UNIT 1 CULTURE AND THE MATERNAL BODY

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Structure

1.1 INTRODUCTION

The concept of the mother is so familiar that you may wonder why you need to study anything about it. After all we have all had mothers and some of you may be mothers yourself. The Oxford dictionary defines the term mother quite simply as 'a woman in relation to a child or children to whom she has given birth'. The verb mothering refers to the caring and protecting most of a child, but occasionally someone other of the child.

In this unit we will draw upon insights from many of the feminist theories you have already studied to evaluate the two important ideas reflected in the above definition, namely: a) the fact that motherhood is a biological process, and b) the assumption that mothers are essentially caring. As with other issues discussed earlier, we will try to understand the relationship between the social construction of motherhood and the lived experience of mothers. At the same time, our concern will be to tease out the multiple meanings embedded in terms like the 'maternal' and the 'mother'.

1.2 OBJECTIVES

After going through the unit, you will be able to:

- Understand the need for feminist theorizing of the maternal;
- Analyze the representations of the maternal in biomedicine, psychology and psychoanalysis;
- Become familiar with feminist theorizing of motherhood;
- Discuss the idea of the maternal feminine in the Indian context; and
- Understand debates around abortion.

1.3 THE NEED FOR FEMINIST THEORIZING OF THE MATERNAL

There are several reasons why debates around mothering have been a problematic area for feminist theorizing. It may be pertinent to begin a discussion on motherhood and the maternal body by considering some of these.

First, the possibility of pregnancy and childbirth create an inalienable difference between the bodies of men and women. Feminists have been concerned with the nature of this difference. Their reproductive capacities have meant that women are often constructed as closer to nature than men. Philosophy particularly as seen in the West has characteristically described human existence in terms of mind body dualism. Taken together this has resulted in an equation of women with nature and men with the mind. In most societies, the psychological characteristics and social roles associated with women are derived from their capacity for birth. Feminists have grappled with the reality of these associations. Are women truly caring and men assertive and dominating, or are these stereotypes that have been ascribed to women by patriarchy? Moreover if the psychological characteristics of women are biologically determined how can the differences between women across cultures be explained?

You have also read about the centrality of the private / public distinction in feminist analyses. The maternal body is located simultaneously in the private and the public spheres. While maternity and motherhood are experienced by an embodied subjectivity (implying that each mother experiences motherhood as felt and lived through the body; not the natural body of biology but a body that inhabits a particular personal and cultural world, the experiences are structured through social and cultural discourses. Medicine and law determine who can have access to contraceptives and abortions, the practices of childbirth within a society, as well as definitions of maternal and child health. While the capacity to bear children seems to

be the overarching feature that distinguishes men from women, the last century has seen many technological developments that have irrevocably altered this. Feminists too have grappled with the question, sometimes arguing that motherhood is the root of women's oppression while at other times suggesting that the capacity for giving birth is their greatest strength. These are some of the issues we will discuss as we course through this unit.

'The mother' has occupied a particularly privileged position in India both in its centrality as a metaphor for India (*Bharat Mata*) and in being that aspect of womanhood that is venerated within society. In the 1975 blockbuster, **Deewar**, Director, **Yash Chopra**, Amitabh Bachchan asks his upright police officer brother, '*mere paas bangla hai, gaadi hai, paisa hai, tere paas kya hai*?' (I have a bungalow, car, and cash, what do you have?). And pat comes the reply, '*mere paas maa hai*.' (I have a mother).The metaphor of the mother has been particularly significant in India as the imagination of the country as a mother and the ubiquitous presence of the figures of mother goddesses indicates. Feminists in India have pointed to the paradox between the veneration of mothers and the poor status of women in society particularly in relation to the problem of sex selective abortion.

In the remaining sections, we will try to clarify some of these paradoxical issues.

1.4 FEMINIST CONSTRUCTIONS OF MOTHERHOOD

The mother of all second wave feminists, **Simone de Beauvoir** saw women as trapped in their reproductive roles, a position taken to a more radical extreme by **Shulamith Firestone**. In *The Dialectic of Sex* (1970), Firestone argued that the original class distinction was that of sex. Prior to the development of contraceptives women were subjected to the biological processes of their bodies. Women would only be free when they were released from the processes of reproduction and lactation using technology to reject their biological entrapment. Firestone was certain that the choice of motherhood would lose its attractiveness once other alternatives were available. The idealization of motherhood was a patriarchal ploy to keep women in a position of subordination.

Contraceptives meant that women could exercise a modicum of control on reproductive choices. As these choices increased, feminists became increasingly critical of the devaluation of women's' bodies inherent in the rejection of maternity. Feminist poet **Adrienne Rich** provides one way out of the debate by making a distinction between the ideology of motherhood and the experience of mothering. Rich distinguishes between motherhood as: "the potential relationship of any woman to her powers of reproduction and to children and to motherhood as the institution which aims at ensuring

that that potential remains under male control" (Rich, 1976, p. 13). This is the distinction that is usually described as the distinction between mothering, and woman's own experience, uncontaminated by patriarchy and motherhood— its institutionalized aspects. In an interesting reversal of conventional understanding Rich says, "the mother child relationship is the essential human relationship. In the creation of the patriarchal family, violence is done to this fundamental human unit. It is not simply that women in her full meaning and capacity is domesticated ....safely caged in a single aspect of her being-the maternal- she remains an object of mistrust, suspicion, misogyny in both overt and insidious forms" (Rich, 1976, p.116).

Similarly, **Mary O'Brien**, a midwife by profession, argued that patriarchy is structured around the lesser participation in reproduction available to men. Mary O'Brien agreed that reproduction and motherhood had become sources of oppression for women. The task for women and feminists was to recognize that these also contained the possibilities for her liberation. O'Brien seriously doubted that reproductive technologies that were themselves a product of patriarchal processes could contribute to the liberation of women. Rather, an excessive dependence on technology would strip women of their powers and enhance the alienation of the woman from her own body.

Radical feminist writing on motherhood seems to somersault between the polar opposites discussed above although the debate recurs in various forms elsewhere. Ferguson highlights this polarity by quoting from two major figures of American feminism, as follows:

"Oh baby, come,...Come closer. Eye to eye, soul to soul. Come say hello to your new born mother" (Phyllis Chesler, 1979, p.189).

"I would like to affirm the rejection of motherhood on the grounds that motherhood is dangerous to women....mother is she whose body is used as a resource to reproduce men and the world of men , understood both as the biological children of patriarchy and as the ideas and material goods of patriarchal culture" (Jeffner Allen ,1984,p. 316).

One of the dominant themes that run across radical feminist writing is the positing of an essentially positive femininity which has been distorted by patriarchal control. An interconnected issue concerns the relationship between this biological capacity and the psychological characteristics of women. **Carol Gilligan** (1982) took a position against the then popular theory of morality as a rational process based on logical thinking and justice. In a classic study, she spoke to women who were in the process of deciding whether to seek abortion or go ahead with pregnancy. Gilligan argued that women's reasoning about moral issues is based on connectedness and relationality. It is sensitive to the context and derived from an ethic of care. The woman deciding about abortion may therefore not think from either the perspective of the rights of the foetus or those of the mother.

Instead she is likely to reason in terms of the care that the infant might require and whether she has the capacity to provide that care. Clearly such thinking would result in varied resolutions to the same moral dilemma.

The possibility of an alternative framework of morality that was gendered in character was both exciting and dangerous. In the beginning of this unit we asked whether psychological characteristics and social roles of the sexes were biologically determined. Gilligan and other feminists such as Sara Ruddick who emphasized 'maternal thinking' seemed to essentialize and decontextualize the voice of the mother, while locating it dangerously close to her biological capacities.

A critique of such essentialist accounts of motherhood and its interrelatedness to other socio-psychological realities was articulated by Marxist and socialist feminists such as **Allison Jagger** and **Ann Ferguson** who argued against the construction of any universal characterization of gender. While they commend radical feminists for bringing the body into the gender question, they are critical of the neglect of the question of history and class relations.

Marxist feminists explain sexism across cultures as arising from the nature of class divided society. Unlike the radical feminists, Marxists see sexism as a means used by the ruling classes to divide the producing classes. Theorists within these traditions extend their work on unpaid housework to childcare describing both as necessary for the reproduction of labour power. The oversimplification of Marxist feminist theory is partly countered by the socialist feminists who understand oppression as arising out of the twin systems of patriarchy and capitalism. Alison Jaggar (1983) points out that women's biology interacts with the environment in which it lives, and does not yield to similar constructions across time and space. She gives the example of the availability of bottle feeding and the possibilities of an altered definition of motherhood offered by it. In order to fuse various strands of feminism with Marxist theory, Jaggar returns to the concept of alienation used in a gender specific context. Just as the worker is alienated from his products, so is the woman alienated from the three areas in which she most often works: sexuality, motherhood and intellect. Writing specifically of motherhood, Jagger points to the rather limited choices women exercise over when, how many and by what process she bears her children. Ultimately these processes prevent even the formation of a positive bond and when they do they may often result in the total crippling of the child. Further, she endorses the point made more emphatically by feminists within the psychoanalytic tradition that such alienated mothering prevents the child from recognizing the mother as a person, thereby continuing the cycle of alienated mothering. Jaggar's response to the motherhood question and incorporates both the gender specificity missing in Marxist thought and the space for rather different articulations of this alienation within varied cultural and historical circumstances.

Check Your Progress:

"Reproduction and motherhood are sources of oppression for women". Analyze this statement with an example.

1.5 MATERNAL REPRESENTATIONS

Let us begin the section by analyzing the representations of mothers in two of the domains that seem to significantly determine the construction of the maternal: Biomedicine and Psychoanalysis. Following this, we will discuss feminist psychoanalysis and motherhood in greater detail before looking specifically at the social construction of motherhood in India.

1.5.1 Biomedicine

As you are aware, the biomedical perspective sees the human body as a complex machine that can be controlled and managed for greater effectiveness. Since the perspective has been central in the understanding of reproduction, biomedicine has significantly altered the lives of mothers.

Perhaps the most significant impact of biomedicine is seen in the management of childbirth. Before the advent of modern medicine it was most often midwives who were the healers in their communities and played a central role in the management of childbirth. With changing conditions of urban life, new perceptions of women, and advancements in medical science, birth became increasingly viewed as a medical problem to be managed by physicians. At the same time, because medical training was restricted to men, women lost their positions as assistants at childbirth, and an event traditionally managed by a community of women became an experience shared primarily by a woman and her doctor.

Box 1.5: Midwife-Universal Reference

The term midwife is used as a generic reference for women who managed childbirth. However this usage hides the differences in the work and social positions of these women. In India, the closest equivalent is the 'dai'. Her role varies from caste to caste and in different regions of India. A 'dai' usually handles process such as the disposal of the placenta, but also had skills to assist in complicated deliveries. Naraindas points out that unlike in the West, the intersection between colonialism and medical science ensured that the transition has been from 'dai' to white women and then Indian women (Naraindas, 2009).

Physicians trained in the specialty of obstetrics and gynecology declared themselves to be the proper caregivers for childbearing women, and the hospital was deemed to be the proper setting for that care. Birth evolved from a physiological event into a medical procedure. According to one of the foremost American authorities of the day, **Dr. Joseph De Lee** said in 1915 that birth was a dangerous process from which few women escaped unscathed, and proper management of this pathological condition required a program of routine medical intervention. De Lee's recommended interventions included anesthesia, episiotomy, and assisted (forceps) which meant that more and more women give birth within hospitals and under the prescriptive gaze of the medical profession. Feminist sociologist **Ann Oakley** (1984) refers to the takeover of pregnancy and childbirth, primarily healthy normal processes of the woman's body, by medicine and technological change as the capturing of the womb.

The powerful discourses of science and medicine have constructed the female body as a universal, stable body that exists beyond differences of time, space and ideology. Many contemporary critiques of science have shown it to be misogynist and racist, even as it espouses the values of objectivity and neutrality. With regard to the maternal, biomedical practices have:

- Brought childbirth into the domain of medicine, and
- Generated a host of reproductive technologies

In the context of the above, many feminists have argued for a return to the processes of natural childbirth. Natural and medicalised childbirth can be thought of as the two official discourses that form the ideologies of childbirth. However the argument that the natural is ideal may also be a feminist fallacy. The presentations of the maternal body simultaneously as natural and as requiring medical intervention suggests that human mothers have been swallowed up by biological explanations and social descriptions (Held, 1993). As in other representations of the maternal, the authentic voices of the mothers, and their experience of pregnancy and childbirth, have been difficult to unravel.

1.5.2 Psychology

A reference to mothers is a frequent occurrence in psychological texts of diverse theoretical persuasions. **John Watson** the behaviorist saw many of the emotional difficulties of children as arising from too much 'mother love'. At another theoretical pole, the evolutionary theorist Bowlby suggested that 'maternal deprivation' was a key factor in the mental health difficulties of infants and children. Although Bowlby was aware that infants can form attachments with other caregivers, he tended to emphasize the role of the mother. In addition to emotional security, psychological research has linked maternal qualities to broader aspects of infant development such as cognitive

and language development, and emotional and social maturity. Some of the terms associated with this stage include 'maternal synchrony' with the child and the use of a form of speech called 'motherese' to facilitate language development.

Clearly, psychology has been instrumental in generating an ideology of motherhood in which the mother is the primary caretaker of the child, the one on whom 'his' (it is usually the male child who is the subject of discussion) well being depends. While the vulnerability of the human infant is an uncontestable fact, psychology has helped in defining the decontextualized 'good mother' without studying the realities of the varied experiences of mothering. The identity issues involved as well as the change in social context that arises out of being a mother were rarely studied in the research which took place until the last few decades. Circumstantial differences were also ignored, as is evident from the use of the homogenous and universal categories of 'the mother' and 'the child'.

Feminist analyses have revealed that psychology has been responsible for widespread mother blaming. Since much of the responsibility for child care is placed on the mother, it follows that she is also responsible for the healthy development of the child. In response to feminist criticism, psychological terminology has changed. The newer discourses tend to employ neutral terms such as parent and care taker. Yet, as psychological expertise increases, mothers are increasingly held responsible for the well being of their children. Differences in the experiences of mothers are often conceptualized within the category of deviant mothers, once again pointing to the universalizing definition of mothers (Burman, 1994). In reality mothers can be young or old, single or living with a partner, heterosexual or not. It is due to mother blaming in psychology that a lesbian, older woman or single woman are represented as if they are inherently incapable of good mothering.

Check Your Progress:

Does the discourse of medicine view maternal body as natural? Give some examples to support your argument.

1.6 FEMINISM, PSYCHOANALYSIS AND MOTHERHOOD

As you have already seen in the unit "Feminism and Psychoanalysis Interrogating Oedipus" (Unit 2, Block 5, MWG 001), the relationship between psychoanalysis and feminism has not been without acrimony. Many second wave feminists rejected psychoanalytic concepts such as 'penis envy' in

girls and the Freudian assertion that anatomy is destiny as fundamentally misogynist. Mitchell (1975) initiated a rapprochement by suggesting that Freudian psychoanalysis be read as a description of the formation of psyche under patriarchy rather than a prescription of it, as earlier feminists had done. Let us begin by looking at psychoanalytic accounts of motherhood.

1.6.1 Psychoanalytic Account of Motherhood

While Psychology constructs the self in largely rational terms, psychoanalytical thought emphasizes the relatively irrational and unconscious aspects of human subjectivity. The second wave of feminist writers including Betty Freidan, Kate Millett, Germaine Greer, and others saw Freudian thought as a misogynistic reflection of patriarchy. However, as we discuss later in this unit, the work of **Juliet Mitchell** (1975), **Nancy Chodorow** (1978), **Luce Irigaray** (1993) and others generated a vital rethinking of the relationship between feminism and psychoanalysis. You will also come across some of these ideas in Unit 3: Body in French Feminist Theory & Psychoanalysis, Block 4 of this course.

Motherhood is one of the central ideas around which contemporary psychoanalysis is constructed. Let us briefly recapitulate Freud's theory of Oedipal development which you have already read about in MWG 001. At birth babies of either sex have a primary attachment to their mothers. Through his/her investment in the breast, the infant internalizes the mother within the self. However the process is disrupted at the Oedipal moment where the infant must learn to be masculine or feminine in its identification. The boy must negate his relationship with the mother to identify with the father and gain access to the world of masculinity. The girl on the other hand must continue in her connection with the mother and give up the desire to acquire masculinity. The Freudian conceptualization leaves space for multiple identifications. Every child is initially bisexual and contains identifications with both the father and the mother. So both men and women have components of masculinity and femininity. The Freudian perspective does provide a frame through which to unravel the gendering of the child. However, the mother is never the subject of analysis in Freud's writing.

This imbalance was corrected somewhat in the 'object relations' tradition which includes the work of **Melanie Klein**, **Donald Winnicott** and a number of other prolific writers. The object relations perspective is particularly significant because it has evoked both intense criticisms because of its singular focus on the significance of the mother, as well as considerable interest within feminist appropriations of psychoanalysis.

Donald Winnicott (1960) assumes a complete entanglement of the mother and infant and argued that "at the earliest stages the infant and maternal care belong to each other and cannot be disentangled" (p. 40).

In this view, the pregnant woman experiences primary maternal preoccupation. She identifies herself with the baby enabling her to achieve an understanding of what the baby needs. This identification lasts for the early part of pregnancy in which it is referred to as holding. Good mothering at this stage must be reliable and sensitive to the inner states of the baby. During this period of merger the infants experience is largely fused with the mother

"The mother knows she must keep alive and allow the baby to feel and hear her aliveness. She knows she must postpone her own impulses until the time when the child is able to use her separate existence in a positive way. She knows she must not leave her child for more minutes, hours, days than the child is able to keep the idea of her alive and friendly" (Winnicott, 1960, p. 71). Once the inner continuity of being has been established the infant starts the process of separation from the mother. Just as much as the earlier phase requires closeness, this one requires of the mother the ability to let go. Theorists of the genre shift the position of the mother from a passive recipient located between the infant and the father to one who is agentic in the development of the child. Moreover despite a degree of idealization of the maternal, they are conscious of the profound feelings of ambivalence and hatred that mothers may feel towards their infants.

At the same time object relations theorists in general and Winnicott in particular shifts the focus from development during the oedipal phase to the pre Oedipal one. Several feminist accounts of the development of gender identity, including the influential works of Chodorow and Benjamin which we will discuss in detail at a later point consider this move to be of immense significance in the understanding of the female psyche. The new assumption here is that the mother-child relationship can be understood without reference to the father. The subjectivity of the daughter is already formed within the dyad of the mother daughter relationship. The daughter does not come to know herself only in her negative identification with the father. Rather she benefits from the continuity between her early relationship with the mother and her identity as a woman.

1.6.2 Nancy Chodorow and the Reproduction of Mothering

The revival of interest in the psychoanalytic tradition after Mitchell was furthered by **Nancy Chodorow's** (*The Reproduction of Mothering)* (1978). In this work Chodorow asks two questions. In an implied critique of mothering as a natural instinct she wonders why women want to have children. The second question concerns how become they mother. In response to the first, she suggests that women neither become mothers because they are biologically destined to do so, nor as a result of consciously taught roles, but in the unconscious internalization of gender relations transferred to the daughter in the process of being mothered.

In order to develop this point, Chodorow focuses on the pre oedipal period. Mothers experience in greater continuity with their daughters than they do with sons. These weaker boundaries between the mother and her daughter imply that the mother and daughter never quite separate. This lack of separation of identities ensures the takeover by the daughter of her mother's role and contributes albeit unconsciously to the reproduction of mothering as well as other aspects of gender ideologies. Chodorow also suggests that this would change if men played a greater role in housework and child care while women sought employment outside the home

Although the reproduction of mothering was welcomed for providing a sociological explanation for the continuity between mothers and daughters, several feminists pointed out that it only addressed maternal practices in white American homes. In addition it seemed to hold maternal practices responsible for the daughter's well being, reiterating the tendency towards mother blaming discussed earlier. A rather different account of mothering may be obtained by reconsidering the issue from the mother's perspective. In the "Fantasy of the Perfect Mother", Chodorow (1980) cites the work of diverse writers including **Nancy Friday, Dorothy Dinnerstein**, **Adrienne Rich** and others as showing a common search for a perfect mother. This fantasized perfect mother emerges both in clinical accounts and in fictional representations. There is no reason to assume these fantasies to be either realistic or actualisable. Nevertheless, it is these rather than any other sources that go into the available constructions of motherhood.

Chodorow and others also suggest that in western discourse, motherhood encompasses the contradictory notions of mother as life giver, self sacrificing and forgiving and simultaneously as demonic, smothering, possessive and destructive. This in turn generates an infantile fantasy of the perfect mother who exists somewhere but is not one's own, a fantasy shared by the feminists who write of it. For the infant the mother is precisely that and no more. Within the limited capacities he or she has, there is no space for understanding that she too has needs, wishes, a personal history as well as a network of social relationships, all of which pattern her life.

Such an analysis denies mothers the complexity of their lives, their selfhood, and their agency in creating from institutionalized contexts and experienced feelings. For those engaged in feminist politics, this analysis also points to the need to question the child centered assumptions of contemporary psychology and its percolation to larger cultural processes. Chodorow is emphatic in cautioning about the use of fantasy for informing theoretical and political understanding. The child's understanding of the mother may be quite different from the reality of the interaction between them. Feminists with a psychoanalytic inclination argued that the usefulness of the theory lies in the clues it provides to the way patriarchy gets constructed within the framework of unconscious fantasy. The reading that mothers are to be

blamed for their daughters' problems does not in the final analysis complete the feminist project.

Psychoanalysts have also made significant contributions to reformulating the problem of mother daughter relations within psychoanalytical feminism. Both assume that changing gender arrangements in the sphere of child care can alter the patterning of masculinity and femininity. In **Jessica Benjamin's** (1988) account, the early relationship between mother and child works to make the mother the sole object of desire for the child. The significant task for the mother is to recognize that despite their interconnectedness, the infant is also another who is real in itself. Benjamin assumes that a mother's lack of agency and de-sexualisation prevents her from recognizing the child in a meaningful way. It is the father who represents agency and subjectivity for the child. The girl is however often denied the possibility of a healthy identification with the father either because of patriarchal norms or the father's fear of coming close to the daughter. This prevents a daughter from recognizing that both mother and daughter are desiring beings with their own needs.

Feminist accounts of Chodorow and Benjamin are critical of the readings of mother-daughter relations in terms of connectedness. Jane Flax who also combines feminism with psychoanalysis believes that such accounts are based on the repression of aggressiveness and sexuality of the mother. Flax points out that maternity is not an essence, nor does it encompass within it the entire category of woman. In contrast to these accounts, the work of Lacan influenced feminists present a challenge to psychoanalytic accounts of mothering from within. Let us look at some of these ideas in greater detail next.

1.6.3 Mothering in Lacan Influenced Feminists

You have already come across some of the ideas of **Jacques Lacan** in course MWG-001, Unit 3, Block 4 and Block 5, Unit 2. For Lacan, the speaking subject exists only in language or the symbolic. Language structured in the phallic order represents the repression of the unity of mother and child. The girl child without a penis is particularly alienated from this order. While gender does not pose a biological problem in Lacan's theory, the problematic of the woman's entry into the symbolic is used as the point from which to theorize an alternative possibility for women. Once again, it is the mother daughter relationship which assumes significance.

Luce Irigaray, Hélène Cixous and Julia Kristeva have all challenged Lacanian theory from within the tradition. Together, the three writers have been classified as belonging to the tradition of 'ecriture feminine' roughly translatable as 'feminine writing'. In the simplest interpretation of their writing, they seem to use the Lacanian notion of women being outside the

symbolic to speak of the possibility of a feminine language that enables the expression of an alternative consciousness. This language is outside the rational, logical structure of formal male language and allows women to express themselves differently.

You have already read about **Irigaray's** work in Block 4, Unit 3 of course MWG-001 and you will be reading in the last unit of this Block. Irigaray argues that the female body itself constitutes pluralities, hence can not be reduced to one single organ or identification. Here, she suggests that Western culture is founded on matricide, a taboo on the relationship with the mother. The dominant patriarchal fantasy of the mother is constructed as a closed volume or container that exists under male control. Men fear both the potential openness of the container and the possible fluidity of femininity. Irigaray understands the unavailability of subject positions for women in terms of the structure of language. She is particularly troubled by the non availability of pervasive symbolic representations of the mother daughter relationship in western culture. This unsymbolised relationship hinders women from having an identity that is distinct from the maternal function. Abandoned outside the symbolic, women are left without a means of entering it, they cannot sublimate. The central question as a theorist of change is how to construct non hierarchical relationships such as friendships or sexual relationships between women. Feminist attempts have usually run into problems because they rely on the paradigm of mother daughter relationships to explain all relationships between women.

Irigaray and Cixous locate the problem in the nature of the symbolic. While the boy can resort to available discourses through which to symbolize his loss of the maternal body, the girl is left mourning a lost object. An authentic feminine language is then the only possibility for the emancipation of women. The problem seems to be that there is little possibility of escaping the symbolic which is patriarchal in nature. At the same time their analysis, in the mode of much psychoanalytically informed theorizing, lacks specificity as far as cultural, historical and social processes are concerned. Restructuring the symbolic requires a return to the body; the source of an authentic femininity and this once again generates the critique of essentialism. In contrast to the above, **Julia Kristeva** argues that the symbolic system cannot be transcended. However she does posit in the realm of pre-oedipality a potential to disrupt these systems in the process of becoming a subject.

The maternal body is located between nature and culture. The maternal body with its other within it is a prototype for subjective relations. Maternal functions exist prior to paternal law. At the same time Kristeva argues for a separation between the maternal body and woman. A woman may experience the maternal through adoption, caretaking or sublimation. Similarly a man may experience the maternal function. Kristeva addresses

the problem of motherhood in contemporary society through her notion of abjection. Through abjection or the experience of horror experienced in negotiating separation from the mother, women are reduced to their maternal functions while their own subjecthood requires abjection of maternal desire.

Despite the potential for a critical reflection on maternal subjectivity, psychology and psychoanalysis are based on a construction of motherhood which essentializes, glorifies and simultaneously excludes the mother. A tendency in feminist psychoanalysis to conflate the terms 'daughter' and 'woman' unwittingly replicates the ideology of mother blaming. This move isolates the mother daughter relationship from the surrounding context, glorifies and finally holds the mother responsible for the entire problem of feminine identity. To **Judith Butler** (1990) this seems like a reification of maternal instincts which is placed outside of culture. She wonders if the feminist project is helped by placing maternal desire outside of culture, suggesting instead, a discursive analysis of the power relations that produce the maternal body.

A first step in destabilizing motherhood is to study the socially constructed nature of the practice of mothering. Following this approach, **Evelyn Nakano Glenn, Grace Chang and Linda Rennie Forcey** (1994) define mothering as a "historically and culturally variable relationship in which one person nurtures and cares for another" (Glenn et.al, 1994, p. 256). It is constructed through the action of women and men in specific contexts and takes place in social contexts that include unequal power relations between men and women as well as between various other group identities. The dominant view of mothering is based on the twentieth century model of white American motherhood. Universalizing definitions of motherhood are problematic even where they appear in a feminist frame for they tend to exclude the significant issues faced by other communities. Although the psychological ideology of appropriate mothering finds its origins in the west, it has gained increasing significance in defining policy across the world. Several early analysis of personality development in the Indian context pathologized the joint rearing of children. Similarly, working mothers today experience guilt at reading about the harmful effects of mother absence on the child. **D.A. Segura** (1994) found that the more traditional women in her sample reported less conflict between mothering and work than the modern sample. Obviously contemporary ideologies are not necessarily more liberating for women. This seems to have some relevance to the Indian situation where relatively young women may be using technologically sophisticated devices to preselect the sex of their child. In the next section, let us look more closely at the social construction of motherhood within the specific context of India.

1.7 THE SOCIAL CONSTRUCTION OF THE MATERNAL IN INDIA

1.7.1 Mother Goddesses and the Maternal Feminine

The presence of Hindu metaphors of an active sexual female power (Nair and John, 2000) has sometimes led to the argument that feminism is irrelevant to the lives of women in India. Indic thought contains several conceptual categories including *prakriti, devi*, *ardhnarishwar* that signify an alternative cosmology to that available in most monotheistic religions. As **Vasudha Dalmiya** (2000) has pointed out, Hinduism and folklore make references to many female deities. While the term Goddess exists in monotheistic cultures too, it is significantly different in India. The goddess Kali in particular appears as a terrifying yet beautiful mother (Dalmiya, 2004). In her representation as a naked, disheveled goddess dancing on Siva's prostrate body, she seems remote from the images of the benevolent but passive maternal that populates contemporary imagination. The possibilities inherent in such representations have captured the imagination of feminists particularly as an alternative symbol of woman's agency.

However, the presence of these symbols does not translate into a just society. Moreover these symbols have been used repeatedly for political agendas such as fundamentalism and nationalism that do not remotely serve feminist functions (Dalmiya, 2004). In India the figure of the mother tends to engulf the woman (Dalmiya, 2000). Despite the representation of women as both sexual and maternal, the social construction of the good woman as mother is reflected in the stereotype of the infertile woman as '*banjh*' or barren. Even the figure of the goddess is appropriated within patriarchy to pressurize women into motherhood, particularly giving birth to sons. Yet, they do offer a possibility for feminist resistance and reinterpretation.

Both **Sudhir Kakar** (1978) and **Ashis Nandy** (1980) suggest that these images signify a greater association of aggression and power with femininity that results in unconscious rage and powerlessness in men. They account for the misogynist attitudes of men towards women in terms of an unconscious fear. However, they also recognize that this feeds into the reality of oppression in the lived experiences of women that is somewhat mitigated with the birth of a son. Son preference and sex selective abortion are not surprising in this context. Misogynist attitudes have also continued to influence debates around abortion, both in the West and in India. Let us look at some of these debates in section 1.8.

Check Your Progress:

Discuss the interrelationship between the 'good woman' and 'mother' from the perspective of a particular culture.

1.8 ABORTION DEBATES

1.8.1 Feminist Struggles for the Right to Abortion in the West

The debate around abortion is one reflection of the manner in which the reproductive body is simultaneously private and public. An abortion is a procedure that uses medicine or surgery to remove the embryo or fetus and placenta from the uterus. Over several centuries and in different cultures, there is a rich history of women helping each other to abort. Until the late 1800s, women healers in Western Europe and the U.S. provided abortions and trained other women to do so, without legal prohibitions.

In 1803, Britain first passed antiabortion laws. By 1880, most abortions were illegal in the U.S., except those "necessary to save the life of the woman". But the tradition of women's right to early abortion was rooted in U.S. society by then; abortionists continued to practice openly with public support, and juries refused to convict them.

Abortion was a dangerous procedure done with crude methods, few antiseptics, and high mortality rates. But this alone cannot explain the attack on abortion. For instance, other risky surgical techniques were considered necessary for people's health and welfare and were not prohibited. 'Protecting'' women from the dangers of abortion was actually meant to control them and restrict them to their traditional child-bearing role. Antiabortion legislation was part of an antifeminist backlash to the growing movements for suffrage, voluntary motherhood, and other women's rights in the 19th century.

In the 1960s, inspired by the civil rights and antiwar movements, women began to fight more actively for their rights. The fast-growing women's movement took the taboo subjects like abortion to the public domain. On January 22, 1973, the U.S. Supreme Court, in the famous *Roe v. Wade* decision, stated that the "right of privacy...founded in the Fourteenth Amendment's concept of personal liberty...is broad enough to encompass a woman's decision whether or not to terminate her pregnancy". The Court

held that through the end of the first trimester of pregnancy, only a pregnant woman and her doctor has the legal right to make the decision about an abortion. States can restrict second-trimester abortions only in the interest of the woman's safety. Protection of a 'viable fetus' (able to survive outside the womb) is allowed only during the third trimester. If a pregnant woman's life or health is endangered, she cannot be forced to continue the pregnancy.

Though *Roe v. Wade* left a lot of power to doctors and to government, it was an important victory for women. While the decision did not guarantee that women would be able to get abortion when they wanted to, legalization and the growing consciousness of women's needs brought better, safer abortion services. For the women who had access to legal abortions, severe infections, fever, and hemorrhaging from illegal or self- induced abortions became a thing of the past.

When the Supreme Court legalized abortion in 1973, the antiabortion forces, led initially by the Catholic Church hierarchy, began a serious mobilization using a variety of political tactics including pastoral plans, political lobbying, campaigning, public relations, papal encyclicals, and picketing abortion clinics. 'The Church hierarchy does not truly represent the views of U.S. Catholics on this issue or the practice of Catholic women, who have abortions at a rate slightly higher than the national average for all women' (www.feminist. com 2011).

Other religious groups, like the Mormons and some representatives of Jewish orthodoxy, have traditionally opposed abortion. In the 1980s, rapidly growing fundamentalist Christian groups, which overlap with the New Right and 'right- to-life' organizations, were among the most visible boosters of the antiabortion movement. These antiabortion groups talk as if all truly religious and moral people disapprove of abortion. This is not true now and never has been.

1.8.2 Abortion in India

The history of abortion in India has been quite different. The Medical Termination of Pregnancy Act (MTP) (1971) became law in India without much fanfare. The act was pioneered as part of a population limiting exercise with considerable support from the medical establishment. Under the act a woman can legally avail abortion if the pregnancy carries the risk of grave physical injury, endangers her mental health, when pregnancy results from a contraceptive failure or from rape or is likely to result in the birth of a child with physical or mental abnormalities. The MTP Act permits abortion up to 20 weeks of pregnancy and no spousal consent is required.

However, the availability of abortion does not translate directly into reproductive rights for women in India. Millions of abortions are performed by untrained persons in unhygienic conditions putting women under grave

risk. Abortion itself seems less stigmatized in India than in other cultural contexts (Ganantra, 2000), specially when it serves the needs of maintaining family honour. In such a scenario, an older married woman who seeks abortion is likely to be supported by her family, since giving birth would be an indicator of her ongoing sexuality. Paradoxically the more vulnerable adolescent whose sexuality is socially illegitimate is denied access to safe abortions.

In the 1970s it first became possible to evaluate the condition of the fetus with the use of techniques such as amniocentesis and ultrasounds. When prenatal diagnosis first became a part of the Indian reality, feminists pointed out that the techniques aimed to detect foetal abnormalities were also capable of providing information about the sex of the unborn child. Responding to the massive protest generated by the spread of sex selective abortions, the central government passed the prenatal diagnostic techniques act in 1974. The ensuing outcry prompted the central government to legislate the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 regulating the use of ultrasound and amniocentesis and forbidding providers from revealing the sex of the foetus.

Yet, as the 2001 and 2011 Census make evident, the incidence of sex-selective abortion has not come down. The latest 2011 census shows a further increase in the ratio of boys to girls. In over 50 districts of the country, a majority in the northwest and western states, the juvenile (0-6) sex ratio has dipped to alarmingly low levels. Most recent research suggests that sex selective abortions are widely used to plan the most acceptable form of the Indian middle class family, the family with two sons and no daughters.

The participation of women in the process of sex selection tears open the myth of the powerful maternal in the context of contemporary India. Yet it also reveals the specificity of maternal experience to local contexts. Simultaneously it becomes apparent that the maternal, far from being a primarily biological process is deeply embedded in public discourses. Despite the valorization of the woman as mother, she rarely appears as an agentic figure who speaks in her own voice.

Check Your Progress:

The construction of the maternal body is itself a social process. Use examples from any movie, television shows, folk songs, and posters to discuss this idea.

1.9 LET US SUM UP

In this unit we have discussed the theorization of the maternal body from feminist and cultural perspectives. We have seen how the association of women with the maternal body cuts across cultures, yet the construction of the maternal differs across time, discourse and culture. On the contrary, the discourse of biomedicine projects the maternal body as stable, and in need of medical intervention. It can be construed that the constructions of the maternal body are fluid and often contradictory in nature. Motherhood and the maternal body have varied representations in the realms of culture, science, psychoanalysis, and language. The unit has shown that the notion of maternal body has been analyzed within the binaries of nature/culture, biological essentialism/social construction, and there is a need to interrogate such binaries.

1.10 UNIT END QUESTIONS

1) Define and explain the notion of maternal body from a feminist perspective.
2) Write an essay on feminism, psychoanalysis and motherhood.
3) Discuss the construction of motherhood and the body in the discourses of bio-medicine, psychoanalysis and the social.
4) Critically analyse the representation of the maternal body in Indian context with special reference to debates on abortion and female foeticide.

1.11 REFERENCES

Allen, J. (1984). *Sinousities, Lesbian Poetic Politics*. Indiana University Press.

Benjamin, J. (1988). *The Bonds of Love: Psychoanalysis, Feminism, and the Problem of Domination*. New York: Pantheon.

Burman,E (1994). *Deconstructing Developmental Psychology*. London and New York: Routledge.

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity*. London: Routledge.

Chesler, P (1979) *With Child: A Diary of Motherhood*. Crowell.

Cixous, H. Keith Cohen & Paula Cohen (1976). 'The Laugh of the Medusa'. *Signs*, 1(4), Summer, pp. 875-893, htttp://www.jstor.org/stable/3173239.

Chodorow, N. (1978). *The Reproduction of Mothering: Psychoanalysis and*

the Sociology of Gender. Berkeley: University of California Press.

Chodorow, N & Contratto S. (1980). 'The Fantasy of the Perfect Mother'. In B. Thorne & M. Yalom (Eds.), *Rethinking the Family: Some Feminist Questions*. (pp.25-36). Boston: North Eastern University Press.

Dalmiya, V. (2000). 'The Indian Subcontinent'. In Jagger,A & Young,I.M.(eds.). *A Companion to Feminist Philosophy*.

Dalmiya,V. (2004). 'Loving Paradoxes: A Feminist Reclamation of the Goddess Kali'. In P.S. Anderson & Clack, B. (Eds.), *Feminist Philosophy of Religion: Critical Readings*.

Ferguson, A. (1989). *Blood at the Root: Motherhood, Sexuality and Male Dominance*. London: Pandora Press.

Firestone, S. (1972). *The Dialectics of Sex*. New York: Bantam.

Gilligan, C. (1982). *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press.

Glenn, E.N, Chang,G & Forcey, L.N (1994). (Eds.). *Mothering: Ideology, Experience, and Agency*. California: Routledge.

Held, V (1993). *Feminist Morality: Transforming Culture, Society and Politics*. Chicago: University of Chicago Press.

Irigaray L (1993). J*e, Tu, Nous: Towards a Culture of Difference*. Trans, Alison Martin. New York: Routledge.

Jagger, A. (1983). *Feminist Politics and Human Nature*. New York: Rowman and Allenheld.

Kakar,S.(1978). *The Inner World: A Psychoanalytic Study of Childhood and Society in India*. Delhi: Oxford University Press.

Kristeva, J. and Goldhammer, A. (1985). 'Poetics Today'.6 (1&2), 133-152. Stable URL: http ://www.jstor.org/stable/1772126

Mitchell, J. (1974). *Psychoanalysis and Feminism*. London: Allen Lane.

Nandy, A. (1980). *Woman Verses Womanliness in India: An Essay in Social and Political Psychology*. In At the Edge of Psychology, Delhi: Oxford University Press.

Naraindas, H. (2009). 'A Sacramental Theory of Childbirth in India'. In H. Selin (Ed.) *Chihldbirth Across Cultures: Ideas and Practices of Pregnancy, Childbirth and the Postpartum*. London: Springer.

Mary John and Janaki Nair (). (Eds.). *A Question of Silence? The Sexual Economics of Modern India*. New Delhi: Kali for Women.

Oakley, A. (1984). *The Captured Womb: A History of the Medical Care of Pregnant Women*. Blackwell Publishing Limited.

Rich, A. (1976). *Of Woman Born: Motherhood as Experience and Institution*. W. W. Norton & Company.

Winnicott (1960). *The Maturational Process and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: Hogarth Press and the Institute of Psycho-analysis.

1.12 SUGGESTED READINGS

Chodorow, N. (1978). *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender*. Berkeley: University of California Press.

Kakar,S. (1978). *The Inner World: A Psychoanalytic Study of Childhood and Society in India*. Delhi: Oxford University Press.

Oakley, A. (1984). *The Captured Womb: A History of the Medical Care of Pregnant Women*. Blackwell Publishing Limited.

Rich, A. (1976). *Of Woman Born: Motherhood as Experience and Institution*. W. W. Norton & Company.

Woollett, A. and Marshall, H. (2004). 'Motherhood and Mothering'. In Unger, R.K (Ed.) *Handbook of the Psychology of Women and Gender*. New Jersey: John Wiley and Sons.

UNIT 2 REPRODUCTIVE TECHNOLOGIES

Sunita Dhal

Structure

2.1 INTRODUCTION

The unit analyses the inter-connections between woman's body and the institutionalization of various reproductive technologies through the discourses of population policy and the market. The focus of this unit is to discuss a range of discourses epitomizing the development of new reproductive technologies since 1970s across the globe.

According to **Lene Koch and Janine Morgall** (1987), there are two forms of reproductive technologies which are categorized as: i. Assisted Reproductive Technologies (ARTs) (e.g., contraceptive and treatment of infertility) and, ii. New Reproductive Technologies (NRTs) (e.g. artificial reproduction combined with genetic engineering). According to **Jyotsna Agnihotri Gupta** (2006), globalization of NRTs is increasingly penetrating in arenas of contraception, assisted conception, and screening of embryo/foetus for genetic purpose and sex selection leaving impacts on the female body and her health. Technologies for sex-selection, genetic testing of foetus, artificial reproduction through IVF, contracts concerning the use of reproductive body and services are some examples of new reproductive technology, which have called for feminist assessment of these technologies across the world.

As a critique of these new reproductive technologies, international feminist movements see these innovations and insertion related to women's body as

a new form of oppression. This is because these technologies are essentially experimental in nature yet are proliferating in the market place with a view to curing infertility. The expansion of these technologies in the West and in the Third World countries not only are evidence of women's access to these technologies but also are reflective of the high-tech subjugation of women's body. With this background, the unit will expose the learners towards understanding of reproductive technologies from a feminist perspective while narrating the embodied experience of women in access to these technologies of various forms.

2.2 OBJECTIVES

After reading this unit, you will be able to:

- Critically analyse feminists discourses associated with reproductive technology debates;
- Describe women's concerns (psychological, social, and health) in the use of new reproductive technologies in a contemporary context;
- Analyze the role of state and market in the promotion of reproductive technologies; and
- State the critique of reproductive technologies from a Third World perspective.

2.3 NEW REPRODUCTIVE TECHNOLOGY AND FEMINIST ASSESSMENT

The issues of reproductive technologies have been the centre of concern in the context of the women's health movement across nations. On the one hand, various feminist movements have linked women's freedom and women's rights issues with their access to various reproductive technologies. On the other hand, the women's movement and health movements have raised different concerns relating to issues of fertility, abortion, use of unsafe contraceptive technologies, medicalisation of child bearing and the adverse effects of reproductive technologies. Feminists are questioning whether the right to choose is not slowly turning into women's duty to choose? (Gupta, 2006, p. 6). Some feminist activists fear that state eugenics, as earlier practiced in Europe and America, might turn into private eugenics with the proliferation of these technologies (Dar & Heidt-Fors, 2012). According to **Cynthia R. Dar** and **Erin Heidt-Fors** (2012), in the Unites States, sperm banking and egg donations are coming up as big businesses in the free market economy to provide reproductive services. They argue that the practices which are followed in various sperm and egg donation banks are based on underlying eugenic beliefs in which sperms and eggs are being traded on the basis of individuals' class, gender, race, occupation, and ethnic identities.

For radical feminists and lesbian women in the West, various assisted reproductive technologies can be seen as alternatives through which single women and lesbian couples can claim their right to motherhood. On the contrary, for some feminists, these technologies are primarily essentializing women by re-enforcing the norm of motherhood and compulsory pregnancy, while health advocates have warned against using fertility drugs (cited in Gupta, 2006). To put it more precisely, the mushrooming of these technologies in the market explain the trend towards reproductive freedom for a few, and technological dependence for a majority, of women.

Differences within feminism continue to exist with regard to the assessment of reproductive technologies. Some have argued that the use of assisted reproductive technologies involves the commodification of woman's body, reproductive process and motherhood. According to **M.E. Gimenez** (1991), the process of commodification may lead to the reinforcement of women's domination by the oppressive pronatalist ideologies. On the other hand, feminists like **Firestone and Beckman & Harvey** see ARTs as offering a wider scope for women to exercise freedom in the arena of reproductive choice (cited in Hammons, 2008). These debates are different and conflicting. However may enable us to draw inter-linkages between women's bodies and the impact of new technologies.

Globally, there has been a shift in health care services from the public sector towards privatization that is making poor people the victims of private health care services. The paradox continues to exist as poor women interact with public health care as objects of bio-medical research, while their need for treatment is met through an unaffordable private sector. Similarly, new reproductive technologies like IVF have come to the market as a type of treatment for infertility for white women of elite class. In Asia, countries like India and Thailand are seen as emerging hubs for promoting reproductive tourism due to factors such as: available medical infrastructure, limited regulatory framework for controlling the ART related services and lower wage structure that allows ARTs to perform at lower costs (Whittaker and Speier, cited in Whittaker, 2010). On the one hand, India is evolving as the preferred international destination for reproductive services. On the other hand, this country has increasing maternal mortality and morbidity rate. To quote, "the basic reproductive health care is available more to Indian women as surrogates than as mothers of their own children" (Bailey, 2011, cited in Jaiswal, 2012, p.19).

These technologies are not empowering for all as they operate within the hierarchies of gender, race, religion, and class. For instance, in the U.S., the marketing practices of sperm and egg banks highlight the fact that masculinity and femininety are intertwined with race and class identities through online advertisements of reproductive services. Similarly, racial and class differences are obvious in the use of these technologies. As stated by

Chandra et.al (2005), in U.S., middle and upper income whites are more than double of African Americans as users of the fertility services (cited in Dar and Heidt-Fors, 2012, pp.720-21). The reproductive technologies, IVFs in particular, are certainly proliferating in the new reproductive market economy, raising serious concerns with regard to their use, access, and their impact on the commodification of the body.

According to **Merete Lie** (2002), in the same way that the pill revolution has brought a change in the social arrangement between sexuality and reproduction, the separation between sexuality and procreation is gaining prominence with the introduction of assisted reproductive technology. Many reproductive groups have also looked at the use of ARTs such as women's access to legalized abortion and pills within a right-based framework. Similarly, the discourse of right to life and the right of the fetus have engaged feminists in the continuing debates.

Some feminists within the reproductive liberal framework have argued that reproductive technologies can enable women's empowerment as they will free women from the burden of child bearing. Hence, reproductive technologies have been seen as liberating measures for women in establishing their autonomy over the reproductive body. For example, in the West, the use of reproductive technologies has been the cause of celebration for certain women as they had access to successful treatment for infertility, pregnancy for post-menopausal women, possibility of gestational motherhood, selective abortion, and IVF. However, the same experience is exploitative for women in specific societies especially where the individual's right over the reproductive body is deeply embedded in the community, culture and norms (Wangari, 2010). Family and community as custodians of the female body often limit a woman's choice to access these technologies. The same family often uses the bodies of poor women (case of gestational surrogacy) in the interest of white/upper class women to secure procreation (Kumkum Sangari, Friday Seminar Series Lecture in IGNOU, 2012). In both these instances, one can see how woman's body has come under the control of technology.

Similarly, in the domain of research, as **Saetnan** (2000) argues, historically, contraceptive research has been accorded a lower status within medical sciences. The lack of financial and professional support for contraceptive research has led to a marginalized status for both the professionals working on contraceptive research as well as its users. This marginalized nature of contraceptive research provides a scope for women professionals to enter into the arena of Pill development as technicians or physicians. Women scientists have often been seen as cultural entrepreneurs for the development and dissemination of the reproductive technologies (cited in Isaacson, 2002), but they have limited roles in the sphere of testing, disseminating and introducing the various reproductive technologies into the market.

According to **Vineeta Bal** et.al. in the field of reproduction and contraceptive research, there is an underlying gender bias link with regard to publishing research papers, development of products and the market. For instance, there is a strong bias towards making research visible for those who work on female contraceptives than on male contraceptives. Similarly, most of the contraceptive research is technological in nature; hence, it strongly governed by social attitude and market demand. The history of contraceptive research has been marked by a continual struggle of women scientists towards achieving mainstream status within the scientific community. Again, working class women's bodies were used callously while undertaking the clinical trials of contraceptive pills. The testing and dissemination of assisted reproductive technologies like contraceptive pills in in the Third World completely targeted women of a particular race and class while paying limited attention towards the potential health risks. As **Clarke** puts it, the moment reproductive researchers attempted to claim the field of reproductive contraception as a legitimate scientific field, simultaneously, women-centered contraceptive research was pushed to the periphery and aggressively infused in the developing countries in integration with population control methods. For feminists both these domains, that is, women's involvement in the development of reproductive technologies, and women as users of these technologies seem to have inherent challenges. Hence, they cannot as always be seen as having liberatory potential for women. Within the field of contraceptive research, the woman as 'researcher' and as potential 'user' have received scant attention.

Check Your Progress:

Name and briefly describe any three issues of concern to feminists in the field of reproductive technology.

2.4 CULTURAL NOTIONS OF REPRODUCTIVE TECHNOLOGIES

In this section, we will primarily look at the proliferation of various reproductive technologies in the market in the context of the notion of motherhood as culturally accepted phenomena. Let us begin by understanding this relationship.

2.4.1 Cultural Acceptance and Reproductive Technology

The development of reproductive technology has been built on the cultural notion of parenthood and infertility. Therefore, new reproductive technologies have been put to use and accessed in relation to infertility treatment exclusively. In this section, we will focus on the understanding of reproductive technologies, in particular, IVF, through a cultural lens. Reproductive technologies are the embodiment of cultural norms and are entwined with the lives of people in a complex way. The advancement of reproductive technology has shaped the way women, in particular, experience their body, motherhood, and their lives. For a majority of women, the female body has been the primary site for innovations in reproductive technology.

These technologies are not liberating in themselves, but are instrumental in shaping the lives and thoughts of men and women in and around conception, childbirth, and infertility. **Sarah Franklin** (1997) uses the term 'embodied progress' to explain the growth of IVF in the late twentieth century as a range of resources which produce new form of reproductive choices for women. Innovations related to reproductive technology have been rooted in the cultural values of scientific growth and moved by market and economic indicators. Here, both scientific progress and reproductive based innovations are supported through the cultural notion of childbirth and the biological family. As feminists and anthropologists argue, the progress of reproductive technologies have not only seen nature as a category that can be manipulated, but also acquired an understanding of human interventions in the process of reproduction as being 'normal'. Women and couples, undergoing assisted conception became the passive recipients of technological culture, which has been created through the new reproductive practices. As Franklin has pointed out, with the new culture of procreation some reproductive dilemmas have emerged as follows:

Box 2.4.1: Associated Reproductive Dilemmas

- **New forms of scientific innovation, new uncertainties are gaining momentum;**
- **Human interventions in reproduction are seem to be a natural process;**
- **Discrepancies are seen between the representation of IVF as a progressive technology and the experience of women and couples with IVF as a failure to achieve progress**

For example, the process of IVF aims at successful pregnancy. However, the procedure might lead to the failure of producing sufficient eggs, failure of eggs to fertilise as embryos, lower sperm counts, and so on. Secondly, the underlying uncertainties became manifest through increasing commodification

of the reproductive organs and technological intervention in the entire reproductive process. Finally, the promise for successful pregnancy ignores the aspects of unintended consequences and unexplained failure of IVF application for the female body. This failure of IVF implies that there is a gap between accepting IVF as a technology and viewing IVF from a woman's perspective. According to **Lene Koch and Janine Morgall** (1987), reproductive technology like IVF can be viewed as involving simple procedures from a woman's perspective. However, the procedures become complicated, the moment the body is subjected to a number of unknown processes. The box below explains the procedure of IVF from a woman's perspective and raises the question about the technique as enabler or obstacle to women's freedom.

Box 2.4.2: Women's Experience with IVF

Women who have undergone IVF described the procedures involved in IVF as a "complex set of practices". It involves an intense procedure, as women are virtually present in the hospital, and their body is under continuous monitoring. In theory, IVF describes that each stage leads to the next stage of successful conception; however, in practice each stage becomes a potential source of failure and is referred to as an obstacle by the women who have had experience of IVF. It is simply a technique that intervenes in the reproductive cycle, and the success of IVF rests completely with the last phase of take-home baby concept. In both altruistic and gestational surrogacy, IVF often brings emotional trauma for the couple, in particular the woman (in case of gestational surrogate mother) due to unanticipated consequences and intensive technological interventions. Salma, a 25 year old housewife doubts that whether using IVF is actually a choice for Indian women or not. With reference to the surrogacy business, Salma narrates her experience with IVF as "I have had a lifetime worth of injections pumped into my body and the doctor made me to take 20-25 pills everyday. I vomited all the time, and was not aware of these medical interventions in the body, but there was no choice for me because of my impoverished condition (cited in Jaiswal, 2012).

In spite of its low success rate at different phases of reproduction, many women from middle and upper classes have conceptualized these technologies as enablers in infertility treatment. Reproductive technologies have been used by both women and men to shape their lives around biological reproduction. This in itself is an embodiment/expression of cultural and social expectations. Not necessarily are technologies used by women to have control over their reproductive bodies—rather their using them reinforces the existing gender norms. In the present context, IVF is primarily

meant for heterosexual couples, and seen as the last hope in dealing with the infertility stigma that is attached to a woman's identity.

Let us take the example of Laura, a thirty-year old woman who underwent IVF treatment and had experienced the failure of the technology. She argues that her experience with IVF treatment had posited her in another identity, i.e., patient-consumer position. The advancement of reproductive technologies has transformed the nature/culture divide (Becker, 2000). Further, she states that the female body is reconceived as a site of technological advancement and biomedical innovations. As a result, the natural process of conception and related reproductive processes get disrupted.

Gay Becker, a feminist anthropologist, describes her experience with IVF as a process consisting of retrieval of eighteen eggs from her body and her realization that the process could not lead to conception in reality. In particular, the hope for success forces both women and men to undergo intensive treatment for childlessness. In this context, women and men feel that these technologies are necessary as a means of having a biological family, which in itself is tried to cultural norms. Couples accept the option of assisted conception even though the process of treatment is unpleasant and often devalues the female body by reducing it to a mere object of reproduction. However, successful pregnancy occurring due to technological intervention and support is considered to be normal and natural in the contemporary context. You can see the advancement of these reproductive technologies subtly forming an integral part of larger cultural preference biases through the processes of modernization and industrialisation. Here, cultural preference for a biological family, a couple's choice of technology, and the process of industrialization reinforce each other to sustain IVF in contemporary times.

As **Anthony Giddens** notes, "although in most parts of the globe, people now live in created environments subject to human control, in everyday life people continue to view their bodies as natural, resisting the idea that the body reflects cultural notions of bodiliness, even when that body has been modified by implants and other technological changes" (cited in Becker, 2000, p. 7). A couple's access and use of these technologies are central to the growth of fertility industries across the globe. Similarly, the presence of these technologies in the market has accelerated their use and has also accentuated the shift from nature to culture, and private to public in case of reproduction. Increasing use of these technologies are fundamental to the transformation of the natural practice of reproduction; however, this has challenged the fundamental norm of prioritizing a biological child over adoption.

2.4.2 Fertility Industry and Its Growth

After the birth of the first test-tube baby in England, IVF and other assisted reproductive technologies had moved from the laboratory and experimental stage to its operational-use stage across the developed and developing worlds. Initially, reproductive medicines such as oral contraceptive pills, IUD (Copper T), hormonal injectable contraceptives, hormonal implant, morning-after pills were developed in order for women to have control over their bodies and for treatment of problems related to the fallopian tube. Other advanced technologies, including IVF, started to focus on the problem of male and female infertility directly while viewing infertility as a form of 'illness'. Eventually, these technologies were advised to patients/couple when they visit infertility clinics for medical guidance and counseling. Recently, IVF has been projected as a viable option within the range of medical options in the name of infertility treatment. Such programmes were specifically encouraging women in their thirties to experiment with the notions of a 'take-home baby'. In spite of its high cost, many couples in the developed world saw IVF as an option to treat infertility. During the 1990s, there was a significant growth of IVF centers in United States to facilitate infertility treatment. Similarly, the criteria for accessing IVF became flexible - raising the age limit from thirty-five to forty, accommodating consumers of various income levels, and treating all kinds of infertility in the name of IVF. With this process of corporatization, IVF aggressively penetrated into the market of both developed and developing countries. The flexibility in the criteria was targeted at creating a consumer-friendly culture towards these technologies. Owing to this, the reproductive technologies have been able to enter into mainstream medical practice, as these technologies are intrinsically associated with social and cultural expectations of the individual and society. Therefore, understanding the growth of these industries entails an examination of such technologies in the context of social relations, norms, social structures and systems.

Similarly, the promotion of IVF related technology in United States and other developing countries is intricately connected with the perception of infertility as an illness within a larger cultural framework which promotes the family and biological children as a form of the old-age social safety net. Hence, reproductive technologies can be seen as propagating a 'culture of reproduction' that had its origin in patriarchal practices and social institutions such as family and marriage. As Becker has pointed out, "new reproductive technologies can tell us about how the consumption of technology evolves as a cultural process; that is how it emanates from social forces. These processes are occurring at a time when technological advances are appearing at quick succession, when cultural meanings are in a flux, gender is in continuous negotiation, and when technology itself can be seen as a culture" (Becker, 2000, p.11).

When a specific aspect of any technology can reproduce and confirm set social norms, identities, and institutions, it can come to have meaning for the individual over any other costs, such as the cost of life, body, and emotion. For instance, IVF is embodying the truth of motherhood or parenthood for every individual promotes itself in a market driven economy. Progress as a modernist ideology gained ground worldwide in the early 20th century. With this was promoted the idea of industrialization and innovation in the fields of agriculture and biomedicine. In American society, innovations in biomedicine were often used as a metaphor for progress. The developments in the field of biomedicine primarily focused on various assisted reproductive technologies for safe conception. Media coverage on new technology along with consumer choice, promoted public acceptability for reproductive technology. This led to a shift in the public's attention from viewing reproductive technology as coercive to 'normal'.

In the West, people often see images about the advancement in medical technologies in the newspapers and magazines with a pictorial depiction, i.e., a doctor holding a baby; often, the mother is placed in the distance background and the father is rarely present (Lie, 2002). Science and technological developments have been the fundamental principles of explaini Since, procreation is seen as being central to motherhood, with the biological child as fundamental to the notion of family technology which promotes these ideas becomes accepted as natural by society. Many women and men in America have felt that their perception about reproductive technology has changed after viewing news reports and talk shows on innovations in biomedicine (Becker, 2000).

When any innovation in biomedicine goes past the stage of experimentation, and becomes available in the market, it simultaneously gets wider dissemination and public acceptance. As you have seen, these technologies had wider popularity as they were viewed as being meaningful by people and were seen to be capable of sustaining and supporting the identity of motherhood. Any resentment of the idea of technology as a form of control over the body gets suppressed because of the larger cultural acceptance of these technologies as they linked to the 'natural'.

Check Your Progress:

How does culture influence the growth of reproductive technology market? Try to explain this in your own words in the context of India or any other country.

2.5 NARRATING WOMEN'S EXPERIENCES WITH REPRODUCTIVE TECHNOLOGIES

In the previous section, you have seen how reproductive technologies embody cultural notions of fertility and promote traditional constructions of gender, motherhood and family. Historically, reproductive technology was advanced with a view to provide women economic empowerment, and to contest patriarchal and expected gendered roles (of enforced motherhood). Various forms of reproductive medicines like contraceptive pills were seen as enabling women's liberation by increasing control over reproductive processes and the body. However, inherent challenges have been associated with reproductive technologies ranging from 'contraception' to 'new reproductive technologies'. For instance, for third world women, use of reproductive technologies such as oral pills and IUDs have raised serious questions in the past with relation to their bodies, because their use is primarily focused on reducing fertility. Population control technologies are meant to prevent conception but have become part of a larger process of surveillance and regulating of the female body. These technologies have an inherent disciplining power, which controls the female body in multiple ways. Here, Foucault's account of bio-power that you have already come across in the Unit1, "Body in Bio-medicine" of this Block will be useful to analyse the relationship between body, technology, market, and development. It is essential for us to debate and discuss reproductive technologies in the context of its use. Let us now discuss the embodied experience of women with various kinds of reproductive technologies.

2.5.1 Women's Embodied Experience with 'IVF'

Feminists have raised concerns about the mental and financial health of couples who are under the surveillance of IVF. Hence, the liberating or empowering impact of these technologies can only be assessed from the individual's embodied experience of new reproductive technologies. In the subsequent paragraphs, we will explore the differential impact of various reproductive technologies on women of privileged position vis-a-vis women from less privileged classes.

Becker narrates the experience of Ashley with IVF as: *"They gave me a 20 percent chance in one cycle, and I see this as 80 percent failure of IVF. But I feel, I need to go through this motion, so that when I look back, I would not feel that I hadn't tried this method. But I do not know if I can stand it. The money that is involved is not covered by insurance, and our saving is just going. I think we are going to see how bad it is"* (Becker, p.13).

The above description shows that often consumers who contemplate opting for assisted reproduction feel hard-pressed to find money to invest in the entire process. Even though the economic costs of these technologies are high, the market reinforces the justification of expensive technologies since

they may help the couple in having a biological child. The cultural construction of reproductive technologies and their costs are valued with regards to pregnancy and gaining a biological family. Since the latter's value is perceived as immeasurable, it sustains the acceptance of these technologies in spite of the high costs involved.

Medical practitioners do not offer new reproductive technologies to patients immediately as they involve high costs and due to the fact that infertility treatment is often not insured. Individual access to such technologies is dependent upon the purchasing capacity of each consumer. Therefore, access to these technologies is limited to those who can afford them. The high costs of these technologies do not help expand the reproductive choices available for women of divergent economic and socio-cultural backgrounds. Similarly, women often prevent themselves from undergoing infertility treatment through IVF due to various reasons. These reasons may include the following factors: i. The treatment entails multiple medical procedures which control women's reproductive cycle ii. Potential side effects of hormonal treatment and iii. Stigma attached to infertility. Thus social apart from the financial burden, infertility treatment with IVF incurs other social burdens on women.

Box 2.5.1: Ethnographic Account of Couple's Experience with IVF

"For me reproductive technology has been just total frustration because we are not covered by insurance. We did a lot of small diagnostic tests, then I was put on drugs, then I had surgery for fibroids, then we were supposed to do six cycles with more drugs, but I didn't respond to it. You know, you have to do everything under rush and stress, and I would do all that, and they would say sorry we can't try this month, but may be next month. So the whole thing has been so frustrating, plus expensive because they want to monitor you real closely" (Ashley and Scott's experience, cited in Becker, p.18).

The above example illustrates how the medical world is infused with specialized techniques and laboratory practices, and medical practitioners have become managers of these technologies. On the other hand, the continuous interventions of assisted reproductive technologies expose women's bodies to expensive laboratory surveillance. Technological developments in bio-medicine have neutralized the idea that reproductive technologies are an alternative means to natural childbearing process.

And neutralized this idea that conception can occur in the laboratories. The naturalization of reproductive technologies as a way of conception in a way challenges the traditional division between public and private sphere. However, it locates the woman's reproductive body in the public domain, i.e. laboratory and technological regulation.

Use of different assisted reproductive technologies for procreation has resulted in the documentation of conception, embryos and fetuses. Such a documentation in turn leads to the control of the female body. **Merete Lie** describes this process as the "new transparency of the body" (p. 186) in which pregnant women's bodies have become the site of experimentation. Thus, the woman's body becomes an integral part of the public sphere and aspects of public life, such as laboratories, medical staff, and medical techniques operate as agencies for conception. The access and use of reproductive technologies has not dismantled the divide between the public and the private. Rather it has made the latter a passive unit in bio-medical innovation and market growth.

2.5.2 Third World Feminist Perspective & Reproductive Technologies

In the last section of this unit, we will try to understand the use of reproductive technologies from a Third World perspective. More specifically, we will look at various contraceptive technologies and practices associated with these technologies from a critical position. In the context of the Third World, women's access to reproductive technologies can be comprehended in two ways: i. the inter-linkages between economic growth, high fertility rate, and enforced family planning and ii. the role of women in developing countries as providers of ova and surrogacy service.

In the global south, reproductive technologies were introduced to women not within a larger discourse of the individual's right to one's body, but within the discourse of family planning and population control. The control of population in developing countries is mainly achieved by imposing restrictions on reproduction and women's sexuality. Developing countries have been viewed as a potential site for introducing contraceptive alternatives to women. In this regard, **Vineeta Bal** et.al. (2008) has critically examined three major issues: sterilization, popularization of hormonal contraceptives, and testing of contraceptives within the field of reproduction. The sterilization drive during the Emergency period in India has been severely criticized. However, scanty attention was paid to the suffering of women who underwent tubectomy operations during that period. Instead of this, international funding agencies in collaboration with the state machinery started pushing permanent methods such as sterilization for women.

Similarly, for popularizing pills and injectable hormonal contraceptives, developing countries like India and Bangladesh are seen as obvious grounds for testing such reproductive medicines. Most of the clinical trials have been conducted on women who are relatively poor and belong to the uninformed section of the society. Therefore, understanding reproductive technologies from a Third World perspective becomes important for all of us, as it reflects the underlying complexities between the state, market

and other donor agencies that project female bodies differently in relation to specific reproductive technologies. According to Richey (2004), the family planning programme in Tanzania categorizes Tanzanian female bodies as traditional and modern in order to facilitate the dissemination of modern family planning technologies. To quote, a service provider who had been working at a regional hospital explained, "times have changed and women do not want as many children as their parents had: you see women who have had many children – they have breasts that hang down to here—breasts like socks" (Richey, 2004, p. 66). Here, Tanzanian female bodies have been referred to as backward, in-disciplined bodies that are in need of disciplining technologies like modern contraceptives. As you can see, family planning technologies are grounded in the wider socio-economic, racial and political structures.

Various factors such as state led policies, lack of gender sensitivity, and opening up of the world market are potential threats to women's individual rights and their access to preferred technologies. To quote Richey, "I am not arguing here that modern contraceptives should not be made available to Third World women, simply that their prioritization in the Tanzanian family planning programme reflects an interest in contraceptive continuity, not one in increasing the choice of individual women" (2004, p. 62). Similarly, **Wangari** (2010) has argued that although feminists have articulated upon the discourse of family planning in the Third World, there is a need to evaluate Western hegemony and its control of resources from class-based, race, and gendered perspectives. For instance, various family panning technologies are imposed upon Third World women through family planning establishments, and multilateral agencies like IMF and the World Bank, and the one child family norm. In the Third World countries, the choice of pregnancy often does not rest with women. Therefore, the idea of 'reproductive autonomy' and third world women's rights as individuals have dissolved down to the community, norms and culture. Although the reproductive rights debates are framed within the context of women's empowerment and development, the question of women's access to reproductive technologies can not be dealt within isolation.

While giving women access to birth control pills is assumed to empower women, and enable them to gain autonomy over their bodies and reproduction, what needs to be questioned is who these women? When such 'population control' measures are introduced within working class populations, or amongst people of colour, the state's agenda needs to be interrogated and questioned. The history of pill research in Puerto Rico stands as a glaring example of understanding the interconnections between biomedical research, women of colour and overpopulation. When **Thomas Parran,** head of U.S. Public Health Service, thought of the use of birth control measures to check the growth of overpopulation, he mentioned

countries like India, China, Java, and Puerto Rico. In these countries, overpopulation was seen as a critical factor to be controlled, while other concerns such as health risks associated with drugs or steroidal contraceptives were ignored (Briggs, 2010). Pill research shows a lack of concern about women's bodies as it was construed that the risks of using an untried pill can be taken since the women involved were largely working-class women from the third world. Hence, Puerto Rico was considered as the laboratory for testing the new drugs for the benefit of other women (from the first world). Later, Puerto Rico was justified as an appropriate site for the research, as the pill was developed and intended for women from the third world and the working-class. Gamble, one of the architects of pill research promoted the slogan—"simple- method for simple–people" to back the distribution of contraceptive pills in Puerto Rico (Williams & Williams, 1978, p. 4, cited in Briggs 2010). The history of pill research shows how women of different class, caste, and region were imbricated differently in the web of policies, programmes, and biomedical research. Therefore, it is important to discuss the individual's rights or rights of ownership of women's bodies from a Third World perspective where reproductive technologies are imposed upon women with the institutionalization of family planning policy and the establishment of international financial institutions.

While western feminists have emphasized the women's agency in reproductive choices, these debates have been articulated largely around abortion. Contrary to this, in India, the rate of illegal abortion or forceful abortion is increasing, as there is a strong prevalence of son preference norms. Reports like *"Planning Family Planning Gender"* clearly indicated that India has been witnessing a drastic decline in overall sex ratio and child sex ratio in particular with an exception to 1971 Census. This trend raises questions pertaining to the missing girls and daughters in Indian society due to the practice of gender differential treatment within the family and community. The study reflects that in the current context, families unconsciously and consciously employ various household strategies to achieve ideal family type with desired number and sex distribution. At the level of conscious planning, families are using various technologies for achieving the family planning goals. Various technologies such as as ultrasound and MTP are intervening at a much earlier stage of pregnancy for sex determination and aborting the female foetus. The Family Planning Programme has been campaigning for a family of two children as an ideal family and families try to adhere to this norm with the introduction of reproductive technologies such as contraceptives and MTP pills. While the increasing use of technology is touted as a normalized part of safe pregnancy, the normalization of certain technologies is undoubtedly helping families to remove female foetuses. The study reported that there is mushrooming of MTP facilities in Punjab and Haryana, and women have been subjugated to multiple abortions

in search for a male child. The maternal body succumbs to technological surveillance under the pressure of family and community (John et.al, 2008). Such a usage of technology throws light on how western notions of women's reproductive freedom can be interpreted differently in other contexts.

The Third World perspective on reproductive technology does not disagree with the notion of women's access to technologies; however, it emphasizes the question of women's autonomy and agency in the context of various issues like access to safe abortion, health care and both women and men making reproductive choices over contraceptive measures. As **Ranjani K. Murthy** observes, "the liberal discourses of reproductive choice are being imposed upon the women of Asia and India in particular, by the international development agencies and the sexual and reproductive rights lobby without educating women towards the discriminatory realities of their lives on the basis of caste, region, migrant workers, and ethnicity" **(Ranjani K. Murthy , 2011).** In the developing countries, the concept of reproductive rights and choice needs to be seen as concomitant with challenging the gendered power relations that govern issues of son preference, female infanticide, sex-balancing, and so on.

The control of women's reproductive system through the use of sterilization, IUDs, and contraceptive pills are not the solutions to Third World poverty and underdevelopment. Rather, this can degenerate and destroy woman's body and autonomy. Pumping of pills or inserting IUDs in women's bodies in the absence of proper gynecological examination, without giving proper counseling about the side effects, or follow-up examinations of using pills and sterilisation, are leading to degradation of women's bodies which further are, affecting their families and their lives.

Box 2.5: Wacera's Embodied Experience with Contraceptive Pills

Wacera's experience with contraceptive pills in rural Kenya is evident of this fact. She is a mother of five children and given pills without any prior physical examination. She accepted the fact of pills as she was believed that pills would improve her life condition by controlling her body and reproduction. She used to walk over twenty miles to reach the family-planning centers to get the pills. The campaign for family planning pills did not include information about various side-effects of the pills, health care delivery system, and issues of transportation and proper nutrition. Since, there was no follow-up examinations after having the contraceptive pills, Wacera was hospitalized three times with heavy bleeding (Wangari, 2010).

The story of Wacera can well represent the experience of many women of the Third World especially, those who do not have decision-making rights over their bodies and reproduction. The women's right to choose to have a baby or not to have a baby in Third World countries is determined by cultural norms and expectations, information, access, availability of reproductive medicines, and the state. Agencies of patriarchy and market driven forces such as, pharmaceutical companies, and the market, turn women into the passive recipients of both banned and new reproductive technologies. Further, determinants such as ethnicity, caste, class, and region, increase the vulnerability of many women. The fundamental factors of women's health like poor nutrition, inaccessibility to health care facilities, and death during pregnancy and childbirth still go unnoticed by population control establishments and policy-makers. Women's health issues in Third World countries are limited to the matter of using contraceptive measures and its distribution. Hence, this limited vision of women's health has led to the infusion of more powerful contraceptive technologies into the market. The acceptors and recipients of birth control are made to believe that their living conditions can be improved by the use of contraceptives; however, for the majority of women in the Third World, it is actually the further exploitation of their bodies. The Third World perspective on reproductive technologies shows us that women's rights to express, control and have autonomy over their bodies has hardly been claimed.

Finally, we also need to ask questions such as: To what extent do new reproductive technologies (IVF) reinforce heteronormativity? Do they possibly de-link reproduction from sexuality and marriage? In other words, have these technologies expanded the option of reproductive choice and rights for LGBT identified communities and individuals? The availability of these technologies is usually limited to heterosexual women, thereby excluding other gendered identities. IVF is simply a technological fix to the socially constructed notion of infertility; within the confines of marriage and biological family, it however, does not enable us to question the notion of infertility as social stigma. As **Koch and Morgall** (1987) have pointed out, single and lesbian women are completely excluded from the treatment of IVF. Hence, while technology in itself may not be gendered, its usage within particular socio-cultural contexts does propagate gendered and exclusionary mindsets and practices. The heterosexual family is upheld as the norm, to the exclusion of all others.

Assisted reproductive technologies can be conceptualized not merely as mere technology. These technologies have inter-linkages with other aspects of society such as social arrangements, patriarchy, power relations, and health issues. We need to contextualise the issues of motherhood, progeny, and the stigmatization of infertility within the framework of new developments, such as the growth of reproductive technologies in the market.

The globalization of reproduction has intensified the growth and establishment of fertility industries in South Asian countries which is further leading to commercialization and commodification of the women's bodies, reproductive tissues and organs. We will be reading more about the new reproductive technologies and the transaction of reproductive body parts in the unit on "Surrogacy" (Unit 3, Block 3). The exploitation of women's bodies has become inevitable in this period of globalization of market and reproductive technology, hence provoking critical questions for feminist engagement.

Activity:

You have already read about different contraceptive technologies. Go to any Primary Health Care (PHC) Centre or any dispensary nearby your locality and find out the contraceptive options available for women. What conclusion can you draw from your findings?

2.6 LET US SUM UP

This unit provides an insight into different ways of linking gender and reproductive technologies within specific cultural and social contexts. We began with a discussion of the feminist interrogation of reproductive technologies as liberating in nature. Next, we looked at the cultural and historical emergence of the fertility industry in the West, and the changing gender relations with relevance to the use of technology. We further analysed the relationship between gender and fertility technology by citing the different experiences of women undergoing IVF treatment. Finally, we employed a Third World perspective in the assessment of reproductive technologies within the discourse of a rights-based approach. Based on the above discussions, you would have seen that the field of medical technology is rapidly developing. Within the area of reproduction, these technologies throw light on the intense complexities between gender, race, ethnicity, and class. The progress of reproductive technology has directly focused on the female bodies as biological resources for its expansion in the market, thereby perpetuating the unequal power relations between genders. It, therefore, becomes important to do a feminist analysis of reproductive technologies as they are increasingly leading towards technological subjugation of the female body.

2.7 GLOSSARY

Pill development : Margaret Sanger dreamt of the idea of a birth control pill since she was a young woman. She and McCormick funded The Pill research in 1962, America. Both the women were the leading forces behind the development of The Pill.

Rights-based Approach : Right-based approach is a framework that aims at integrating the norms, principles, goals, and stanadards of international human rights system for implementing into the processes of development. It aims at incorporating marginalization, injustice, discrimination and exploitation as the causes of poverty and forms of human right violation (http://www.humanrights.dk/files/pdf/Publikationer/applying%20a%20rights%20based%20approach.pdf).

2.8 UNIT END QUESTIONS

1) Discuss and debate the use of reproductive technologies from a feminist perspective.

2) Reproductive technologies are liberating in nature. Do you believe this and if so, for whom?

3) How do socio-cultural expectations attached to the female body help in the growth of reproductive technologies in market?

4) If you know any doctor or couple who are willing to share experiences with IVF treatment, you can interview them and relate the associated dilemmas and risks that you have become familiar with.

2.9 REFERENCES

Bal, Vineeta, Vani Subramanian, P. Sundaraiah, and Leela Raman (2008). 'Contraceptive Research: Is there a Gender-Neutral Approach ?' In Mary E. John (Ed.), *Women's Studies in India: A Reader*. New Delhi: Penguin Books.

Becker, Gay (2000). *The Elusive Embryo: How Women and Men Approach New Reproductive Technologies*. Berkeley: University of California Press.

Briggs, Laura (2007). 'The Pill in Puerto Rico and Mainland United States: Negotiating Discources of Risk and Decolonization'. In L. Reed and P. Saukko (Eds.), *Governing the Female Body: Gender, Heal, and Networks of Power*. United States of America: Suny Press.

Crozier, GKD (2010). 'Protecting Cross-Border Providers of Ova and Surrogacy Services?'. *Global Social Policy*, 10 (299).

Franklin, Sarah (1997). *Embodied Progress: A Cultural Account of Assisted Conception*. London: Rutledge

Gupta, Jyotsna Agnihotri (2006). 'Towards Transnational Feminism: Some Reflections and Concerns in Relation to the Globalisation of Reproductive Technologies'. *European Journal of Women's Studies*, 13(23),1-17.

Jaiswal, Sreeja (2012). 'Commercial Surrogacy in India: An Ethical Assessment of Existing Legal Scenario from the Perspective of Women's Autonomy and Reproductive Rights'. *Gender, Technology and Development*, 16 (1), 1-28.

Lie, Merete (2002). 'Science and Father? Sex and Gender in the Age of Reproductive Technologies'. *European Journal of Women's Studies*, 9 (4), 381-99.

Morgall, J and L. Koch (1987). 'Towards a Feminist Assessment of Reproductive Technology'. *ActaSociologica*, 30(2). 173-191.

Murthy, R.K. (2011). "Rethinking Sexual and Reproductive Choice from a Social Feminist Perspective". *The Movement of India*. 5(5), 20-210.

Richey, L.A. (2004). 'Construction, Control and Family Planning in Tanzania: Some Bodies the Same and Some Bodies Different'. *Feminist Review*, 78, 56-79.

Stephen, E.H. (2000). 'Demographic Implications of Reproductive Technologies'. *Population Research and Policy Review*, 19(4). 301-315.

Wangari, Esther (2010). 'Reproductive Technologies: A Third World feminist Perspective'. In Mary Evans (Ed.), *Gender*. London: Rutledge.

'Unravelling the Fertility Industry: Challenges and Strategies for Movement Building' (2010). International Consultation on Commercial, Economic and Ethical Aspects of Assisted Reproductive Technologies. New Delhi: Sama-Resource Group for Women and Health.

Schultz, Susanne (2010). 'Redefining and Medicalising Population Policies: NGOs and Their Innovative Contributions to the Post-Cairo Agenda'. In Mohan Rao and Sarah Sexton (Ed.), *Market and Malthus: Population, Gender, and Health in Neo-liberal Times*. New Delhi: Sage Publication.

Dar, Cynthia & Erin Heidt-Fors (2012). 'Gendered Eugenics and the Problematic of Free Market Reproductive Technologies: Sperm and Egg Donation in the United States'. *Signs*, 37(3), 719-747.

2.10 SUGGESTED READINGS

Franklin, Sarah (1997). *Embodied Progress: A Cultural Account of Assisted Conception*. London: Rutledge.

Gupta, Jyotsna Agnihotri (2006). 'Towards Transnational Feminism: Some Reflections and Concerns in Relation to the Globalisation of Reproductive Technologies'. *European Journal of Women's Studies*, 13 (23), 1-17.

Morgall, J and L. Koch (1987). 'Towards a Feminist Assessment of Reproductive Technology'. *Acta Sociologica*, 30(2), 173-191.

Richey, L.A. (2004). 'Construction, Control and Family Planning in Tanzania: Some Bodies the Same and Some Bodies Different'. Feminist Review, 78, 56-79.

UNIT 3 SURROGACY

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Structure

3.1 INTRODUCTION

You may have heard the word 'surrogacy' in T.V. programmes or read about it in newspapers and magazines. Let us understand what surrogacy means, and familiarise ourselves with some of the terms associated with it. The word 'surrogate' is derived from the Latin word 'subrogare', which means 'appointed to act in the place of', or, in other words a substitute. In simple terms, a surrogate woman is one who agrees to carry a pregnancy to term for a couple or an individual, in case it is not possible for the couple or individual to do so themselves. Although surrogacy can be done through different techniques/technologies, it in itself is not a procedure, but an arrangement. Generally, this arrangement is placed under the umbrella term of Assisted Reproductive Technologies (ARTs), which you have read about in the previous unit on 'Reproductive Technologies'. The surrogacy arrangement involves the use of these technologies and procedures. In this unit, we are going to discuss various issues related to surrogacy like the growing commercialization of surrogacy, surrogacy as a form of sexual and reproductive labour, and the status of surrogacy regulation in India.

3.2 OBJECTIVES

After going through the units, you will be able to:

- Understand the meaning and types of surrogacy arrangements;
- Familiarize yourself with the political economy of surrogacy arrangements;
- Critically analyse surrogacy within feminist thought and action as a form of sexual and reproductive labour; and
- Learn about some of the legal complexities and regulatory challenges that emerge from surrogacy arrangements, through case studies.

3.3 SURROGACY: MEANING AND TYPES

The arrangement of surrogacy can be defined on the basis of whether the child is born using the egg of the surrogate woman, or of the intended mother, or of the egg donor. In the first instance, where the surrogate provides the egg, the arrangement is known as **Genetic Surrogacy** or Traditional Surrogacy. This is done through the process of Artificial Insemination (AI) or Intra Uterine Insemination (IUI). Since the genetic material (egg) of the surrogate is being transferred, this kind of surrogacy is termed as Genetic Surrogacy. The other kind of surrogacy is known as **Gestational Surrogacy**, where the surrogate conceives through Embryo Transfer, following the procedure of *in vitro* Fertilization. The embryo might be a result of the fertilised gametes of the intended parents, or gametes (either sperm or egg or in some case both) obtained from the donors. Since the surrogate is not providing the genetic material (i.e. her egg), but only gestates or carries the child in her womb for nine months, such an arrangement is known as Gestational Surrogacy. Surrogacy is not a new or recent phenomenon, but has been in existence for a long time. What has changed over time, however, is the nature of the surrogacy arrangement. With advancements in the realm of reproductive technologies, surrogacy has moved from genetic to gestational. Further, in the case of gestational surrogacy, many permutations and combinations are now possible.

i) Intended Couple/ individual – Surrogate

ii) Intended Couple/ individual – Sperm Donor (where the sperm of the husband /male partner cannot be used) – Surrogate

iii) Intended Couple/ individual – Egg Donor (where the egg of the wife/ female partner cannot be used) – Surrogate

iv) Intended Couple/individual – Sperm Donor- Egg Donor (where both the sperm and the egg needs to be obtained from donors) - Surrogate

Another way of identifying different types of surrogacy is on the basis of the motive behind entering into the surrogacy arrangement, and the payment made to the surrogate. In this category, two types of surrogacy can be defined. One is **Commercial Surrogacy** and the other is **Altruistic Surrogacy**. Commercial surrogacy is a form of surrogacy in which the surrogate enters the arrangement purely for financial reasons. In such instances, the gestational carrier (surrogate) is paid to carry a child to maturity in her womb. This is usually resorted to by well off infertile couples who can afford the cost involved, or people who save and/or borrow in order to fulfill their dream of being parents. In comparison, instances of altruistic surrogacy have moral connotations, as they are done for the 'greater good' and to help someone have a child. In such situations, the surrogate receives no financial reward for her pregnancy and the relinquishment of the child (although usually all expenses related to the pregnancy and birth are borne by the intended parents; such as medical expenses, maternity clothing, and other related expenses). In altruistic surrogacy, it is mostly members of the same family who act as surrogates. Media reports have also brought to light many cases of mothers becoming surrogates for their daughters.

3.4 THE COMMERCIALIZATION OF SURROGACY

How can we contextualise and better understand surrogacy as we see it today? Here it becomes imperative to scrutinise the larger systems within which surrogacy— particularly commercial surrogacy— is located and operationalised.

Box 3.4: Some Reasons for India's Dominance as a 'Surrogacy Hub/Capital'

- **Lower costs (l/4th of the costs in the West)**
- **Large top-notch private healthcare providers**
- **English-speaking providers**
- **A socio-political climate that encourages the outsourcing of Indian labour**
- **World-famous tourist destinations**
- **Presence of a large number of women willing to be surrogates**
- **The absence of government regulation**

Over the years infertility 'treatment' in India, including surrogacy, has achieved the proportions of an industry. Though projected as pro-women and couched in the language of choice, rights and altruism, this market seeks women as clients and their reproductive body parts as commodities. In the case of surrogacy, poorer women have emerged as 'rentable wombs'; the suppliers of cheap reproductive labour. Surrogacy has now become a major component of the larger fertility industry, which also includes

technologies for assisted conception. This reveals significantly that economic globalisation today is no longer restricted to goods but includes services as well. Medical services, and now fertility services, are becoming increasingly commercialised, and this has resulted in a phenomenal growth in people travelling across the globe to access these services. India is the newly emerging destination for this medical, and now reproductive, tourism.

India's health care sector has emerged as the largest in the service sector in the country, contributing 6.2 per cent to the country's GDP; by 2012, this figure is expected to rise to 8 per cent, thus employing a staggering 9 million people (http://shodhganga.inflibnet.ac.in/bitstream/10603/2590/9/09_chapter%201.pdf). It is estimated that the size of the medical tourism market in the country will be Rs.1, 95,000 crores in 2012. An integral part of the growing medical tourism industry, the fertility industry, is slated to bring an additional revenue of $1-2 billion by 2012 (Sarojini et.al, 2011). In fact, India is already regarded as the surrogacy outsourcing capital of the world, and is often termed the "mother destination". According to one estimate, India's rapidly growing commercial surrogacy industry is worth U.S. $445 million per year (Economic Times, 2008). There are no reliable statistics available for how many surrogacies are arranged in India for foreigners, but there is a lot of anecdotal evidence of a sharp rise in the instances of commercial surrogacy. This is also corroborated by various media reports, which range from being laudatory to critical of the surrogacy industry. In 2008, Rudy Rupak, co-founder and president of Planet M Hospital, California, a medical tourism agency, pointed out the growth trends in surrogacy, and mentioned that he expected to send at least 100 couples to India for surrogacy, up from 25 in 2007, the first year that he began offering the service (http://www.planethospital.com).

While friends or relatives can act as surrogates in altruistic surrogacy arrangement, in instances of commercial surrogacy, the surrogates are generally recruited through:

- fertility clinics, which have surrogacy programmes
- surrogacy agents, and websites or online recruitment links
- advertisements in the classified section of magazines (both English and Hindi)
- voluntary advertising by individuals looking to act as surrogates.

Apart from ART clinics that offer surrogacy as one in a range of services, other organisations have also sprung up to provide diverse kinds of support services to further the growth of the surrogacy industry. These include private healthcare consultants, travel agencies, the hospitality industry, government tourism departments, surrogacy agents, hostels for surrogates and surrogacy law firms. ART clinics in India have tied up with foreign hospitals and companies to solicit 'clients' globally in a bid to expand their

clientele. As is evident in the example of Planet M Hospital above, some of these companies are headquartered in the United States or in other countries, from where the 'clients' are sourced. Often these companies also employ on-the-ground support staff in India, where the surrogates reside. They act as 'full-service' brokers between commissioning couples/ individuals and the clinics, providing all 'services' in surrogacy. Typically, surrogacy is just one of the many medical tourism services these companies offer, but its exponential growth in recent years has resulted in it becoming a critical service component on offer. Commercial egg donation is emerging as another commercial venture where reverse tourism is seen to occur, with companies bringing in women from first world countries to donate their eggs as well as travel in India.

Clinics and other actors offering/ promoting surrogacy services claim that by providing surrogacy as an option, they are simply responding to the existing market demand of desperate women to become mothers. In interviews conducted by **Sama**, a resource group for women and health, as part of a research project on the growing commercialization of ARTs, providers communicated their discomfort with "emotional" surrogacy. They see commercial surrogacy as a win-win situation that gives the commissioning parents the child they want, and the surrogate mother the money she needs. They insist that surrogacy is opening up new avenues for women to earn money and "better their lot". It is argued that Indian women have high fertility as it is, and often give birth to four or five children. As such, one surrogate pregnancy that will help them improve their living conditions, or pay for a child's operation, cannot be a 'bad thing'. From the surrogate's perspective, financial benefit is cited as the main reason why women are ready to act as surrogates. The money earned from surrogacy can be used to provide the surrogate's own children with a good education, to buy a house, to overcome a financial crisis, or to generally improve the living standard of the family. Surrogacy is thus projected as a better option than, and even a way out of, the sex trade. While the comparison between surrogacy and sex work is not a simple one, it does provide an additional dimension to examine and understand commercial surrogacy. The comparison between the two in the public imaginary as stigmatised work, also results in constant negotiation by the surrogates both at an ideological and practical level.

Anand [a town in the western state of Gujarat] has become the epicentre of the commercial surrogacy industry in India. In surrogacy hostels here, surrogate mothers are carefully chosen and cared for with rich nutritional support, and medical supervision that is comparable to international standards. However, this is ironic given that most of these mothers were probably deprived of basic nutritional support and medical facilities when they gave birth to their own children, as they often belong to the lowest socio-economic rung of the population.

Further, surrogacy arrangements where both sperm and eggs are required from donors create three mothers for the child; the gestational mother (surrogate), the genetic mother (donor) and the intended mother (commissioning parent/s). This raises a whole range of ethical dilemmas.

Box 3.4.1: Advertisements for Fertility Services

The website of a fertility services provider Institute of Reproductive Medicine and Women's Health (IRMWH) has the heading 'A woman's best friend', under which the caption reads 'They say women make the world go round. How true! It is because they are mothers: The creators and sustainers of every generation.' Their work is described as 'revolving around women' and is a 'harbinger of hope for childless couples'(http://www.madrasmedicalmission.org/irm.html).

Agencies make large profits by recruiting commercial surrogates, whose services are aggressively advertised by the agencies. The 'selling point' becomes the 'quality' of the surrogate, which is determined by her social background, looks and, preferably, by proven fertility. The advertisements for surrogates highlight this, and typically read, "Good looking, fair, 27-year-lady from respected family available for surrogate mother. Only rich and genuine people contact" (Sama, 2009, p.14). As a whole, ART services are advertised on websites, in fancy brochures, on walls and hoardings on streets, near adoption agencies and on local cable channels and bus stops. The images, language and slogans used serve to reinforce the tragedy of childlessness and the sentimentality of childbearing, particularly motherhood. At the same time, concerns and complications that come with medical intervention (like side effects, costs, efficacy, and so on) are pushed into the background. Within the larger discourse of the medicalisation of childlessness, surrogacy is projected as the altruistic and noble 'gift' of motherhood, from one woman to another. Surrogacy is most often associated with the values of benevolence and altruism. 'Giving the gift of life', 'helping someone build a family' and other such phrases are often used to emphasize the 'good deed' of renting one's womb. This is deployed equally in commercial surrogacy, wherein the economic aspect is disguised as well as justified in altruistic terms. The ever expanding access to ARTs and the option of surrogacy also means that alternative forms of parenthood or voluntary childlessness are not even considered and more or less excluded as choices.

It is therefore not surprising to find that today, commercial surrogacy has been routinised and normalised to a large extent, with 'stories' of surrogacy slowly finding their way into popular imagination, as well as local moral worlds and discourses. Though very few and highly dramatised, there are some films and television dramas on childlessness and treatments for childlessness like IVF and surrogacy. Director Meghna Gulzar, **Filhaal** (2002) is a mainstream Bollywood film is about a surrogacy arrangement between

two friends and its many accompanying emotional complications. Many television channels (including regional channels) in recent years have telecast serials depicting the issue of infertility and surrogacy. It is possible for childless women to gain a sense of community and solidarity from these shows, which are about the suffering of 'others like them'. However, the focus of these productions tends to be on the emotional and even 'moral' dilemmas of surrogacy, rather than its wider social, economic and political realities and complexities. In order to understand the wider social, economic and political dimensions of surrogacy, we must examine surrogacy within the particular context of its operation, and its implications for the actors involved.

In the absence of regulation, the surrogacy industry lacks any standardised treatment protocol, which paves the way for the potential economic and physical exploitation of surrogates. The Draft Bill to regulate the practice of ARTs and surrogacy permits only Gestational Surrogacy. This indirectly means that only surrogacy with IVF can be conducted. This also implies that the surrogate would possibly face all the side- effects of the drugs and the procedure of IVF. Previously proven fertility is an essential criterion to be a surrogate, though surrogacy is not like any 'normal' or 'natural' pregnancy for the surrogate. Therefore, there are considerable implications for the health of the surrogate. Further, surrogates often lack or have very limited capacity to negotiate with the clinics and the intended couples, due to the hierarchy of power relations. This is also reflected in the contract that the surrogate signs with the couple, usually with little say and without any legal recourse. This compounds the vulnerability of her position.

Given the existing patriarchal structure within which a woman's reproductive role is seen as determining her personhood, it is not surprising that infertile or childless women experience stigma, ridicule, violence, and abandonment. As such, it is understandable why a commissioning mother in a surrogacy arrangement would subject herself and the surrogate to long and often perilous procedures, however costly, in a bid to have a child. By entering the contract primarily for financial reasons, the surrogate is subjecting herself to a whole range of ethical, social, legal and medical implications. On the other side, the lure of money that comes with surrogacy may well be impossible to resist for economically marginalised women, who may have little or nothing by way of better alternatives. As such, the stage is set for a flourishing market based on capitalist principles of profiteering, deployed to cash in on patriarchal values.

Activity:

Identify a film in any Indian language which deals with the theme of surrogacy. Discuss it with your peers at the Study Centre or in the online discussion forum keeping in mind the various issues you have read about in this unit.

3.5 SURROGACY AS SEXUAL AND REPRODUCTIVE LABOUR

The use and abuse of women's bodies has been written about extensively. You have already read about the mind-body dualism in the first unit "Body in Bio-medicine" of this course. This dualism re/presents women as close to nature, living through their bodies, and men as close to culture, living through their minds. As such, women's bodies are subjected to control by male agents, while all forms of their labour (public and private) are devalued. This includes their sexual and reproductive labour, which is domesticated and therefore, not recognized or rewarded as typically 'productive'.

3.5.1 Feminist Perspectives on Surrogacy

The debate around the female body being 'inferior' and 'weak' has been a matter of long standing contestation, and feminists have long struggled to challenge this patriarchal notion of 'biology as destiny'. Surrogacy is able to push pregnancy from the private to the public, from care to work, and in doing so, is able to destabilise binary notions of women's capabilities and roles. **Shulamith Firestone** (1971) has hailed reproductive technologies as having the potential to emancipate women by liberating them from motherhood, which is their primary link to the private sphere. With surrogacy, not only is the domestication of women's sexual and reproductive labour challenged, but women's autonomy—financial and otherwise— is also enhanced. In regarding surrogates as providers of a 'service', we are recognizing reproduction as a resource in society, for which we are compensating surrogate women as economic agents in the public sphere. As such, the surrogacy contract may carry the potential to extend to all pregnancies *as contracts*, or at least, to sexual and reproductive labour as work. However, this romantic image of surrogacy arrangements needs some critical analysis.

Suze G Berkhout (2008) argues that the objectification inherent in commercial surrogacy diminishes women's self-respect, which is critical for a robust sense of autonomy. In a similar vein, **Ellen Goodman** (2008) finds the commercialism of "a free-market approach to baby-making" problematic and compares it to slavery and baby-selling. She describes surrogate women as a "new coterie of international workers who are gestating for a living" (www. infertilityanswers.typepad). She stresses that no matter how good the 'deal', some things cannot be sold. As such, international surrogacy arrangements can be seen as crossing not just geographic borders, but also ethical ones. Goodman objects to the commodification of the body in surrogacy, be it the child who becomes a product, or the woman whose body becomes a resource.

On the other hand, **Amrita Pande** (2009b) proposes that rather than taking a moral position, surrogacy should be seen as a new kind of sexualised care work; "a structural reality, with real actors and real consequences" (Pande, 2009b, p.144). In its alleged commercialisation of motherhood, surrogacy involves the body of poor women. Like other feminist scholars writing on sex work, domestic workers and women factory workers, the author argues that "moral rhetoric and stigma are often evoked whenever the bodies of poor women are in focus" (Pande, 2009, p. 154). **Sabala and Meena** point out that the "low status accorded to the manually labouring body" seems to be a strong marker of caste and class (2010, p, 44). As such, the notion of surrogacy as "dirty work" must be subject to critical scrutiny (Hughes, 1951 cited in Pande, 2009, p.155).

Chayanika Shah's (2009) work examines the politico-historical context of surrogacy and in doing so, arrives at a middle ground in the surrogacy debate. She draws attention to notions of chastity and naturalness that make sexual and reproductive labour acceptable only within marriage. Taken outside the domestic sphere of family, childbearing for explicit commercial gain is completely stigmatised. Feminist understandings of surrogacy are usually uncomfortable with viewing motherhood as pure and sacrosanct, because that serves to glorify motherhood as special. This view can trap women into the role of the mother as the primary and essential feature of their personhood. Rather, according to Shah, the conflict about surrogacy surrounds the "disconcerting use of the language of 'rights' and 'choice' by the promoters of these businesses on behalf of the women going in for these technologies" on the one hand, and "the assertion of rights over the body as a resource" on the other (Shah, 2009, p. 5).

In a context that is overwhelmingly patriarchal and heternormative, women's bodies become resources with which they negotiate their complex realities. As such, the body can be a survival tool for some, and motherhood can become their only available access or route to greater comfort and privilege within the family and the community. For instance, it is common to find women being accorded more respect, control, and mobility once they have had children, especially male children. Perhaps it is necessary to understand sexual and reproductive labour as "a possible choice, restricted but made with dignity, knowledge and consent" (Shah, 2009).

However, does an admission that surrogacy is a 'legitimate' choice satisfy all political and ethical concerns associated with surrogacy? Acts of agency framed within patriarchal institutions—like marriage—also contribute to the functioning of heteronormativity. As such, it becomes important to view the 'compulsions' behind a choice, as well as the implications that flow from it. In the case of commercial surrogacy, there is a coming together of patriarchal ideology that equates womanhood with motherhood, as well as a market that has turned health technology into a consumer good, and left

poor women with few work options. Let us now try to understand the wider context in which this 'choice' to be a surrogate is articulated and regulated within the market economy.

3.5.2 The Context of 'Choice'

Can it be said that women become surrogates because the other options available to them are even worse? There are cases in India, where women have undergone surrogate pregnancy more than once for financial reasons. Authors like Pande (2009) have documented how poor women take to surrogacy out of compulsion in order to ensure the survival of their families (cited in Jaiswal, 2012).

Here it is pertinent to interrogate the context of political economy that determines women's work environment under globalization. Women have always been part of the unorganized informal sector in urban and rural areas. However, they now find themselves pushed into contractual, small sector work such as export zones and sweat shops. They are considered cheap labour: docile, nimble-fingered and easily dispensable. Women have to contend with low wages, long hours, poor work conditions and sexual exploitation. With a shrinking of their already-limited access to resources, women from marginalised communities find themselves more impoverished and powerless than before. Even as traditional livelihoods are in jeopardy, new markets for their labour—especially sexual and reproductive labour—are opening up. Surrogacy comes at the "peculiar intersection of a high reproductive technology and a low-tech workforce" (Goodman, 2008).

In a rapidly commercialising ART market, service providers use the language of altruism to promote surrogacy. The exploitation of, and profiteering from, surrogacy is concealed within discussions of women's economic 'empowerment' on the basis of surrogacy, the booming medical tourism industry, the supposedly high success rate of cutting edge technology, and the 'gift' of a baby. Some of the many significant aspects that go unaddressed, particularly due to the absence of state regulation, include the inefficiency and health risks of invasive procedures, the disruption to women's lives, the insecurity of surrogacy dealings, the possible legal tangles regarding the citizenship of the child, inadequate compensation and lack of bargaining power of surrogates. There is an urgent need to acknowledge the vulnerability and marginality of surrogate women, whose rights must be secured through a fair and binding contract, as is the practice for all other forms of labour bought and sold in the market. Currently, a woman who is recruited by an agent to be a surrogate is likely to be taken to an IVF doctor, who may be high-handed and intimidating, and may give her a very basic and sketchy picture of what surrogacy entails. It is highly unlikely that all short term and long term health risks of the medicines and procedures involved will be told to her. You may refer to the Unit 2 on 'Reproductive Technologies' to reacquaint yourself with these procedures. The surrogate may not even

be told that a Caesarian delivery is likely, or that there is a higher than usual possibility of multiple births. The cost, however, is fixed at the outset, and the surrogate is given a long list of Dos and Don'ts.

The surrogate mother is told not to have sexual intercourse with her husband for the duration of her pregnancy. The contract that is signed is drawn up by the doctor, the commissioning parents and their lawyer. Normally, it is in English and may be read to the surrogate in Hindi before she signs, but she has no legal counsel to guide her through this process. Since there is no law to regulate surrogacies at present, there is no standard according to which contracts must be drawn up. As such the surrogate remains at the mercy of the other stakeholders, and has little bargaining power. Even if the contract is not honoured, she is unlikely to be in a position to take legal action against these parties. Moreover, the social stigma surrounding the practice means that most commercial surrogates keep their arrangements secret, sometimes even from family. Thus, we can get a sense of the extent of vulnerability of women who become surrogates.

Finally, a recognition that women have agency vis-a-vis their bodies is evident in the shifts that gender theory and the women's movements have made in discussions and positions around sex workers or bar dancers. As **Sabala and Meena** state, such shifts in theorising within the women's movement should not be seen as inconsistency or the inability to have one stable position, but rather as "a reflection of the strength of the movement to engage with diversity and multiplicity" (2010, p. 43). Women's complex and layered relationships with their bodies in a patriarchal society are further complicated and intensified for those who earn their living through their bodies. Moreover, with a globalised economy throwing up new and numerous options for women's employment that heavily deploy women's bodies (in sectors like entertainment, travel, hospitality, fashion, care and so on), new and numerous conflicts are going to be created in the contemporary moment. To be able to confront these, a continued engagement with women's diverse experiences will be required.

3.6 THE STATUS OF REGULATION IN INDIA

As mentioned previously, recent years have witnessed rapid growth in medical tourism, including fertility tourism in India. This has resulted in more and more people coming to India for ARTs, surrogacy and egg donation. The lack of a regulatory or monitoring mechanism has resulted in the unregulated proliferation of ARTs and surrogacy. This, combined with the growing legal complexities around surrogacy, has necessitated proper and comprehensive regulation. The Indian Council of Medical Research (ICMR) and the Ministry of Health and Family Welfare (MOHFW) have made an effort towards this by first developing Guidelines (2005) and more recently drafting The Assisted Reproductive Technology (Regulation) Bill and Rules-2010. The Bill was made

available for public perusal in the year 2008. Even though this was an important step, some scholars and activists were of the opinion that the document did not address the issues in a comprehensive manner from a women's rights perspective. Some clauses have been added and some changed from the previous draft. In addition to the Draft legislation under consideration, the Law Commission of India also put forward a report in 2009 (http://lawcommissionofindia.nic.in/reports/report218.pdf). In comparison to the proposed legislation, the position of the Law Commission is starkly different with regard to allowing commercial surrogacy. The Commission recommends legalising surrogacy only for altruistic reasons, and completely banning commercial surrogacy. It remains to be seen how this recommendation will be read along with the Bill. Once the legislation is finalised and implemented, it will be the framework for the monitoring and regulation of ARTs and surrogacy arrangements. Therefore, let us briefly take a look at the some of the important terms as defined in the proposed legislations.

Table 3.6: Definitions of Terms Associated with Surrogacy

Surrogacy means an arrangement in which a woman agrees to a pregnancy, achieved through assisted reproductive technology, in which neither of the gametes belongs to her or her husband, with the intention to carry it and hand over the child to the person or persons for whom she is acting as a surrogate.
Surrogate mother, who is a citizen of India and is resident in India, who agrees to have an embryo generated from the sperm of a man who is not her husband and the oocyte of another woman, implanted in her to carry the pregnancy to viability and deliver the child to the couple / individual that had asked for surrogacy.
Surrogacy agreement means a contract between the person(s) availing of assisted reproductive technology and the surrogate mother.

It may be noted that the Draft Bill does not allow the surrogate mother to be the egg donor. As per the proposed Bill "*A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy*" [Clause 34(13)]. This means that no genetic surrogacy is allowed and only gestational surrogacy is permissible. Such a clause also implies that the surrogate has to undergo the more complicated and invasive procedure of Embryo Transfer (ET) instead of Intra Uterine Insemination (IUI), even if her own eggs are viable.

In the absence of a proper regulation, it is not surprising that there are many cases which highlight the inability of the Indian state to deal with surrogacy complications, and the need for a comprehensive legislation and regulatory mechanism.

Box 3.6: Surrogacy and Draft Bill-2010

- **The maximum age at which a woman can become surrogate has been reduced from forty-five years (Draft Bill 2008) to thirty-five years. However, the Draft has also increased the number of successful live births that a surrogate is permitted, from three (in the previous Draft) to five.**
- **While it explicitly permits single women to access ARTs, the Draft Bill- 2010 (like the previous one) neither prohibits nor explicitly permits single women to be surrogates. Whether single women are permitted to be surrogates or not has been left open to interpretation.**
- **The Bill permits only Indian citizens to act as surrogate, and states that no ART bank/ART clinics shall receive or send an Indian for surrogacy abroad.**
- **The present bill also states that the commissioning parent(s) shall ensure that the surrogate mother and the child she delivers are 'appropriately' insured till the child is handed over to the commissioning parent(s)…. till the surrogate mother is free of all health complications arising out of surrogacy. However, the Bill does not elaborate on the nature and the kind of insurance, nor does it state the factors, which determine the 'appropriateness' of the insurance.**
- **In case the intended parents are from outside India and refuse to take custody of the child born out of the surrogacy arrangement, following a period of one month, the local guardian shall be responsible for either bringing up the child or handing over the child to an adoption agency. In either instance, the child shall be given Indian citizenship.**
- **Payment to the surrogate is to be made in five installments instead of three (previous Draft) with the majority, i.e. 75 per cent, to be paid as the fifth and final installment, following the delivery of the child.**
- **A positive addition in the Draft Bill-2010 is the requirement of legal documents from foreign couples declaring that surrogacy is permitted in their respective countries and that the child born out of such an arrangement will be the legal citizen of their country. Such a provision will be useful in addressing legal complexities and citizenship issues arising out of surrogacy arrangements.**

Source: The Assisted Reproductive Technologies (Regulation) Bill, 2010, Ministry of Health and Family Welfare, ICMR.

The Draft document in its present form is a significant step towards regulating the industry. However, some scholars and activists opine that it is skewed towards the interest of the medical market and providers, while compromising on the rights and concerns of the surrogates. For instance, the clause regarding the shift in the mode of payment reflects the higher priority accorded to intended parent(s) than the surrogate, and negates the potential health risks faced by the surrogate. As such, the rights of the surrogate are multilayered, and need to be understood separately and in addition to the regulatory framework. Let us read some case studies which will help you understand better the position of surrogate mothers in this business.

3.6.1 The Case of Baby Manji

A Japanese couple, Ikufumi and Yuki Yamada travelled to India to have a child through surrogacy. In November 2007, they visited the Akanksha Fertility clinic in Anand, Gujarat, selected the surrogate and began the process. The surrogate mother was implanted with an embryo which had been created using Ikufumi's sperm and eggs harvested from an anonymous Indian egg donor.

In June 2008, during the course of the pregnancy, the couple got divorced. On July 25 2008, baby Manji was born to the surrogate mother. The father, Ikufumi, came alone to take the baby back to Japan. The mother, Yuki, did not want to raise the child. Baby Manji had three mothers; the egg donor, who had no rights over her, the surrogate by contract, who had relinquished all her rights to the baby, and the intended mother, who did not feel genetically or legally responsible for the baby. Nonetheless, there was a clause in the surrogacy agreement stating that if the couple separated, the father would raise the child.

However, the trouble began when the father initiated the process of taking the baby back to Japan with him. The Japanese Embassy did not give the required travel documents to Manji on the grounds that the child's mother was Indian, and the Japanese civil code does not recognise surrogate children. Ikufumi Yamada tried to adopt the child, but in India, the law does not permit a single man to adopt a baby girl. Finally, he approached the Indian Government for an Indian passport for the baby. However, a passport requires a birth certificate, and with the confusion over which mother should be considered Manji's mother, the Anand Municipal Council refused a certificate. But as Ikufumi was not Indian and it was not clear whether the Indian surrogate should be considered the mother, the national offices in India refused to issue the passport. Following an appeal filed on 8th August 2008, the Municipal Council of Anand granted a birth certificate to Manji with only the father's name. Meanwhile, Ikufumi's mother and Manji's grandmother, Emiko Yamada, came to India to take care of the baby.

Baby Manji was shifted to Jaipur by Indian friends of Ikufumi. She was hospitalised because she had septicemia and viral infections. However, even after recovering she continued to be in the hospital in Jaipur, as there was no clarity on who should be granted her custody. As soon as the vital records office granted the birth certificate, Emiko Yamada filed a petition in the Rajasthan High Court for temporary custody as Manji's closest blood relative in India, until such time that custody could be transferred to her son. However, in mid- August 2008, a Jaipur-based NGO, Satya, filed a habeas corpus petition in the Rajasthan High Court claiming that baby Manji was a victim of a child trafficking racket and that she had been abandoned. The NGO sought custody of the child on the grounds that custody cannot be granted to Yamada in the absence of laws to govern surrogacy in India.

The matter reached the Supreme Court, which immediately quashed the NGO's plea for custody of the newborn, and issued a notice asking it to explain its interest and stand in the matter. It granted temporary custody of the child to the grandmother Emiko. The Solicitor General of India, G.E. Vahnavati, was asked by the Court.to clarify India's stance on Manji's parentage and citizenship.

The Solicitor General told the Court on September 15, 2008 that the decision about Manji's passport rested with the Union Government. A month later, the Rajasthan regional passport office issued Manji an identity certificate as part of a transit document, which would enable her to get a visa for Japan. It was the first such certificate issued by the Indian Government to a surrogate child born in India. It did not mention the child's nationality, mother's name or religion, and was only valid for Japan. On October 27, 2009 the Japanese Embassy gave a one year visa to Manji on humanitarian grounds, stating that she would become a Japanese resident only after a parent-child relationship had been established by Ikufumi Yamada; by proving his paternity, or by adopting her. It was only after this prolonged legal battle that baby Manji could be taken back to Japan (Points, http://www.duke.edu/web/kenanethics/CaseStudies/BabyManji.pdf).

Baby Manji's case attracted much media attention and coverage. However, this is not an isolated case highlighting the legal problems of surrogacy arrangements. An equally contentious issue is access to surrogacy for gay couples. Since many countries prohibit surrogacy, it is not uncommon to find a number of gay couples coming to India to have a child. The following case study pertains to one such couple from Israel.

3.6.2 The Case of Dan Goldberg's Twins

Dan Goldberg and his homosexual partner, both from Israel, had twins by a surrogate mother in India. The twins were born to a surrogate mother in February 2010 by fertilizing an anonymous Indian woman's ova with Dan Goldberg's sperm. However, he had to wait for two months due to the

family court's refusal to issue a standard legal order that would pave the way for the children to obtain Israeli citizenship. Dan Goldberg spent two months with his twin sons, Itai and Liron, at a Mumbai hotel, awaiting permission from the Jerusalem Family Court to proceed with a paternity test that would determine whether he is indeed their biological father. Until the test was performed, the babies would not be granted entry into the country, nor would they be eligible to receive health insurance or medical treatments. In many prior instances, family courts issued decrees requiring Israeli parents of children born abroad to undergo DNA testing to confirm that they are in fact the biological parents - a prerequisite for the children's naturalisation as Israeli citizens.

However, the Judge Philip Marcus dealing with the case rendered a decision in March 2010, in which he stated that he lacked the jurisdiction to issue a court order for Goldberg to take a paternity test. In explaining his decision, Marcus stated: "If it turns out that one of the [purported fathers] sitting here is a pedophile or serial killer, these are things that the state must examine" (http://www.haaretz.com/print-edition/news/). An appeal was filed on Goldberg's behalf with the Jerusalem District Court and a panel of judges said that Marcus did have the authority to issue an order for a paternity test. At the same time they ordered that a legal guardian be appointed to represent the minors, and that the case be referred back to Judge Marcus. Meanwhile, Dan Goldberg had to face considerable financial problems in sustaining himself in India.

The lesbian, gay, bisexual and transgender (LGBT) community in Israel rallied to the support of Dan Goldberg. A spot protest was held in front of the office of the Interior Ministry in Jerusalem in May 2010. This was to urge its members to speed up the process of granting citizenship to the twins. Finally three months after the twins were born, officials from the Israeli consulate informed Dan in person that his twins had been granted Israeli passports. This case highlights not just potential problems which can arise in cross country surrogacies, but also particular problems or biases that arise against the gay community.

3.7 LET US SUM UP

The above mentioned examples highlight the complexities and the dilemmas associated with surrogacy, especially in the legal domain (including the issues of citizenship). Although surrogacy as an arrangement has increased the 'reproductive choices' of couples, it has also opened up a Pandora's box of questions. Both commercial and altruistic surrogacy raise complex ethical and legal dilemmas with more questions than answers. Importantly, issues of commercialisation and commodification of women's bodies in such arrangements cannot be ignored or underestimated. At the same time the

use of commercial agencies and other negotiations in such arrangements are extremely complex. Therefore, we need to critically examine the larger social, economic, health and ethical factors that influence surrogacy contracts. These issues are multiple, intersecting and complex in nature. It is hoped that the above discussion will help you to reflect upon and debate on these issues in a considered manner.

3.8 GLOSSARY

Assisted Reproductive Technologies : Any medical technique that attempts to obtain a pregnancy by means other than by coitus is defined as ART. In other words, these techniques manipulate the sperm and oocyte (egg) outside the body, and the gametes or embryos are transferred into the uterus.

Artificial Insemination(AI): Artificial Insemination is the procedure of transferring semen into the reproductive system of a woman. The technique comprises of artificial insemination with the husband's (AIH) or the donor's sperm (AID)

Embryo : An embryo is the fertilised ovum that has begun cellular division and continued development up to the 'blastocyst' stage till the end of eight weeks of pregnancy.

Embryo Transfer : The transfer of an embryo from an *in vitro* culture into the uterus.

Gametes : This is a mature sex cell, namely, the ovum of the female or the spermatozoon of the male.

Intrauterine Insemination (IUI) : IUI refers to the placement of washed sperm into the uterus.

IVF (*In Vitro* Fertilisation) : *In Vitro* Fertilisation- Embryo Transfer is the fertilisation of an ovum outside the body and the transfer of the fertilised ovum to the uterus of a woman.

Oocyte : The female gamete (egg).

Spermatozoa : The male gametes produced in the testicles and contained in the semen.

Surrogacy with Egg Donation : Surrogacy with egg donation is a process in which a woman allows insemination by the sperm/semen of the male partner of a couple

with a view to carry the pregnancy to term and hand over the child to the couple.

Medical Tourism : A term used to describe the rapidly- growing practice of travelling across international borders to obtain health care.

3.9 UNIT END QUESTIONS

1) What is surrogacy? Discuss it from a gender perspective.

2) Surrogacy is a form of reproductive labour. Justify the statement with examples.

3) How does commercialisation of surrogacy impact women from developing countries?

4) Select any two cases of contractual surrogacy which have appeared in the media and discuss them in the contest of some of the feminist debates that you have read in this unit.

3.10 REFERENCES

Berkhout, Suze G (2008). *Buns in the Oven: Objectification, Surrogacy, and Women's Autonomy: Social Theory and Practice*. Florida State University.

Corea, Gena (1985). *The Mother Machine: Reproductive Technologies From Artificial Insemination to Artificial Wombs*. New York: Harper & Row.

Firestone, Shulamith (1971). *The Dialectics of Sex*. New York: Bantam Books.

Goodman, Ellen (2208). 'The Globalization of Baby-Making'. *Featured in The Boston Globe*, 11th April.

Gupta, Jyotsna Agnihotri (2000). *New Reproductive Technologies, Women's Health and Autonomy: Freedom or Dependency?* Indo-Dutch Studies on Development Alternatives Series, Sage Publications Pvt. Ltd.

Karkal, Malini (1997). 'Surrogacy from a Feminist Perspective', *Indian Journal of Medical Ethics*, 5(4), Oct-December.

Mulay, Shree & Emily Gibson (2006). 'Marketing of Assisted Human Reproduction and the Indian State', *Development*, 49(4), 84-93.

Pande, Amrita (2009a). 'It May Be Her Eggs But It's My Blood: Surrogates and Everyday Forms of Kinship in India'. *Qualitative Sociology*, Spinger, 32 (4), pp.379-405.

Pande, Amrita (2009b). 'Not an 'Angel', not a 'Whore': Surrogates as 'Dirty' Workers in India', *Indian Journal of Gender Studies*, 16 (2), pp.141-73.

Points, Kari (2009). 'Strategies for Protecting the Health and Human Rights of Surrogates in India: A Multicounty Legislative Analysis'. Duke University: The Standard Institute for Public Policy.

Points, Kari (2009a). 'Commercial Surrogacy and Fertility Tourism in India: The Case of Baby Manji', Duke University: The Kenan Institute for Ethics, http://kenan.ethics.duke.edu/education/case-studies-in-ethics/institutions-in-crisis/. Accessed on 3rd Sept, 2012.

Qadeer, Imrana (2009). 'Social & Ethical Basis of Legislation on Surrogacy: Need for Debate', *Indian Journal of Medical Ethics (IJME)*, 6(1), pp.28-31.

Raymonds, Janice (1998). 'Reproduction, Population, Technology and Rights: North and South', *Women in Action*, 2 (75).

Sabala and Gopal, Meena (2010). 'Body, Gender and Sexuality: Politics of Being and Belonging', *Economic and Political Weekly*, 45(17), April, pp. 43-51.

SAMA (2006). *ARTs and Women: Assistance in Reproduction or Subjugation*? Delhi: Resource Group for Women and Health.

SAMA (2007). *Making Mothers; Gender, Fertility, Sexuality and Assisted Reproductive Technologies*. New Delhi: Resource for Women and Health.

SAMA (2008). *Cheap & Best: Analysis of Websites, Brochures and Advertisements on Assisted Reproductive Technologies in India*. New Delhi: Resource Group for Women and Health.

SAMA (2009). 'Assisted Reproductive Technologies, A Critique'. *Newsletter: Indian Association for Women's Studies*, Special Issue, 2(5), www.iaws.org/content/newsletter/IAWS accessed on 13th Aug.

Saravanan, Sheela (2010). 'Transnational Surrogacy and Objectification of Gestational Mothers'. *Economic and Political Weekly*, April 17, pp.26-29.

Sarojini, N. & Aastha Sharma (2009). 'The Draft ART (Regulation) Bill: In Whose Interest?', *Indian Journal of Medical Ethics (IJME)*, 6(1).

Sarojini, N., Vrinda Marwah and Anjali Shenoi (2011). 'Globalisation of Birth Markets: A Case Study of Assisted Reproductive Technologies in India'. *Globalisation and Health*, 7(27).

Shah, Chayanika (2009). 'Regulate Technology, Not Lives: A Critique of the Draft ART (Regulation) Bill'. *Indian Journal of Medical Ethics* (IJME), 6(1).

Shah, Chayanika (2009). 'Surrogate Motherhood and Women's Sexual and Reproductive Rights', Paper Presented at the *Asia Pacific NGO Consultation; My Body, My Life, My Rights: Addressing Violations of Women's Sexual and Reproductive Rights*, 7-8 December, Bangkok.

Spar, Debora (2006). *The Baby Business: How Money, Science, & Politics Drive the Commerce of Conception*. Harvard Business School Press.

'Surrogacy a $445 mn Business in India' (2008). *The Economic Times*, August 25.

www. infertilityanswers.typepad.com, accessed on 14th Aug, 2012.

http://www.haaretz.com/print-edition/news/ gay-father-of-twins-born-to-indian-surrogate-denied-permission-to-bring-his-sons-home 1.289128. Accessed on 3rd Sept, 2012.

3.11 SUGGESTED READINGS

Anleu, Sharyn Roach (1992). 'Surrogacy: For Love but Not for Money?' *Gender and Society,* 6(1), pp. 30-48.

Banerjee, Sneha (2012). 'Emergence of 'Surrogacy Industry'. *Economic and Political Weekly*, March, XLIV (11).

Pande, Amrita (2009a). 'It May Be Her Eggs But It's My Blood: Surrogates and Everyday Forms of Kinship in India'. *Qualitative Sociology*, Spinger, 32 (4), pp.379-405.

Pande, Amrita (2009b). 'Not an 'Angel', not a 'Whore': Surrogates as 'Dirty' Workers in India'. *Indian Journal of Gender Studies*, 16(2), pp. 141-173.

Qadeer, Imrana (2009). 'Social and Ethical Basis of Legislation on Surrogacy: Need for Debate'. *Indian Journal of Medical Ethics*, 6 (1), pp. 28-31.

Spar, Deborah (2006). 'For Love and Money: The Political Economy of Commercial Surrogacy'. *Review of International Political Economy*, 12(2), pp. 287-309.

Vora, Kalindi (2009). 'Indian Surrogacy and Commodified Vital Energy'. *Subjectivity*. Palgrave Macmillan,Issue28,pp.266-278, http://www.surrogacyaustralia.org/download/researchCenter/Social%20Policy%20&%20Ethics/Vora%202009%20Indian%20transnational%20surrogacy%20and%20the%20commodification%20of%20vital%20energy.pdf, Accessed on 26th Nov, 2012.

UNIT 4 THE MATERNAL BODY IN URBAN INDIA

Anu Aneja

Structure

4.1 INTRODUCTION

In recent decades, feminist theorists of motherhood have begun to interrogate and dismantle constructions of maternal metaphors specific to South Asian cultures. In the west, there already exists a considerable discourse on motherhood and its inherent ambivalences, its literary representations, sociological analyses, and its complex psychoanalytical trajectories with and beyond Freudian theories. Some of the questions towards which western theorists of motherhood have turned their attention may also be useful in a critical appraisal of motherhood in urban India. However, specific bearings of culture, class and caste impact women, especially in their 'embodiment' as mothers, in very determined and particular ways. In the last unit of this block, we will examine the situation of urban middle-class Indian women, in their specific situations as mothers, in the light of cross-cultural discourses of motherhood originating in western cultures and more specifically, in urban Indian settings. We will also look at the situations of rural migrant women, hired as domestic help in urban settings, in order to analyze their roles in comparison to that of women from the upper classes.

4.2 OBJECTIVES

After going through this unit, you should be able to:

- Locate the analysis of motherhood in urban India within cross-cultural theoretical discourses on motherhood;
- Understand and analyze women's roles as mothers in the context of urban India;
- Comprehend the relationship between motherhood and class and caste structures, especially within the middle-class and upper middle-class urban scenario;
- Place motherhood and other roles played by women within the context of patriarchal and capitalist structures in urban India;
- Relate to the relationships between women's bodies as mothers, and as labouring bodies, from the point of view of urban mothers and rural migrant women hired as domestic help; and
- Engage with the changes in women's lives within the context of contemporary transitions in culture and economy.

4.3 THE MATERNAL BODY IN A CROSS-CULTURAL CONTEXT

Before we turn our attention to Indian context, let us begin with a brief analysis of motherhood in one particular western culture, the United States, where a considerable body of knowledge and critical appraisal around related issues has already been generated. This has led to an active feminist scholarly engagement with questions of motherhood in relationship to larger questions about gender identities. As in many other industrialized nations where controlled organizational structures are seen as essential for efficiency in terms of capitalist relations of production, in the US too, motherhood, among other social institutions, ends up being governed by similar disciplinary structures. It becomes incumbent that the mother's body, as well as the child's, be coerced into methodical patterns of behaviour so that they both begin to submit to the larger regulations perceived as the bedrock of cultural and economic prosperity. Intellectual discourses which give their due to individuality and non-conformity, may not necessarily hold true for cultural practices, especially those concerned with women. Hospitalization procedures during childbirth re-enforce the malady of motherhood by privileging medicine and cure over facilitation and care At the same time, the systematic and almost complete institutionalization of all personal needs in the US (as in hospitals for the sick, therapists for the disturbed, and retirement homes for senior citizens), has led to an increasing dependence

on institutional structures to take care of any unforeseen exigencies in an individual's life. Daycare centres are often projected as the panacea to all the worries and concerns a new parent might have.

Various feminist scholars have observed how 'maternity' has been conceptualized and institutionalized as a 'disease' in western cultures. Some feminists, like **Eva Feder Kittay**, attribute this phenomenon to patriarchal control: "Male control of the process of pregnancy and childbirth in the United States today is exercised by the physician who habitually treats maternity as a 'disease'" (Kittay, 1983, p. 114). It is possible for us, on the one hand, to read the disciplining tendencies of western culture towards maternity and motherhood in the light of motherhood theory to explain it, as in Kittay's conclusion above, as a unilateral function of patriarchal control over women's bodies and reproductive functions. However, another type of reading of this phenomenon is also possible and may be somewhat more instructive.

Taking a cue from the work of **Michel Foucault**, certain Foucauldian feminists have attempted to view the disciplining structures of patriarchy as part of a larger nexus of power structures. Women, along with men and those other genders who get left out of the normative heterosexual network, may be equally caught and confined within such structures. **Jana Sawici**, for instance, in her discussion of Foucault and the role of "discipline," states that "for a Foucauldian, patriarchy is the name of a global effect of domination made possible by a myriad of power relations at the micro-level of society" (Sawicki, 1991, pp. 59-62). Rather than focusing solely on patriarchy as the root cause of women's oppression, it may be useful for us to take under serious consideration a perspective which locates patriarchy as part of a larger domain of power structures. This would allow us to shift the locus of women's oppression and domination slightly away from the universalized 'other' of motherhood theory, namely, an abstract 'patriarchy', to a nexus of patriarchal and other repressive forces, such a capitalism, racism and casteism. Mothers, along with others, may be equally victimized as well as implicated in such a nexus.

While effects of race, class and caste inequalities may all be examined in relation to patriarchy, such an analysis could help us to view the various unequal power structures not just as effects of a common enemy called patriarchy, but rather as forces which uphold and are supported by patriarchal norms and strictures. For instance, in examining the position of urban domestic maids, who also happen to be mothers, one would have to take into account factors beyond their oppression or exploitation by the rural patriarchal structures to which they belong. These factors may include the role of urban patriarchal households, the unequal distribution of wages for domestic work done by women, the exploitation of lower class and lower caste women by their upper class/caste counterparts in urban domestic

households, and so on. Moreover, each of these relationships would need to be examined not in isolation, but rather as part of a larger nexus of patriarchal, capitalist, and hierarchical social structures which benefit from each other and thus sustain each other. Such an analysis would thus open up spaces within which cross-cultural comparisons of the effects of complex patriarchal social structures in different cultural milieus may become possible and productive.

Keeping the above in view, let us attempt a critical examination of motherhood in urban middle-class Indian society in an attempt to understand and analyze some of the forces which act together to construct specific representations of motherhood which a certain section of Indian women may be subjected to. This limited analysis should not be seen as a generalization of the position of all Indian mothers, but rather used as a comparative/analytical model against which the situations of various categories of women and mothers can be examined. Thus, it would be useful for you, as you read through the following sections, to make your own comparisons and analyses with women of different class, caste or religious backgrounds, in their roles as mothers.

4.4 MOTHERHOOD IN URBAN INDIAN CONTEXTS

The patriarchal framework within which motherhood has been conceptualized, framed and imbued with specific codes in Indian history and culture has led to a peculiar manifestation of maternal care amongst the urban middle classes. In the aftermath of the government's policies of economic liberalization, and a booming economy, Indians in every social and economic tier are caught in a web of class hierarchies. Being located in an increasingly capitalist structure can often imply that a great deal of importance is placed on the individual's struggle in climbing to the next rung of the ladder of financial success, and therefore, such a struggles may get projected in the culture as one of life's primary goals.

In urban India, especially, some of the growing effects of this phenomenon can be seen in an increasingly consumerist culture, flagrant appetite for money and its disposable resources, as well as, on the positive side, revolutions in music, art and cinema, greater personal freedoms, and a privileging of individual creativity and inventiveness. A fierce competitiveness and the desire to display symbols of wealth and status may also be found to accompany the heightened trends towards consumerism. In cultures where women's bodies are often projected as sexual objects, and in capitalist cultures with very strong sexist leanings, women, especially from upper classes, come to occupy peculiar positions as they must posture both as possessors of valued commodities as well as commodified bodies owned by wealthy men. In this regard, middle class and upper class urban Indian women occupy positions which are not that different from the trophy wives

of the western elite. Here, it would be significant to note the complex role played by women's 'agency' which implies that women from the upper middle and upper classes are to some extent at least, 'free' to choose such roles. However, an analysis of women's subscription to, or rebellion against, occupying pre-determined class and gendered roles may reveal a good degree of conscious or unconscious internalization of these roles, thus making the issue of 'agency' both debatable and complex. In the section which follows, we will look at some of the specific manifestations of these cultural phenomena in regard to their impact on women's roles as mothers and the maternal body in urban India.

4.5 BEAUTY MYTHS

You may have noticed, through media representations, that an explosion in consumerism, technological revolution, new money and upper class snobbery, all curiously mired in old patriarchal values, are often represented through images of the upper-class hi-tech mother toting the latest cell phone as fashion accessory, and advertising the family's recent foreign vacation, new car, or latest party on social networking sites. While the tools are obviously available only to the very rich, one can see that women, and especially mothers, themselves become tools in the larger programme of projecting the wealth owned by men. Similarly, for young upper-class mothers, body spas, diet clinics and the booming beauty industry all feed the frenzy fanned by the craze to possess the thinnest, fairest, most attractive body splattered in magazines and dailies alike. It is, however, a certain kind of beauty, projected most ostensibly in urban beauty pageants, that is projected as the ideal to be emulated by young urban women. The peculiar features of such representations of beauty are that they work to combine western notions of 'sexiness' (mainly light-skinned, chiseled, skinny, 'artificially enhanced' and sexually exaggerated bodies) along with Indian standards of 'femininity' (mainly projected through ethnic outfits such as the traditionally worn sari, or the docile 'namaskar').

As a result, a westernized 'sexiness' gets transplanted onto the urban female body without essentially disturbing its 'Indianness'. In her discussion of the role of 'beauty queens' and 'beauty pageants' in contemporary Indian culture, **Huma Ahmed-Ghosh** describes the current craze and adulation for "Miss India" who "is simultaneously 'modern' and 'traditional'.... She represents the ultimate modern Indian woman, preserving tradition while heralding modernization" (**Ghosh, 2003, p. 223).** The Miss India's of today are projected as the future Miss Worlds, Miss Universes or Miss Earths, in an ever-expanding circle of worldliness and universalization to which the modern Indian wishes to lay claim, while still clinging onto a morally superior attitude whose locus is the Indian woman, still in many ways the 'womb' and 'mother' of Indian moral and religious values. In recent years, one can

witness the eponymous presence of similar representations of motherhood which combine modern and traditional values and attributes both in popular commercial cinema and in television serials and programmes, as in the 'Mrs. India' beauty contest. While the female characters portrayed on big and small screens may be stylized in ostensibly western ways, the values of motherhood embodied by them tend not to stray too far from culturally acceptable roles. This ensures that patriarchal and traditional constructions of motherhood remain intact, despite the aspirations towards westernization.

Check Your Progress:

Think of a female character or characters in a television serial who appears to conform to western notions of beauty but embodies traditional Indian values of womanhood and motherhood. Analyze the extent to which the western norms of beauty impact the cultural values upheld by the character and vice versa. What do you think would be the impact of such representations on female viewers in India, who are either mothers or would be mothers? Note down your observations and discuss in your peer group, or on the online discussion forum.

4.6 PUBLIC SPACES, PRIVATE DESIRES

As you would have noted in the above section, traditional value systems still upheld in a majority of urban middle-class households ensure that the mother's role continues to be constructed as that of the primary care-giver, while the father is seen as the primary provider. In the middle-classes, where economic necessity forces many women to work outside the home, mothers still have to deal almost single-handedly with the large burden of childcare and housework. In extended families, the burden may be shared by other women living in the household, but the stresses of co-habiting with numerous relatives and in-laws may off-set the help and support on the domestic front. The office space is fast becoming, for such women, not just a space for professional growth and satisfaction, but also a release from an oppressive patriarchal control domestic environments which may offer very limited space for romantic, conjugal relationships. At the same time, the financial contributions made by the middle-class woman are very welcome in most urban households, but it is still largely expected that the man will bring home more than the woman, so that her earnings can be safely labeled a 'side-income' rather than the bread and butter of the family.

The recent tolerance of women's sexual agency outside the four walls of the marital bedroom seem to run counter to the grain of the normative representation of the middle-class Hindu woman as someone devoid of sexual desires. However, it is important to note that this ostensible tolerance does not radically upset the fiercely held-onto notion of the inviolable private sphere within which middle-class women continue to uphold so called 'traditional family values' such as subordination or even subservience to the husband and in-laws, and their primary responsibilities as mother and caregiver of children. Very often, only acceptable public roles of the middle-class woman, such as teacher, assistant, secretary etc, are deemed appropriate within such socially contractual arrangements, while certain other types of jobs may be seen as less responsible.

The contractual arrangements mentioned above rest firmly on an understanding that the private realm and the public sphere are to remain clearly separated. You have already read about the public/private dichotomy in Unit 2, Block 2 of MWG 002. The clear cut divide between private and public spaces is informed by the difference between traditional morality (read, middle-class notions of respectability) and modernization (read, acceptable western liberal values which can be accommodated within, or reconciled with, middle-class Indian notions of respectability, primarily for economic and personal gains). The reconciliation of these contradictory forces does not, however, threaten the core of so-called traditional moralities, but does result in complex representations of women and mothers, aptly described by **Shilpa Phadke** as "modern urban middle-class progressive but respectable" women (Phadke, 2005, p.68). In her incisive analysis of the forces that comprise middle-class female sexuality, Phadke adds, "Middle class sexuality, then, is respectable not only because it operates within socially sanctioned norms but also because it recognizes the need for what is private to remain hidden from the public gaze. For women, being respectable involves understanding this dichotomy and playacting the scripts of sexual femininity in public, while making it clear that private spaces cannot be transgressed" (Phadke, 2005, pp. 74-78). Phadke convincingly argues the need to analyze the roles of consumption and desire in the lives of middle-class heterosexual feminists in India, especially in the context of marriage, since the majority of such women continue to remain impacted by marital codes imposed by a class system which is itself the product of capitalist and patriarchal forces (see Phadke, 2005).

Thus, while patriarchal demands on women's modesty, sexual invisibility, and household responsibilities invoke the image of a woman oppressed within the domestic sphere, capitalist and consumerist demands, with their ever-widening penumbras of desire and greed, create the need for women whose labor can be exchanged for money, and whose bodies can at times be represented in sexually objectifying ways in materialist cultures. The

distinctions between sexual objectification and sexual agency often get confused because of willing or coerced adherence by women to capitalist representations of sexuality. The increasing influence of capitalist values and demands amongst the middle-classes have become largely responsible for opening up spaces where women's sexual agency and desire are beginning to make themselves visible, albeit in performative and largely unstudied ways. It would be important to analyse the impact of such influences on women's roles as mothers in urban India.

4.7 UPPER-CLASS LABOURING MOTHERS

While prevailing notions of morality and respectability are the determining factors of women's public roles among the urban middle-classes, in upper middle-class and upper class families, the 'side-income' of women is equally, if differently, delimited by the kind of work that these women can be involved in. Despite class differences between women's economic roles, the one common factor across the class divide seems to be the representation of women's work as 'non-threatening'. As seen above, just as subordinate work of any kind is viewed as more acceptable for middle-class women, their upper-class counterparts must equally succumb to maintaining gender hierarchies. Preferably, the upper class woman should not be engaged in any activity that may be perceived as 'real work', since this would automatically reflect on the husband's inability to be an adequate provider. It would also imply that the woman is forced to spend time away from home and children, still viewed as her primary responsibilities. It is therefore not uncommon to see a growing number of young, married women in upper class neighborhoods engaged in 'non-threatening' commercial activities, such as supply of baked goods and chocolates, handbags and fashion accessories, decorative items such as gift envelopes, candles, and other products meant for consumption within the domestic sphere. Since these activities can be carried out inside the controlled confines of the upper-middle class home, (or occasionally in upscale locales), they are viewed patronizingly as acceptable distractions for upper-class, wives and mothers.

Moreover, the ostensible aim is not presented as an increase in financial income, but rather as a distraction for upper-class wives and mothers who may otherwise succumb to boredom, given the surfeit of wealth and time at their disposal. In other cases, the desire to 'work' outside the home may also be driven by the perceived competition from the modern, competent working mother whose image is idealized by an increasingly materialistic society. While these women may have a deceptive sense of power and control over their own lives and that of their children, the underlying patriarchal parameters within which they must function ensure that they behave in certain ways and play their pre-determined roles to uphold the old sexist values thinly disguised under the garb of new westernized

materialism. As **Shilpa Phadke** observes, new circumscriptions of modernity "in a Foucaultian sense" are "clearly part of the apparatus of disciplining women's bodies and rendering them docile" (Phadke, 2005, p. 75). Interestingly, the perspectives of Jana Sawicki and Shilpa Phadke, while separated by cultural boundaries, seem to converge at the point where they both surmise the effects of disciplining pressures on women's bodies as relationally linked to forces within which patriarchy is but one strand. As you have seen in the above analyses, one cannot extricate patriarchy as the sole factor of women's oppression; rather, it becomes imperative to follow the various pathways opened up to examination by the specific nexus operating in a particular class and culture.

Check Your Progress:

Does the experience of motherhood differ in relation to caste, class, and culture. Take any one structure to answer this question.

4.8 CHILDCARE AND EDUCATION

A further commonality shared by mothers across the urban middle and upper middle-classes is their pre-determined role as the provider of children's 'education' which in traditional Indian culture, encompasses both formal education and the much more nebulous areas of moral, social and religious instruction imparted to children, for which the mother is seen to hold the primary responsibility.

In her study of education and the roles played by middle-class mothers in Kolkata, West Bengal, Henrike Donner concludes that "the discursive construction of a child's 'needs' is linked to the intimate knowledge gained within a relationship only the mother possesses. Even if homework is set by the school in the first place, it is only the mother who can make the child perform" (Donner, 2008, p. 143-144). She goes on to add that "in theory, only the mother and her child are involved in schooling and the mother is free to devote herself fully to school-related activities" (Donner, 2008, pp. 143-144). The insistence on the mother as the 'natural' source for the child's formal as well as informal education once again places the burden of upholding religious and moral values upon the mother, since this holds special significance for the sustenance of the patriarchal family. Furthermore, by turning the mother into the font of such family values, and of collective community history, the patriarchal structure ascertains that women's sexuality remains subdued since such women draw their sense of identity, and their

limited sense of empowerment, from their primary role as the guardian of privileged moralities played out through maternal roles.

4.9 RURAL MIGRANT CAREGIVERS AS SURROGATE MOTHERS

It is quite commonplace to witness that in many upper middle-class households, the actual care of young children is left to the 'ayah', the much in demand female help who is usually a young, rural migrant woman hired to do light housework and childcare in return for a salary, room and board. In some cases, one can witness the transformation of these 'ayahs' or 'didis' (older sister) from maid to nanny to surrogate mother, as they take on almost all of the childcare duties from changing diapers, bathing, and feeding, to accompanying their wards to parks, playground, birthday parties and excursions. But owing to differences in caste and class, and the fact that the surrogate 'mothering' is based on a financial transaction, emotional bonding between the 'ayah' and the child is severely curtailed. The unspoken but implicit contract between employer and employee recognizes the economic, class and caste differences which obstruct any possible emotional attachment that the 'ayah' may develop towards the child as her position is clearly demarcated by her inferior social status. This, of course, may not be true from the perspective of the child who may naturally experience a closeness to her/his caregiver, and who would have to be 'trained' to understand social hierarchies by family members. As noted by **Maithreyi Krishnaraj**, "When care-givers do mothering, the care-taker gets emotionally attached to the child. Yet, she is not entitled to full ownership because there is a money transaction involved" (Krishnaraj, 2010, p. 23).

On the other hand, 'ayahs' who are also mothers often leave behind their own young children in the villages, to be looked after by older siblings, mothers or mothers-in-law, and are usually able to visit the children only on annual trips home. A deep sense of resignation and fatalism may often become an integral part of their lives, as they force themselves to get habituated to the long separation from their own young children. Ironically, the traditional joint family structure which functions as a rural childcare support system for poor women migrants, and thus makes it possible for them to move to distant urban areas in search of employment, is also often the one that decides if, and when, a young woman must migrate to the big city in search of paid domestic labour. The earnings, or most of them, are usually sent home to feed the family. More often than not, choosing a partner, getting married, bearing children or being later parted from them, are not decisions that the lower class/ lower caste migrant woman makes for herself.

Educational opportunities, marriage and freedom of movement are also often determined by complex caste hierarchies. This may be evident from the recent spate of what are ironically termed 'honor killings' being carried out to 'protest' against inter-caste marriages in certain villages around Delhi. One of India's foremost newspapers indeed describes two adjoining neighbourhoods of New Delhi, separated only by a 1 km narrow lane, as "two different Delhis. One has gyms, spas and palatial houses. . . The other has dingy lanes and . . . chaupals where village elders share hookahs and lament declining morality". The attacks on 'declining morality' mostly target young women and men who have dared to marry against caste restrictions forcefully imposed by self-proclaimed guardians of ancient patriarchal and social (mainly caste-based and community-based) laws/norms. By exerting strict control over marital alliances, these laws restrict the mobility of women and their offspring, within or across caste barriers, in order to maintain control over communal property. The female body, especially in its capacity to produce future off springs, remains the site of territorial battle and violence; perhaps not such a shocking contrast to the images of the waif-like and cosmetically enhanced women and mothers pervasive in contemporary Indian and western media. On the one hand, the basic freedoms and rights of the former are circumscribed based on the notion of family and community *izzat* or honour; any threat to *izzat* is a potential invitation to violence against the female body. In the latter case, women of the upper classes may consciously or unconsciously internalize beauty norms made prevalent by media in patriarchal societies, such as that of the thin, anorexic, 'sexy' body, where body parts may even be surgically or artificially enhanced to live up to certain standards of prevalent norms, thus inviting a different kind of violence inflicted by women upon their own bodies.

Check Your Progress:

'Honour Killings' executed by Khap Panchayat have become a common occurrence as reported by the media. Look at one such case and analyse it in the context of the cultural expectation of the 'maternal body'.

4.10 FAMILIAL "BONDING" AND VERTICAL PARADIGMS OF MOTHERHOOD

It would be evident to you from the above that despite obvious class and caste differences and disparities in personal freedoms, the domestic maids who are playing surrogate mothers to hundreds of children from well-to-do families in big cities in India are bonded in an invisible way with the women

who employ them. Both the employer mothers and the employee surrogates play out roles defined for them by their families, which themselves reflect the larger male dominated social and economic structures of which they are a part. The heterosexual family unit, in its nuclear or extended form, idealized throughout history and still often upheld or glorified in many contemporary cultures, may continue to shackle women by offering them prefabricated metaphors of femininity and motherhood, instead of liberating them through shared work, exchangeable roles and responsibilities, and communal relationships. When asked her opinion about "family relations" vis-a-vis women, **Luce Irigaray's** response was unequivocal, "As far as the family goes, my response will be simple and clear: the family has always been the privileged locus of women's exploitation". Regarding the power of mothers within the family, she goes on to add, that "this power exists only 'within' a system organized by men. . . historically, within the family, it is the father-man who alienates the bodies, desires and work of woman and children by treating them as his own property" (Irigaray, 1985, p. 142-143).

In contrasting vertical paradigms of motherhood against potential lateral relations between women, Juliet Mitchell observes that "the shift from the importance of giving birth to the importance of caring for offspring" is directly linked to the shift "from kin to class society and an economy of surplus profit in which capital not people increases..." (Mitchell, 2007, p. 176-185). In increasingly capitalist economies such as those of urban India, such a shift is easily perceivable in the increasing dependence of women from the upper middle-classes (especially working women) on their poorer rural sisters, who take on some of the burden of child-care. It is worthwhile to note, however, that irrespective of class differences, it is still primarily women who share childcare responsibilities, thus leaving the gender divide intact. In Joyce Trebilcot's early pathbreaking anthology on mothering, Rivka Polatnick had argued that "the allocation of childrearing responsibility to women,... is no sacred fiat of nature, but a social policy which supports male domination in society and in the family" (Polatnick, 1983, p. 37). More than three decades after feminists like Polatnick made similar observations about women's and men's responsibilities towards childcare, such a conclusion still rings true, cautioning us against any hasty moves towards post-feminist complacencies.

Thus, while women, as mothers, remain trapped in the gender hierarchy of socially and culturally sanctioned maternal identities, both wealthy and poor women continue to perform destined roles prescribed by capitalist driven, caste-based and male-dominated economies. As **Juliett Mitchell** wryly observes, "the economically rich or becoming rapidly rich countries or the economically successful within poorer societies are opting for one-child or child-free status per two adults; the condemned of the earth continue to have children, which means the wealthy can replace their children from elsewhere". (Mitchell, 2007, p.176-185). You have already

seen how this may be illustrated through cross-cultural surrogacy relationships in the previous unit. The children produced by the poor thus feed into a future labour pool of workers which will continue to sustain capitalist economies, while those from financially secure backgrounds may reap the economic benefits of having smaller families and larger incomes.

4.11 CHANGING SCENARIOS IN CONTEMPORARY URBAN INDIA

The above analysis does not imply a completely bleak picture, or that there are not many women who have charted out their destinies outside of the parameters described in the above sections. In contemporary urban India, at least, the patterns are fast changing, and the number of women resisting and charting out personal freedoms and identities is growing multifold. However, it is worth noting that those who are able to break free are usually those who have managed to seek out for themselves educational and professional opportunities which lead to some level of economic and personal independence. However, they must often deal with the emotional price of re-defining their lives beyond the traditional family structure. For women, personal freedoms are very often won through an acceptance of alienation from the stifling but very tight emotional bonds created by familial and communal relationships within patriarchal societies. Fortunately, for many women in urban India, which is an India clearly in transition, public as well as non-governmental funded programs emphasizing the role of the girl child, growing social acceptance of women's contributions and equality, emergent educational and employment opportunities, as well as an increasing participation by men in childcare and parental responsibilities, are all promising signs for the future.

Such women must constantly re-define newly won 'feminist' rewards in relation to what they perceive as their 'femininity', a 'femininity' beyond the one ascribed by the dominant heteronormative urban Indian culture. These struggles are certainly not new; rather, they are battles contended with by our feminist foremothers for centuries. For instance, in her study of **Simone de Beauvoir's** understanding of femininity and feminism, **Lori Jo Marso** discusses the commonly misunderstood conflictual representations of the above forces in Beauvoir's life and works to conclude that: "Beauvoir demonstrated that for the independent woman in patriarchal society, movement toward a life of transcendence and freedom is experienced in tension with the temptation to simply accept and perpetuate the conventional life that society has chosen as appropriate for women" (Lori Jo Marso, 2006, p. 142). The current status of middle-class and upper middle-class urban women in India is an indicator that the tussle between resignation to socially acceptable but unjust norms on the one hand, and rebellion against these in the search for what Beauvoir and others like her saw as

our collective "transcendence", is still very much alive. While the former has always been the path of least resistance, it is the difficulties surmounted by the struggles of many women and mothers before us that have shown us the benefits of rewards won out of risk-taking ventures. More recently, contemporary feminists have begun to call for a re-thinking of the subject position of motherhood in ways which allow us to sidestep essentialist and universalist traps, while keeping in view the specific historical and cultural limits within which women and mothers perform gendered roles (see in Patrice Diquinzio, Jana Sawicki, and Shilpa Phadke). Whether women are, or perform as, mothers, their real and staged desires both ultimately impact their lives in very real ways.

4.12 LET US SUM UP

We have looked at representations of the maternal body from the perspective of cultural expectations, beauty myths, the public/private divide, and in terms of urban/rural and class and caste differences. As you have seen in the above discussions, the collective narratives of women and mothers continue to be written at least partially by the structures which dominate and define their lives and from which they can begin to extricate themselves only by continuously examining, analyzing, and developing a joint critical awareness. Such a shared critical awareness has already led feminist theorists around the world to call into question the oppressive familial, racial and class structures within which gender relations are cast. To register protest through critical interrogation, while simultaneously marking our acknowledgement of changing positive trends, may be the initial step in the re-creation of a different set of parameters where women, and women-as-mothers, can begin to envision their lives and define themselves as 'women' and as 'mothers' in entirely new and liberating ways.

4.13 UNIT END QUESTIONS

1) Read the articles by Diqunizio, Kittay and Mitchell. Based on your readings, compare the situations of urban Indian women with their western counterparts, in their roles as mothers.

2) Do you agree or disagree with the discussion of public-private dichotomies and the prescribed roles of mothers as described in sections 4.6 and 4.7 above? Discuss and explain.

3) What is the impact of placing the burden of childcare and children's education and upbringing almost entirely on mothers in India? Discuss this in the light of the relevant sections that you have read. Then offer an alternative model, which according to you, would be preferable for both women and men in urban society. Explain why you think your model would be better.

4) Compare the situation of upper-class and upper-middle class urban women with that of the rural migrant women hired as domestic help to function as 'surrogate mothers'. Discuss some of the disparities (economic, social, etc) in their situations, as well as any commonalities.

5) In what ways do you think the urban Indian scenario is being currently transformed and what is the impact of these changes on women and on women as mothers? Is the trend towards a growing capitalist economy helpful or harmful for urban women in India? Explain.

4.14 REFERENCES

Ahmed-Ghosh, Huma (2003). 'Writing the Nation on the Beauty Queen's Body: Implications for a Hindu Nation'. *Meridians*, 4(1), 224-227.

Diquinzio, Patrice (1993). 'Exclusion and Essentialism in Feminist Theory: The Problem of Mothering'. *Hypatia*, 8(3), summer, 1-20.

Donner, Henrike (2008). *Domestic Goddesses: Maternity, Globalization and Middle-class Identity in Contemporary India*. Ashgate Publishing. 143-44.

Ghosh, Abantika (2010). 'Ashok Vihar and Wazirpur: A Tale of Two Different Delhis'. *The Times of India*, June 24, New Delhi, Capital Edition: 1+.

Irigary, Luce (1985). *This Sex Which is Not One*. Trans. Catherine Porter. Ithaca: Cornell University Press, 142-143.

Kittay, Eva Fedder (1983). 'Womb Envy: An Explanatory Concept'. In Joyce Trebilcot. Rowman & Littlefield (Eds.). *Mothering: Essays in Feminist Theory*, 114.

Krishnaraj, Maithreyi (2010). (Ed.). *Motherhood in India*. New York: Routledge, 23.

Marso, Lori Jo. (2006). *Feminist Thinkers and the Demands of Femininity*. Routledge.

Mitchell, Juliett (2007). 'Procreative Mothers (sexual difference) and Child-free Sisters(gender)' in Jude Brown (Ed.). *The Future of Gender*. Cambridge University Press, 176-185.

Phadke, Shilpa (2005). 'Some Notes Towards Understanding the Construction of Middle-Class Urban Women's Sexuality in India' in Geetanjali Mishra and Radhika Chandiramani (Eds.), *Sexuality, Gender and Rights*. Sage Publication, 74-78.

Polatnick, M. Rivka (1983). 'Why Men Don't Rear Children: A Power Analysis'. In Joyce Trebilcot. Rowman & Littlefield (Eds.), *Mothering: Essays in Feminist Theory* (p.37).

Sawicki, Jana (1991). *Disciplining Foucault: Feminism, Power and the Body*. Routledge.

4.15 SUGGESTED READINGS

Ahmed-Ghosh, Huma (2003). 'Writing the Nation on the Beauty Queen's Body: Implications for a Hindu Nation'. *Meridians*, 4(1), 224-227.

Diquinzio, Patrice (1993). 'Exclusion and Essentialism in Feminist Theory: The Problem of Mothering'. *Hypatia*, 8(3), summer, 1-20.

Donner, Henrike (2008). *Domestic Goddesses: Maternity, Globalization and Middle-class Identity in Contemporary India*. Ashgate Publishing. 143-44.

Kittay, Eva Fedder (1983). 'Womb Envy: An Explanatory Concept'. In Joyce Trebilcot. Rowman & Littlefield (Eds.). *Mothering: Essays in Feminist Theory*.

Krishnaraj, Maithreyi (2010). (Ed.). *Motherhood in India*. New York: Routledge.

Mitchell, Juliett (2007). 'Procreative Mothers (sexual difference) and Child-free Sisters (gender)' in Jude Brown (Ed.). *The Future of Gender*. Cambridge University Press, 176-185.

Phadke, Shilpa (2005). 'Some Notes Towards Understanding the Construction of Middle-class Urban Women's Sexuality in India'. In Geetanjali Mishra and Radhika Chandiramani (Eds.). *Sexuality, Gender and Rights*. Sage Publication, pp. 67-81.