility treatment is not a part of the reproductive health services. There is no public health plan that focuses on infertility in the Indian context. Where it figures in public policy document since the ninth five-year plan of the Government of India, is only as partial redressal of the infertility problem in the National Reproductive Child Health Programme. This despite the fact that the International Conference on Population and Development (ICPD) Programme of Action states that reproductive health services should include prevention and appropriate treatment of infertility (Widge, 2002).

Besides, there have been very few studies dealing with practices of fertility particularly in relation to infertility and childlessness and its socio-cultural context and even fewer on the social implications of infertility and assisted reproduction (Widge, 2002). The fact that there is no common definition of infertility also hampers research in the area. For eg., in English demographic terminology, primary infertility is defined as the inability to bear any children either due to the inability to conceive or the inability to carry a pregnancy to term and a live birth whereas the term 'infecundity' refers to the inability to conceive after several years of exposure to the risk of pregnancy. In medical studies, however, infertility is usually defined only as the inability to conceive and most clinical studies often use a one-year period of exposure. According to World Health Organization the epidemiological definition of infertility recommended is the inability to conceive within two years of exposure to pregnancy. In demographic studies however it is common to use a period of five years of inability to conceive as the standard practice (Rutstein & Shah, 2004)

In an overpopulated country like India, it is understood that infertility has acquired very little or no significance among policy makers as well as women's groups until now. In such a scenario, technologies assisting reproduction has taken root and are available for those who can afford the treatment, although infertility itself is not class biased and affect women across class. Again, irrespective of the number or the class of women affected by infertility, the infertile woman invariably becomes an object of ridicule and a site for patriarchal exertion of power, with major socio-psychological consequences for the woman. The system of patriarchal descent, patri-local residence, patri-lineage, caste which form a part of middle class values are all responsible for the extreme importance given to fertility in the Indian society with the focus being on the woman. Traditionally womanhood in the Indian context is defined by her capacity to mother, motherhood being a rhetoric eulogised in the nationalist discourse mediated particularly in and through the middle class. Given the Indian context it is not surprising that it is the woman who has to bear the brunt of being childless even when the male may be the one who is infertile. The experiences of childlessness and infertility is usually marked by anxiety and fear which is accompanied by societal pressures to conceive and social stigmatization in case of failure to conceive. What is found to be absent is a public health system addressing this issue effectively by providing simple services affordable to the poor woman. The poor women are left at the mercy of traditional healers and are left susceptible to follow superstitious beliefs in their pursuit of a child, mostly a son. The city of Guwahati in Assam every year is witness to hordes of people landing up from all parts of the country during the Ambubachi mela² held at the Kamakhya Devi temple³, seeking blessings from the goddess of fertility in providing them the much desired male child.

However, for those who can afford the cost of ART, using the technology to procure a progeny of their own has become an irresistible proposition. As Imrana Qadeer points out 'The existing demand (more by professionals and the middle class) for these services distorts the priorities in the organisation of health care

¹ NFHS-3 collects information from a nationally representative sample of 109,041 households, 124,385 women of the age group 15-49 years of age and 74,369 men of the age group 15-54 years of age. The NFHS-3 sample covers 99 percent of India's population living in 29 states. It includes questions on several emerging issues such as perinatal mortality, male involvement in maternal health care, adolescent reproductive health, high risk of sexual behaviour, family life education, safe injections and knowledge about tuberculosis (IIPS, 2007)

² This mela is also known as Ameti or Tantric fertility festival since it is closely associated with Tantric Shakti cult prevalent in eastern parts of India

³ The Kamakhya Temple is a Hindu temple dedicated to the mother goddess Kamakhya. Situated on the Nilachal Hill in western part of Guwahati city in Assam, India, it is the main temple in a complex of individual temples. It is an important pilgrimage destination for general Hindu and especially for Tantric worshippers

services as pressure is built to set up hi-tech within open markets and public sector service infrastructure without building the basic facilities that help prevent infertility' (Qadeer, 2010).

III. GLOBALISATION AND THE MIDDLE CLASS

It is widely acknowledged that health care services are singularly affected by a global market economy. The opening up of the Indian economy in the 1990s with the reduction of state interventions to foreign investment increased the availability of consumer goods in the Indian market. Health also began to be increasingly looked at as a consumer good/product rather than as a 'right' as it was earlier viewed within the social-welfarist paradigm. This was touted as a natural progression and development in keeping with the political economic and social shifts with the ushering in of globalisation. Broadly, the neo-liberal market economy extending into hitherto traditional societies like India, leading to highly uneven patterns of change in different components of development along with sweeping economic and political changes and technological advancements is what is often termed as Globalisation. Subsequently when liberalisation policies became more pronounced it was the middle class which emerged as the most important market for consumer goods. The potential of the middle class as a market for consumer goods was in turn largely defining the class itself, its culture as well as its relationship to the national culture. 'In most works on the middle class, consumption is seen as both significantly shaping middle class culture and identity and mediating the relationship of the middle class to the nation and national culture and identity' (Wessel, 2004).

Economically the middle class represents a class with an ability to lead a comfortable life enjoying stable housing with health care and educational opportunities up to college for their children, reasonable retirement and job security as well as a discretionary income that can be spent on vacation and leisure pursuits. The calculation of the size of the middle class is done through a measure of the per capita income per household with a threshold of \$10 as the minimum, also accepted as the global minimum threshold for the middle class. As evidenced in a recent NCAER-CMCR publication the Indian middle class is said to have doubled in size over the last decade, growing from 5.7 percent of all Indian Households in 2001/2002 to 12.8 percent of all households in 2009/2010. This corresponds to about 28.4 million households with a total of 153 million people (Shukla, 2010) and still counting.

Globalisation has brought in avenues and possibilities particularly for the middle class, which were unheard and unknown before. The idealised notion of globalisation suggests that through the process of growing interconnectedness and interdependence on a global scale, huge technical advancements and accompanying economic and socio-political changes, a barrier free world would be ushered in where individual freedom, cooperation and a non-hierarchical order would be the norm. There is no denying that certain sections of women from the affluent and middle class have particularly benefitted through increased opportunities of employment and education. This leads to an altering of gender roles posing a challenge to the traditional gender dynamics within families. With newer work opportunities and alternative lifestyles making an impact, technology has come to the assistance and become a part of middle class lives in a big way. Technology has entered everyday lives and have ended up reshaping all areas of life from the most specific and technical activities to the most trivial and mundane everyday experiences. However, most importantly it has made available choices in such aspects of our lives that were unthinkable before. Choice related to reproduction is one such area where technology aided by a global capital economy have successfully made foray. The rise of the middle class contributes to the world wide proliferation of ARTs which are essentially on the look-out for newer markets and potential consumers. What has further aided the entry of reproductive technologies so expeditiously into the traditional Indian society is a stark absence of any regulatory mechanism whatsoever.

It is therefore in the interest of the global capitalist players who control the market, to tap middle class 'resources' as well as 'sentiments' in propagating ARTs. In such a scenario the implications for gender relations are immense as meanings and allusions to concepts of fertility and infertility traditionally assigned are now redefined and reintroduced.

IV. PROLIFERATION OF ART IN GUWAHATI CITY

As Assisted Reproductive Technologies have spread across India and the world, Assam located in North Eastern part of India, and particularly Guwahati is no exception. The people of this region have also felt the impact of globalisation especially neo-liberal economic policies, resulting in change of lifestyle patterns and altering gender roles. A micro level study to gauge the spread of Assisted Reproductive Technologies was undertaken within Guwahati city in order to understand the level of awareness among women regarding ARTs, their perception of infertility and how it affects their reproductive choices. For the purpose, interviews were conducted with women visiting fertility clinics seeking medical help to understand the implication of ART in their lives. Group discussions were held with young women students in universities to understand their level of awareness regarding reproductive choices available to them. Couple of Interviews were also conducted with service providers in two of the most popular and reputed fertility clinics in the city.

The two clinics where the study was conducted are the Institute of Human Reproduction located at Fatasil Ambari near Bharalamukh and Pratiksha Hospital which is a super speciality hospital specialised in Assisted reproductive Technologies located at Borbari VIP Road. Both the clinics lie at quite a distance from each other, besides having a considerable operational age gap. The IHR has been in the business for more than three decades whereas Pratiksha Hospital, a relatively new state of the art clinic being functional not more than a decade back. It is interesting to note that the Institute of Human reproduction was set up in Guwahati city in 1980, only six years after the first ever test tube baby was born into the world. Although the procedures that took place at that time in the clinic were hardly as sophisticated as they are now, nevertheless there existed a clientele to whom the clinic catered to and provided services like the relatively simpler Intra-Uterine Insemination procedure. Today both these clinics are equipped with state of the art technologies for undertaking highly sophisticated procedures comparable with such clinic anywhere in India and both the clinics boast of a clientele from not only across India but also abroad. Interviews were conducted with women visiting these clinics. Given the secrecy emerging from the stigma attached with infertility, they could however be contacted only in the doctors' waiting rooms. Given such constraints and the limited universe, it must be pointed out that the study does not claim any generalisation, however it is significant as it points out the way technologies have penetrated middle class lives and the implications it has for women in particular.

V. PRESSURE OF A BIOLOGICAL CHILD

The social pressure either overtly or covertly exists to conceive a child of their own was what was admitted by all the 15 respondents (who lay in the age group of 20-42), as a primary reason for their seeking medical help to conceive. All but three admitted that they themselves wanted to and were willing to undergo any treatment possible to have a biological child of their own. Out of the three one claimed that she would have happily adopted a child had her family members been willing. The other two who were comparatively younger women did not have much of an opinion and preferred to follow the advice of family members. 30% of the women interviewed worked outside the home and 60% of them had been married for more than 3 years. The internalisation of the ideology of motherhood was very clear from the responses. The woman confided in undergoing a feeling of emptiness or incompleteness in not being able to produce a child. The other perplexing questions in their minds seemed to be that of having an heir and the need to fulfil the 'burden' of perpetuating the family line.

To the question of social pressure on a women to conceive the service providers responded by saying that it is because such pressures exist that technology has become even more significant especially in such cases where conceiving without technological intervention is near impossible. They agreed that infertility is a grave social issue, which can be removed not by questioning the way it is socially constructed which is what causes the problem, but through technological solutions. The dominant view of women as 'beneficiaries of technology' was espoused to justify the existence of ART. Adoption was considered as only a last option for most infertile couples according to the service providers and that too when they exhaust all treatment options.

The idea of infertility as a disease which needed to be treated was found to be predominant among the service providers who blamed the lack of proper awareness for the increase in cases of infertility. Other than the usual medical reasons for infertility, the service providers listed out some social practices, which have of late become common as reasons for rising infertility. What figured in the list are women marrying late, being career oriented delaying pregnancy and childbirth till they reach their thirties. All of the above interestingly singles out only women whereas the medical reasons clearly pointed out that male infertility was equally common. It is obvious that the burden of infertility is being placed exclusively on women and her life choices. Such reasoning invariably emanates from an understanding of women as natural mothers with their primary identity being linked only to motherhood.

Discussion with the young group of ten female University students on the issue of infertility and the desire to have biological children did result in responses that questioned the social construction of infertility. However, as solution to the issue only one among them reiterated that she would remain childless or at the most adopt a child. The remaining nine students felt that it was a vicious cycle as most of the time women do heed to societal pressures to have biological children however, they did raise questions on motherhood being a 'natural' instinct in women.

VI. AWARENESS OF ART PROCEDURES

The procedures adopted to assist reproduction in infertile couples are not only complicated and lengthy but also involve pain and risk as well as possible side effects. It was imperative to know how much of such information, which would invariably influence the decision of couples to avail ART was actually available to them. Questions on awareness of the procedures were addressed to the female respondents who were prospective ART users. Out of the fifteen women, two had undergone Intra-Uterine Insemination (IUI) in multiple cycles and were aware of what it entailed, although they were not very sure of what would be involved if they had to resort to a more sophisticated treatment like the IVF. In three women interviewees, infertility

rested with the husband due to low sperm count and motility and they had to undergo the IVF or IVF-ICSI (Intracytoplasmic sperm injection) procedure. They were not found to be aware on the number of eggs that would be retrieved and were not informed about what would happen to the unused eggs as most such procedures involve extracting five or more gametes or eggs from a single woman. Most of them responded that they had some form of information on the procedures and had faith in the doctors they were consulting and in the high success rates that they claimed. They also said that they were counselled on discomforts, side effects, and the costs of the procedures.

The service providers were also asked questions on whether couples are provided all the relevant information about the procedures and what it entails. All possible side effects were explained to the patients according to the providers with the assurance that the procedures have a high rate of success. Counselling if any was provided in only special cases where both or either of the couple suffer from some life threatening disease or in case of the need for donor sperm/ eggs. In most other cases, the doctors provide some kind of piecemeal information about the procedures and techniques that would be used. Being a highly technology driven procedure for assisting reproduction the odds are against the woman who it is presumed by the providers, would not be in a position to understand the practical details of such procedures. More often than not, women who had undergone IVF complained very little about the affects of the medicines or the discomfort during the invasive procedures involved, taking the pain in their stride. None of the women were aware of their legal rights and avenues to redress grievances arising in case of a mishap.

The young unmarried students on the other hand had very little awareness on the nature of the treatment the duration or cost involved. Couple of them had varying information owing to some acquaintances undergoing such procedures. They seemed more familiar with the term test tube baby and were aware that it involved fertilisation of the egg outside the woman's body before implantation into the uterus. The lack of awareness of young women on such issues is an alarming sign in the light of the impact that the presence of such techniques can possibly have on their reproductive choices in the near future. The women students also had no knowledge of their legal rights or about the existence of any regulatory mechanism for ART.

VII. REGULATING ART

There is as on date no official regulatory body for Assisted Reproductive Technologies. 'India has neither the Guidelines nor legislation for the ethical practice of ART, acknowledged the Indian Council of Medical Research (ICMR 2002). Some steps have been taken since then aiming to standardise and regularise the use of ARTs and to chalk out the appropriate conditions for IVF. The two clinics visited for the purpose of the study claimed to have started the procedure for inclusion into the National Registry of ART clinics and banks under ICMR. However, only the name of Pratiksha Hospital was found listed in the website of ICMR National Registry. It was surprising that the Institute of Human Reproduction, Guwahati, which had pioneered infertility treatment in this part of the country and is the first clinic to successfully bring to term and deliver an IVF baby, has not been enrolled in the National registry list yet.

The Draft ART regulation Bill 2008 was expected to be truly regulatory in nature providing adequate protection to women's health and well being as well as legal remedies to users of ART. It has however been criticised for failing to do so. 'Through various clauses it tends to promote the interests of the private sector providers of these technologies rather than regulate them' (SAMA, 2009). A closer examination of the attempts made to regulate ART reveal that there is a failure to address all the concerns and issues that emerge with regard to advanced technological advancements like the ART. One clear example of it is the fact that the Draft Bill aims to maintain secrecy of the egg donor in order to protect the child born and avoid complications. However, in India where it is found that relatives altruistically agree to donate their eggs such a measure would only lead to encouraging selling and buying of eggs creating a market for it. It is found that in the field of Assisted Reproductive Technologies commercial interests take precedence over human interests.

VIII. CONCLUSION

The ART has been touted as liberating for most women as it gives them the opportunity to make choices regarding their reproductive lives. However, the fact that within the ambit of 'reproductive choices' also falls the choice not to have a child of one's own is almost inconceivable especially in patriarchal societies like India. There is no denying that technological advancements in the field of reproduction have helped women get pregnant and deliver babies. However the question remains if such advancements have really altered women's lives positively by challenging entrenched ideologies which were discriminatory towards them or have they been geared towards creating a reproductive market where like other human body parts, eggs and sperms are also being sold. It stands as a fact in the context of India where an unregulated, under-researched and largely unaddressed perpetuation of ARTs is prevalent that such technologies are often harnessed to the service of institutions like hetero-patriarchy, marriage, the medical market, etc, through their overuse or misuse. (Marwah & Sarojini N, 2011)

‘Research findings have highlighted the fact that ARTs were promoting and consolidating the idea of motherhood as women’s destiny, and capitalising on the stigma and trauma of childlessness within marriage. Within this logic, alternative family formations, such as in(voluntary) childlessness were seen as socially invalid, and adoption was seen as a last resort, and not as an equal option. In the case of gamete donation, users and providers alike sought “desirable” characteristics, such as fair skin, and in some cases, even a “higher” caste background. Some couples were anxious that the child should look like it was their own biological child, “born out of wedlock” and not through artificial means’ (Marwah & Sarojini N, 2011). Reproductive organs and parts have not only assumed an individual and independent existence but they are also subject to dominant and prevalent physical social and cultural attributes. The option of selecting the sex of the child becomes possible and being difficult one-time pregnancies it is nobody’s guess what the preferred sex of the child in such pregnancies would be. With a horrendous history of female infanticide and repeated incidences of sex selective abortion in India, ART can make overcoming such social malice even more difficult. ‘The focus for the Indian woman in a patriarchal context is not so much the experience of pregnancy or childbirth but the enormous social pressure and the feeling of security she gets as a result of having a child, especially a male child’ (Widge, 2002).

The disturbing trend of egg donation that have emerged through various studies follows the standard patterns of organ trafficking i.e., from the more affluent to the less affluent. Such a pattern stratifies reproduction by empowering and enabling the reproduction of persons with relative affluence, usually the middle and the upper classes while disempowering the fertility of the poor and the lower class.

A stronger regulatory mechanism aimed at woman’s well being can be an answer but there is also a need for a more consistent movement towards making the health care system accountable. Practices in the name of technological advancements, which are discriminatory towards women in general and poor women in particular therefore have to be subject to continuous scrutiny.

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