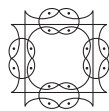


Birthing A Market

A Study on Commercial Surrogacy



Sama–Resource Group for Women and Health

The information provided in this report is for wider dissemination, and may be used with due acknowledgement to Sama.

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Introduction

Over the past few years, India has seen an explosion of fertility services that promise a cure for the allegedly increasing rates of infertility. Assisted Reproductive Technologies (ARTs),¹ a group of technologies that assist in conception or in the carrying of pregnancy to term, have proliferated unchecked, becoming a veritable 'fertility industry'. This industry is an integral part of the country's expanding medical market and medical tourism industry. Within this, surrogacy,² particularly commercial surrogacy, the practice of gestating a child for another couple or for an individual through the use of ARTs and in return for remuneration, has drawn much attention and raised several ethical concerns.

In the absence of any kind of regulatory or monitoring mechanism for the ART industry in India (including a national registry), it is difficult to arrive at the exact statistics pertaining to the existing surrogacy industry. However, the sharp rise in the number of surrogacy arrangements based on media reports and anecdotal evidence is a significant indicator for estimating the scale and spread of the commercial surrogacy market. An exponential growth in the industry is evident from the comparative figures over the years that estimate it to be an industry worth more than USD 400 million (Warner 2008³, Kohli, N., 2011)⁴. According to the National Commission for Women (NCW), there are about 3,000 clinics across India offering surrogacy services (Kannan 2009)⁵ to couples from North America, Australia, Europe, and the other continents. These figures reflect the status of India as the most favoured destination for commercial surrogacy. In the Indian context, the following factors have created a conducive environment for the expansion of the industry: lack of regulation; comparatively lower costs in relation to many developed countries [for instance, Canada, the United Kingdom (UK), and the United States of America (USA/US)]; shorter waiting time; the possibility of close monitoring of surrogates by commissioning parents; availability of a large pool of women willing to be surrogates, and infrastructure and medical expertise comparable to international standards.

For instance, a surrogacy arrangement, including In Vitro Fertilization (IVF), costs about \$11,000 (approximately Rs 5,00,000) in India, while in the US, surrogacy alone, excluding ART charges, costs \$15,000 (approximately Rs 6,75,000). A similar arrangement in the UK costs about £10,000 (approximately Rs 7,00,000)⁶.

In addition to the clinics that are engaged in providing and promoting ARTs, including surrogacy, the industry in India includes several other players. These include a wide array of organizations and personnel catering to clientele, both national and international - health care consultants, various bodies associated with the hospitality industry, travel agencies, law firms, surrogacy agents, tourism departments, and surrogacy hostels. The players have sprung up to provide diverse kinds of support services to the ART and surrogacy industry.

A significant number of the websites of these players contain material designed to attract clientele, both domestic and international. Some of these sites even have an exclusive section for overseas couples, promoting 'packages' that include several incentives, discounts, and 'deals' with regard to the services provided. These generally combine boarding, lodging, and other facilities for local tourism alongside claims of high success rates with ARTs and surrogacy arrangements. Part of such packages is the recent phenomenon of surrogacy hostels, growing fast since they ensure surveillance of the surrogates so that they follow prescribed care.

Many ART clinics in India have tied up with foreign hospitals and agencies to solicit 'clients' globally in a bid to expand their clientele. These are included in the medical tourism services that are supported and incentivized under international agreements such as the General Agreement on Trade in Services (GATS) under the World Trade Organization (WTO). In the absence of any potent national legislation and inconsistent state policies globally, how such international agreements give effect to and shape the industry, is a matter of grave concern. As pointed out in the Global Health Watch 3 Report⁷, the lopsided free trade mandate brushes aside all ethical questions in the expanding 'bio-capital' industry.

In this scenario, commercial surrogacy is often portrayed as a win-win situation. It is seen to give 'desperate and infertile' parents the child they want, and to provide poor surrogate women the money they need. In the face of this growing globalization of capital and shrinking local avenues for jobs and resources, women from marginalized communities and regions find themselves more impoverished, powerless and vulnerable. For these women, access to work and occupations has decreased over time, while new markets have opened up for both their sexual and reproductive labour. Commercial surrogacy for the domestic and international markets is one such avenue and it is gaining ground in many urban and semi-urban areas in India today.

Sama, a Delhi-based resource group working on women's and health issues, has been engaging with ARTs for more than eight years, raising concerns around gender and health rights emerging from the unchecked proliferation of ARTs. Previous research initiatives by Sama on this issue have contributed to uncovering the social, medical, ethical, and economic implications of ARTs on the lives of women accessing them, as well as the various issues regarding access to these commercialized technologies as part of the ART industry. The findings and conclusions have enabled the location of discussions and debates on ARTs within the framework of women's health, women's rights, and social justice, and have contributed to the consolidation of existing knowledge and analysis of ARTs and of the reproductive tourism industry.

Sama's previous research findings hinted at developments that merited further investigation, particularly into those related to commercial surrogacy, which is part of a larger transnational business. Commercial surrogacy is beginning to assume the proportions of an industry, with many complex issues involved, including ethical practice.

While studies have looked at ARTs and reproductive tourism, there has not been much scholarship that examines the life of a surrogate or that seeks to understand who the surrogate is, where she comes from, what her motivations and choices are, or examines the process of surrogacy through her experiences and her understanding of its complexities and her position in the industry.

There is an urgent need to initiate processes for a critical understanding of commercial surrogacy, that has assumed the proportion of a transnational industry towards building a collective, feminist response to it. This requires a strengthening of linkages between academia and activism that builds a perspective on the interaction of market, technology, patriarchy, and hetero-normativity as seen in this practice.

Further, the Draft ART Bill - 2010, prepared by the Indian Council of Medical Research (ICMR), necessitates a parallel process of mobilizing a wider response, particularly because this proposed legislation will be the first of its kind in South Asia, and is a step forward in checking the untrammled commercialization of ARTs. In its current form, the Bill is hugely lacking in addressing this as well as the disadvantaged position of the surrogate.

Being a part of debates on the regulation of ARTs, which currently flourish in India in the absence of any state regulation, Sama has often been confronted with issues concerning citizenship, surrogates' payments, and the contract between the surrogate and the commissioning parents.

Given this, Sama initiated the present research to gain insights into the lives of those at the heart of these issues – the surrogates – in order to make visible, and to better understand their perspectives, subjective experiences, and lives. The study scrutinizes the existing practices in the selected sites of research. Foregrounding the surrogate's position in the arrangement and in the industry, the study examines several complexities regarding the terms of the contract, the multiple institutions and actors involved, their expectations and conditionalities regarding the surrogate pregnancy, medical practices and technological interventions.

Methodology

This study aimed to document and analyze the experiences of surrogates, situating them within current debates in feminist theory. Sama sought to examine the processes that have evolved as part of the practice of commercial surrogacy and to use the resulting evidence to generate a debate on the need for creating and implementing a comprehensive legal framework for regulating the ART industry, including surrogacy, in India.

Research Questions

- How do surrogates perceive surrogacy? How do they look at their motivations and the implications of such arrangements?
- How is the use of the body in surrogacy being imagined and contested? What does this represent?
- Regarding surrogacy, how has medical practice evolved? What protocols, guidelines, and standards, if any, are being followed insofar as the surrogate is concerned?
- In this multilayered and growing industry, what accounts for the vulnerability of the surrogate who is otherwise central to the surrogacy arrangement?

Selection of Sites and Clinics

The study was designed as a multi-sited qualitative study. A Web search on existing information and media reports was completed to discover patterns, if any, pertaining to the variations in,

and the spread of, the industry. Two sites were purposively selected in India, namely Delhi and Punjab. Delhi was selected since it is home to many ART clinics that arrange and oversee surrogacy arrangements, and because it is already an accessible and established international destination (as the national capital) for medical services. Punjab was selected because it is a growing hub for surrogacy services and has significant diasporic links, with many Non-Resident Indians (NRIs) reportedly amongst the couples accessing surrogacy services. The industry in Punjab is not as well organized as the one in Delhi. We looked at the semi-urban/smaller city belt of Ludhiana, Jalandhar, and Amritsar, as well as the state capital, Chandigarh.

We identified the providers in the selected sites through internet searches, the Indian Society for Assisted Reproduction (ISAR) directory, and through lists drawn up for previous research studies on ARTs, noting the number of institutions offering surrogacy arrangements in each instance. Clinics offering both in vitro fertilization (IVF) and surrogacy services were fewer in number in Punjab than those offering IVF services alone. Since there is no single source of information or official database of all clinics – and since not all the clinics featured in the Web search – some of the clinics offering these services were identified during the course of the fieldwork.

Within these sites, variables such as temporality (when clinics were established) and selection of clinics on the basis of the profiles of surrogates or commissioning parents were considered while conceptualizing the research goals. However, due to severely restricted access, and, more commonly, the unwillingness or reluctance of the various actors involved to share their experiences, such variables did not prove to be conclusive as selection criteria.

In order to capture the heterogeneity and plurality of the industry, a few third-party agencies were also identified, such as medical tourism agencies, surrogacy agencies and individual agents offering services of contacting and arranging for surrogates and ensuring their surveillance.

Advisory Committee

An advisory committee of four members with expertise in research in the areas of gender and public health was constituted. Meetings were held with the members of the advisory committee to discuss ethical challenges and concerns, and to determine the research methodology, design, tools, etc., in conceptualizing the research study, before undertaking the fieldwork. These meetings, in the later stages were used to update on the progress of the study, and to seek feedback on the framework adopted for review and analysis.

Literature Review

A review of literature was undertaken to explore the existing body of literature on surrogacy and to contextualize Sama's research in terms of the debates and gaps that it should address. Since surrogacy is an intersecting site for various debates, the review also attempted to highlight how inquiries into surrogacy have been informed by the chosen theoretical frameworks as well as by the critiques of these frameworks. The review also adopted a critical perspective on the practice of surrogacy in developing a framework for the analysis as well as for the chapterization of the report.

Tools of data collection

Research tools such as the interview guide, the consent form, and the permission letter were prepared in consultation with the members of the advisory committee. A formal letter describing the objectives of the study was also prepared for providers⁸ towards seeking interviews with them, surrogates, agents and any other players.

The informed consent form was developed in the local languages of the respondents – in Hindi and Punjabi – to provide participants with information about the purpose and intent of the study, and to assure them that the data being collected would remain confidential. The form was signed by both the respondent and the researcher, and a copy of the form was given to the respondent. This procedure and its importance were also explained to the respondent verbally.

Interview guides were developed for each of the varied players – surrogates, providers, agents. It included open-ended questions and check lists for pursuing a desired line of enquiry covering particular themes. It was a flexible tool, meant to be adapted by the researchers according to the time duration and the nature of the interaction that was possible with the respondents. The guide was also modified for conducting repeat interviews according to the quality of the data collected previously.

A field diary, which included the notes and observations of the researchers during the fieldwork, was maintained.

Respondents

After conducting a Web search and after referring to an existing database of providers compiled from previous research studies, we identified 17 clinics in Punjab and 12 in Delhi. We attempted to make contact with all these clinics for participation in the research study through emails and telephone calls as well as by meeting the staff at the clinics and seeking appointments. Meetings were held with doctors in 15 clinics across Punjab and in eight clinics in Delhi. Meetings were also held with the staff of two medical tourism agencies and of one surrogate recruitment agency (unregistered) in Delhi and with two independent agents in Delhi. However, not all meetings materialized into interviews.

After repeated meetings with the identified respondents, the following interviews were eventually conducted:

Location	Surrogates	Agents	Doctors	Commissioning Parents
Delhi	6	1	2	-
Punjab	6	1	3	1
Total	12	2	5	1

The sample size was kept small as the emphasis was on conducting qualitative, in-depth interviews within the time frame allocated for the fieldwork. This implied conducting repeated meetings and interviews for a significant amount of time, which presented some challenges, as discussed in the next section. An interview with one commissioning parent was possible in the course of the research. Although not the focus of the study, it provided some important insights into surrogacy arrangements and the perceptions of the commissioning parent.

Fieldwork

The fieldwork for the study began in December 2011, with contact being established with various IVF clinics providing surrogacy services and medical tourism agencies. The fieldwork lasted until April 2012.

Access: During the process of fieldwork, it was difficult to locate and contact surrogates. Most of the doctors and the agents/agencies contacted, expressed unwillingness to participate in the study. Getting appointments proved to be very difficult. Meetings with doctors, even when possible, were not always fruitful; while they may have agreed to give an interview themselves, they refused to put us in touch with surrogates. The reasons given were varied such as 'the surrogates do not want to talk to anyone', 'it is against the policy of the hospital', 'we do not have any current cases', and 'we have done hardly any surrogacy at our centre'. In one case, doctors expressed their unwillingness to be interviewed when they learned the purpose of the study, a reluctance strengthened by their knowledge of Sama's previous work on ARTs.

Similarly, in the case of surrogacy agents too, there was a general reluctance to arrange meetings with surrogates. Many potential respondents were contacted and it was only after repeated visits to clinics, and interactions with doctors and chance meetings with agents, that eventually it was possible for us to come into contact with surrogates and with a couple of agents who were willing to participate in the research. However, not all the surrogates contacted were keen on participating because they preferred to keep their identities as surrogates hidden. In some instances, information regarding contacting possible respondents was also given by surrogates during interviews.

In order to contact surrogates independently, and not through agents or doctors, we placed a notice about the research in local Hindi, Punjabi, and English magazines, inviting surrogates to contact us if they were willing to share their experiences as part of the research. Most of the telephone calls in response to the notice were made by prospective commissioning parents and agents asking us about surrogacy clinics, agents, and contacts of surrogates respectively. We received one call from a surrogate who wanted to enter a second surrogacy arrangement, and after she learnt about the study, agreed to participate.

Nature of interactions and interviews, and challenges faced: The nature of the interviews conducted was contingent on several factors. The doctors often insisted that the interviews be conducted within the hospital premises. Similarly, the agents insisted that the interviews be conducted under their supervision or at their office or home. In all cases except two, we were able to talk to the women at such venues in a separate room without actual physical supervision. A medical tourism agency arranged the first meeting with two surrogates at its office premises, and the second meeting at the surrogate home run by it. In each case, the interviews had to be conducted in the presence of an agent. In these instances, we were not able to talk to the surrogates for a long duration, and such settings had an inhibiting influence on the surrogates. It was also difficult to explore in depth questions about the surrogates' relationships with other actors such as doctors, agents, and commissioning parents in this setting, or to probe further into their narratives.

It was not always possible to interact with surrogates repeatedly. It was possible to hold in-depth repeat interviews with four surrogates. There was a considerable difference in the quality of interviews where the first-time interaction took place in doctors' clinics or at agents' homes.

When interviews were conducted at the surrogates' own residences, they were far more comfortable and candid. During the interviews, we were able to explore and discuss some themes with each surrogate, taking up a particular line of inquiry in more detail depending both on the time we were able to have with the surrogate and her willingness to engage.

Chapterization

Keeping the research questions in mind, the data have been analyzed and presented while foregrounding the surrogate's position in the industry. We critically examine various aspects of the surrogacy arrangement, the processes adopted in practice, and the relations between the various actors in order to understand the power relations that determine or influence their organization and interrelation. We also look at various cultural references deployed as part of the surrogacy practice and the processes of generating new meanings and subjectivities for the smooth functioning and growth of the industry.

Chapter 1 presents the profiles of the surrogates. We look at variables such as class, caste, religion, marital status, age, and income, and attempt to understand and highlight the socio-economic background of women who opt for surrogacy and how their identities and backgrounds are reflected in the choices they make. We look at their work histories and the nature of the work in which they have been engaged to better understand the place of surrogacy in this trajectory.

Chapter 2 examines the ways in which the surrogates enter the surrogacy market or industry. We inquire into the motivations of the surrogates and look at the decision-making processes and the various considerations and the kinds of information that they possess while deciding to become surrogates. We trace the existing recruitment patterns and chains of contacts that have been built as part of the practice of surrogacy and the role of the various actors.

Chapter 3 looks at the medical practices and the process of medicalization that the surrogates undergo. We examine the rationale for the use of technology and of various medical procedures, the prescribed regulation of the daily conduct of the surrogates and their lives, and the various standards or protocols followed, if any. We also discuss the experiences of the surrogates in hospital settings and the implications of the prescribed medical regimen for their health and lives.

Chapter 4 focuses on the relinquishment of the child by the surrogate to the commissioning parents and the processes that have been put in place to ensure that the transfer takes place smoothly. We look at the dilemmas faced by the various actors involved in this process, the significance of the contract, the importance of counseling services, and the effect of decisions regarding medical procedures and breastfeeding. We also examine the factors that shape the relations between the surrogate and the commissioning parents.

Chapter 5 looks at the remuneration transactions involved in surrogacy arrangements and the considerations that influence decisions about the amount and pattern of payments made to surrogates. We further explore how the existing norms of reproduction impact the interactions and negotiations between the surrogates and the commissioning parents, agents, and doctors.

Chapter 6 throws light on the public perceptions of surrogacy. We explore how surrogates encounter stigmatized perceptions and how they negotiate the meanings assigned to this

labour during the course of the surrogacy. We look at how these considerations lead to certain practices and their impact on the lives of surrogates.

Chapter 7 discusses the main trends and themes that have emerged in the previous chapters, locating them in the debates on surrogacy and raising critical questions for feminist politics as well as for policy making and regulation.

Codification

Codes have been used to maintain the anonymity of the research participants as per research ethics. Codification has been done in the following manner:

Surrogates: 'S' followed by the initials of the state, 'P' for Punjab or 'D' for Delhi, and the relevant number. For instance: SDI (Surrogate-Delhi-1) or SP1 (Surrogate-Punjab-1).

Agents: 'Ag' followed by the initials of the state, 'P' or Punjab or 'D' for Delhi. For instance AgD (Agent Delhi) and AgP (Agent Punjab).

Doctors: 'D' followed by initials of the state, 'P' for Punjab or 'D' for Delhi, and the relevant number. For instance: DD1 (Doctor-Delhi-1) or DP1 (Doctor-Punjab-1).

Notes

- ¹ Assisted Reproductive Technologies (ARTs) are a group of technologies that assist conception and pregnancy. These technologies are designed to increase the number of eggs and/or sperm, or to fertilize them, resulting in the improved 'probability' of conception/pregnancy that is not otherwise possible. The technologies used for assisting reproduction range from simple or 'low-tech' methods such as intrauterine insemination (IUI) to 'high-tech' methods such as in vitro fertilization (IVF) in all its variations. Although surrogacy is an arrangement, it has been included in ARTs.
- ² According to the Draft ART (Regulation) Bill and Rules - 2010, " 'Surrogacy' means an arrangement in which a woman agrees to a pregnancy, achieved through assisted reproductive technology, in which neither of the gametes belong 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." For more details, see the Glossary.
- ³ Warner, J. (2008). Outsourced Wombs, *New York Times*, 3 January.
- ⁴ Kohli, N. (2011). Moms Market, *Hindustan Times*, 3 January.
- ⁵ Kannan, S. (2009). Regulators Eye India's Surrogacy Sector, *BBC World News*, 18 March.
- ⁶ Sama - Resource Group for Women and Health. (2010). *Constructing Conceptions: The Mapping of Assisted Reproductive Technologies in India*. New Delhi.
- ⁷ The Global Health Watch (GHW) Report is an alternative report, which is an evidence based assessment of the political economy of health and health care, and is aimed at challenging the major institutions that influence health. It was initiated by the People's Health Movement, Global Equity Gauge Alliance and Medact.
- ⁸ The term provider implies doctors and embryologists in ART clinics, involved in surrogacy arrangements.

Literature Review

In a range of discourses and representations, commercial surrogates capture the imagination because they are seen as doing something new and different, complex and controversial. Surrogates are being seen as the 'bearers' of a different kind of baby, the conduits of a commercialized form of reproduction. An industry that has outpaced the legal system has led to many instances that have raised questions, most fundamentally regarding family, the definition of citizenship, the extent of the market, and the role of the state. In this section, we look critically at the development of various opinions and positions on surrogacy, their central arguments and concerns, and the context in which they were or are being voiced. Thus, we seek to develop clarity on the feminist principles we support, and on those principles that contradict our arguments, and to examine the consequences that this can have on the lives of women and on feminist politics and its representations.

Biology and Kinship

How does surrogacy define the body, and, indeed, biology itself? The body and its biology is made, and made meaningful, only within socio-cultural, economic, and political processes. Gender is performative; discourse materializes the bodies it names, and makes normal certain markers by circumscribing or ab-normalizing others. How is surrogacy doing this, that is, making up and making real biology as it goes along?

Menon (2011) quotes Martin to point out that science is an 'interpretive exercise'. She discusses surrogacy as creating three mothers—the gestational, the genetic, and the social. Which mother the child belongs to, however, is discursively constituted, and validated by "biology". depending on the case at hand. In commercial gestational surrogacy, the commissioning couple is told that the child is theirs since the gametes and genes are theirs. However, not only have the answers or clues to life contained in DNA been over-emphasized by the scientific community, but DNA is also only partly responsible for how humans turn out. In contrast, a woman who is gestating the baby she intends to raise, but who has used donor eggs, is told by the same medical establishment that the baby is hers because the blood is hers, and the cells from which the baby is growing are hers. Thus, Menon argues that science is engaged in constituting the natural, rather than only objectively identifying it.

Given that commercial surrogacy pluralizes kinship, particularly motherhood, in new and particular ways, a key question needs to be addressed: In deciding the legal claim of these different mothers to the child, what relative weight will be, or should be, given to genetic material (ovum), gestation, and social upbringing?

It has been suggested that recognizing the woman who provides ova as the mother makes maternity comparable to paternity in a way that ignores the role of pregnancy (Rothman 236:1989 in Anleu 31:1992). Rothman concludes that in terms of contributions to the life of a child just born, it is the claims of the gestational mother that seem paramount, with other claims based on money, marriage, or genetic material having lesser weight (238-9:1989 in Anleu 34:1992).

While engaging with the question of which parent has the rightful claim over the baby, Pande (2009b) points out that surprisingly little has been written about the ways in which the actors involved in surrogacy understand and experience their relationships. In Pande's study (2009a), although surrogates recognized that having no genetic connection with the baby makes it simpler to give the baby away, they also simultaneously laid some kind of claim to the baby. One surrogate emphasized that the baby had her blood, even if the genes were those of the intended couple. Similarly, another surrogate emphasized her 'sweat ties' with the baby, formed through the labour of gestation and of giving birth.

One surrogate invoked Hindu mythology, where the infant Lord Krishna is born to, and brought up by, two different mothers, to argue that surrogacy is not new, and is, in fact, part of Hindu religion. Another surrogate compared giving away the baby to giving away a daughter at marriage—a culturally appropriate analogy between two practices that are, according to her, difficult, but for which one needs to be mentally prepared.

Some surrogates in Pande's study noted that surrogacy is emasculating for men because it requires a minimum contribution by and from them. Another stated that the husband's role has been overtaken by technology (injection gives sperm instead of penis). These assertions based on, and drawn from, lived experiences must be read together with larger analyzes, but it is nonetheless noteworthy that they are markedly different from assertions made by some feminist theorists on the subject of reproductive technologies.¹

Thus, Pande's work highlights the ways in which the constructions of everyday kinship by surrogates disrupt the dominant patterns of relatedness. She asserts, "By emphasizing connections based on shared bodily substance (blood, breast milk) and by de-emphasizing the ties [that] the baby has with its genetic mother and [with] the men involved in surrogacy (the genetic fathers and the surrogates' husbands), the surrogates challenge established hierarchies in kin relationships – where gene and male seed triumph above all". (2009b:380)

Yet Pande is careful to add that the articulation of everyday forms of kinship ties by surrogates cannot be seen as a straightforward challenge to either patriliney or patrilocality. Rather, these experiences emphasize the multivocality of kinship (386: 2009b), by highlighting blood ties and the labour of gestation and of giving birth as the basis for making kinship claims. However, not all kinship ties are equal. Ultimately, gestational surrogacy is flourishing today because the genetic tie "remains a powerful and enduring basis of human attachment". (392: 2009b)

Thus, it appears that while surrogacy has the potential to pluralize kinship ties beyond biology, this potential is managed – through the surrogacy contract – in a way that continues to, and in fact *must*, narrow kinship ties.

Yet surrogacy also has the potential to unsettle traditional notions of heterosexual parenthood by creating previously inconceivable offspring(s) for single-sex couples. Should we see the use of ARTs by such constituencies simply as a desire to conform to the 'natural' or 'normal' institutions, or is there a greater challenge that such families can pose?

By opening up the 'family' to single women and queer couples, the institution is being changed constitutively. The fact that homosexual couples can access these technologies and become parents, thereby creating their own families, is evidence that the 'family' is not a 'given' fact. At the same time, it also questions the very foundations of patriarchal constructions of gender identities and roles. On the one hand, it challenges the idea that lesbians and gay men differ in ways that make them outlaws to the family, an institution that has been central to social understandings of what it means to be gay or lesbian (Calhoun, 2000). On the other hand, it challenges the heterosexual matrix since the sexual division of labour cannot be a definitional component of such families and the process of socialization for gender identification through parents may not occur, or structure parent-child relationships. For instance, the notion that women are naturally fit for mothering finds no place in a family of a gay male couple raising children. Similarly, in the case of single parents, they have to perform the functions of both the 'mother' and the 'father'. Who, then, is a 'mother' and a 'woman'? (Sarojini, Mahajan & Sheno, 2012).

In this scenario when multiple forms of kinship can be forged, is there a possibility of going beyond a prescription of who can be the right parent? How should a feminist response to the broadening of the family be tailored within the format or framework of a surrogacy contract?

Reproductive Autonomy and Justice

If women have the right to make reproductive choices like contraception, abortion, and pregnancy, then shouldn't surrogacy be one of these choices as well? (Andrews 1988 in Merrick 166)

The view expressed in the above extract is one that has been echoed by many who analyze surrogacy. For instance, according to Christine Sistare (1988), the "fundamental moral issue in the surrogacy debate is the nature and extent of women's freedom: their freedom to control their bodies, their lives, their reproductive powers, and to determine the social use of those reproductive capacities"(228:1988). Thus, she argues that the question really is: "Is there sufficient justification for society to deny to adult women the disposition of their reproductive capacities according to their own desires?" (229:1988)

An appropriate response to this rather free-floating ideal of choice is contained in other writings on reproductive technologies in general, and on surrogacy in particular.

"The manipulation of women's fertility, for whatever purpose, needs to be understood within the context of [the] population policies in the North and South. Women as procreators are central to pro-natalist and anti-natalist population policies. It is not surprising that developed countries practice pro-natalist policies domestically and anti-natalist policies in the developing countries. Women from the North are expected to procreate and develop 'pro-natal behavior' whereas women from the South are the targets of an international war against the population problem" (Lingam, 4-5:1998).

Lingam problematizes the slogans of 'choice' and 'reproductive rights' that have gained currency in recent years. According to her, these terms are easily co-opted and perverted to the detriment of women. Most technologies in the realm of reproduction are hailed as widening women's choices, much like the case with commodities or consumer goods under capitalism. The body is seen as a woman's property – to be hired, sold, donated, and so on.

Campbell (1992) argues that "contemporary medicine has transformed the human body into a source of instrumental value, a resource of value to others: patients, physicians, and researchers... Such practices seem to presuppose a basic feature of property, that is, the capacity and power of alienation or transfer... More often than not, the body as alienable property will no longer be a whole, organically unified body (let alone a whole person), but will instead be reduced to a 'source of spare parts'. Some of these spare parts (corneas, marrow, sperm) when collected from different bodies are stored in 'banks', language that reinforces both the instrumental value of the body and the commercial dimension of the property paradigm."

Whether the body should be seen as property or not is a concern, according to Sharp (2000), that is "heavily skewed by Western and capitalist interests", which emphasize a universal right of autonomy.

"Once issues of property and ownership and autonomy take center stage, they displace competing cultural constructions of the body, other possible reactions to the dilemmas of biotechnologies, and[,] finally, the shaping of alternative ethical responses" (Sharp 299:2000).

Petchesky (1995) also shows how the prevailing economism itself can be found in the idea of property in demanding a right to ownership over the body. The idea that a woman 'owns' her body stands out not as a description of reality but as an achievement as an articulation.. Petchesky cites articulations from within feminism that have challenged this dominant Euro-American dichotomism of the self and the community. For instance, black women's articulation of the right over their body took form in the context of the struggle against the absence of control over their sexuality and reproduction. They look at self-ownership as a maternal, caretaking concept. 'Those who tend, care for, [and] carry are[,] by definition[,] those with authentic claims to be named owner of the things or people whose growth they nurture].' Through the claim of ownership, they were establishing or articulating their connection 'to a larger group and community' (Schneider 1991:309 in Petchesky, 1995).

Petchesky questions how the idea that 'your body is your own' can make sense when women's control over their bodies is heavily mediated through kinship structures and through the discourse around social relations, when women take care of their bodies and health last, their foremost concern being that of feeding their families and ensuring their good health. Citing an example of a white woman's outrage at the birth of a black baby after artificial insemination with the sperm of her white husband, Petchesky writes, "We do not 'own' our bodies so long as they are occupied, colonized by this racist history."

Similarly, Bailey (2011) employs a reproductive justice perspective in analysing the question of commercial surrogacy. She situates her article as a response to the two dominant Western feminist approaches to surrogacy, both of which she finds problematic. The first she identifies as political frameworks – liberal, socialist, or radical – that make normative or moral judgments about surrogacy; this approach falls into the trap of 'discursive colonialism', which fails to

capture the lived experiences of non-Western subjects. The second approach is that of feminist biomedical ethnographies, which correct the errors of the first, but suffer from 'weak moral absenteeism' by under-theorizing structural harms and injustices. For instance, ethnographers explore moral issues only when interviewees raise these questions themselves.

Bailey's work is concerned with epistemic honesty. She notes that surrogates' voices are reduced to sound bites, filtered in turn by doctors, clinic staff, and intended parents in whose presence they give interviews, as well as by the international press in a language different from the one they use. Significantly, Bailey reminds us that Western feminists, in the context of the global hegemony of Western scholarship, have "constructed third world women as backward, poor, illiterate, culturally oppressed, and in need of rescue". For instance, the rhetoric used by the global press when presenting surrogates' stories is one of choice and, by extension, of opportunity and fair exchange. Bailey insists that a single-pointed focus on 'choice' obscures the injustice behind these choices. Contract pregnancy is one of the few routes available for poor women to attain basic social goods. Critics of globalization warn of a race-to-the-bottom when outsourcing surrogacy to the third world will become a routine matter; as has been seen in the case of the textile and electronics industries, competition may force surrogates to settle for smaller and smaller fees. There is enough anecdotal evidence to suggest that surrogates and donors are chosen on the basis of their caste, religion, skin colour, attractiveness, etc. In the marriage of free market and neo-eugenics, does anything and everything go? Also, surrogates have limited autonomy over their contract pregnancies, a fact also highlighted by Saravanan's study (Saravanan, 2010).

Saravanan, in her study of gestational surrogacy in Anand and Ahmedabad, both in Gujarat, argues that one of the most important criteria for choosing gestational or surrogate mothers is their submissiveness to the demands of doctors and intended parents. The women she interviewed were 'on the edge of poverty' (2010:27) because of indebtedness or homelessness, and were not educated beyond the higher secondary level. Women who are not inert and who display aggressive characteristics are politely rejected on medical grounds, and replaced by clinics with other surrogates. Once selected, surrogates have to submit to several rules. Some clinics make it mandatory for women to stay at surrogate homes, while others provide them with separate family accommodation away from their permanent residences. Saravanan terms this as a 'denial of subjectivity', because women have little to no say in decisions, including decisions about their own bodies. The surrogates further have no right to choose the terms of relinquishment of the baby; the clinics decide whether the baby is to be handed over to the intended parents immediately or soon after birth. There is no consensus on how the mother-foetus attachment will be resolved; that there could be a bond between the surrogate and the child is itself often not recognized. Saravanan concludes that while doctors use the social context and ideology of motherhood to exploit the surrogates and to make them care for the baby during and after pregnancy, these doctors do not actually consider the surrogates parents in their own right.

It is this question of autonomy, as well as larger structural issues, that lead Bailey to suggest the framework of reproductive justice as necessary for understanding and responding to surrogacy. Bailey traces the reproductive justice approach to the SisterSong Women of the Color Reproductive Health Collective in the 1990s, whose mission recognizes that life conditions such as a living wage, quality education, affordable health care, and freedom from both

environmental hazards and state violence must be in place for women to truly enjoy reproductive autonomy. Bailey locates a similar approach in the work of other organizations, one that seeks to create structural change and to challenge power inequalities. Also, reproductive justice takes into account reproductive oppression, which gives the approach a strong moral character. Bailey recognizes that reproductive justice does a better job of raising questions than of answering them, and suggests that other approaches might pick up from where reproductive justice leaves off.

With reference to surrogacy in India, an international destination for surrogacy services, Bailey highlights the need to take a long-term view of medical health, one that takes into account women's health over a lifetime. Bailey points out that the women who sign up for surrogacy may well be from the same class or demographic that is medically vulnerable, and one that has some of the highest maternal mortality rates in the world, has poor access to health services, and is subject to coercive population control, malnutrition and anaemia, and sex selection. Further, India's fertility industry is currently operating in an unregulated environment. This means that surrogates have no legal protections, including for health risks.

Overall, Bailey argues for Indian surrogacy to be seen as a social justice issue. Nonetheless, she is not inattentive to the limits of the reproductive justice approach; she recognizes that a surrogate's life circumstances—immediate need of housing, debt, illness and disease—may make the health risks associated with contract pregnancy worth taking. It is precisely for this reason that Bailey argues that reproductive justice should be taken as a moral indicator, and not merely as a moral theory.

Like Bailey, Lingam (1998) reminds us that, "Women not only want an informed choice in contraceptives, small families, health care facilities and a better future for their children, but they also want control over their life situation, sustenance, a safe work place, clean drinking water, sanitation, secure living, harmonious gender relations, no violence, no abuse and no wars".

The demand for self-ownership, then, cannot be separated from the demand for access by all people to essential health care and services. Connecting our right to self-ownership to our right to communal resources, Petchesky highlights the need for a language of reproductive freedom that enlarges the frame of reference of a rights discourse to include questions of who and what counts as an owner.

Political Economy

Reproduction historically has been, and continues to be, a means for women to gain certain kinds of access and privilege—social, material, emotional, and familial. Babies have always been a resource. Reproduction has always been an exchange. So the more pertinent question then becomes: What is it about surrogacy that visibilizes it as a problematic where other kinds of reproduction are invisibilized, or at least, normalized?

Is altruistic surrogacy preferable to commercial surrogacy? Anleu (1992) argues that 'the distinction between commercial and altruistic surrogacy is socially constructed.' Both types of surrogacy involve the application of pervasive gender norms, specifying that the motivations

of women to have children should be based on emotion, selflessness, and caring, not on self-interest, financial incentive, and pragmatism.

However, much has been said about how a practice like surrogacy commercializes reproduction in unprecedented ways. These debates focus on whether taking money for rendering certain services is especially degrading to women, on who decides this issue, and on who the women in question are, thus raising important questions about what kinds of work are considered degrading; what political, economic, and legal factors make possible the existence of such kinds of work; and what the responses of a consistent feminist politics to this issue could be.

Many like Ketchum (1989) have equated entering into surrogacy arrangements by women to the selling of their bodies and their babies by women. By understanding payment as a means of establishing full control over surrogates' bodies and behaviour, Ketchum forecloses any possibility of agency on the part of the surrogate in forging an arrangement according to her own needs or choices. A greater concern, however, is that of the disruptive effects that surrogacy may have on kinship ties and those from commercializing activities 'that are too close to our personhood'. One needs to ask a critical question here: Are there any activities that define women and that must be carried out in a non-commercial form and at present whether they exist in a non-coercive manner?

Anderson attempts a more in-depth discussion of the objection that surrogacy is wrong because it commodifies women's reproductive labour. She writes that the application of economic norms to the sphere of women's labour violates their claim to respect and consideration. "First, 'by requiring the surrogate mother to repress whatever parental love she feels for the child, these norms convert women's labour into a form of alienated labour'. ('Alienated labour' here is understood in the twofold Hegelian sense, that is, as a situation in which (1) the product of labour is separated from its producer, but (2) in which it is separated from the producer precisely because the producer surrendered it to someone else and, more generally, to the market). Secondly, Anderson continues, 'by manipulating and denying legitimacy to the surrogate mother's evolving perspective on her own pregnancy, the norms of the market degrade her'" (Anderson, 1990 in Niekerk and Zyl 346:1995).

For Niekerk and Zyl (1995), "Anderson's point is not that surrogacy is immoral because it is a form of alienated labour, but because pregnancy should not become an act of alienated labour. Being denied the legitimacy of one's perspective on one's labour, being alienated from one's feelings, and having to act against one's emotions is not wrong per se, but is wrong only if the labour in question is women's reproductive labour (or another special form of labour). It is in this sense that surrogacy is similar to prostitution, not in the sense that both are forms of alienated labour, but in the sense that in both cases a physical capacity (sexual intercourse and gestation) that should be afforded special respect is degraded to a form of alienated labour. What lies at the heart of the objection that surrogacy is similar to prostitution is that women's reproductive labour, like their sexuality, should not be compared to, and be treated in the same way as, other forms of physical labour" (Anderson, 1990 in Niekerk and Zyl 346:1995).

This leads us to the following questions: On the basis of what principles and concerns do we distinguish women's reproductive labour from other forms of labour? Is the relationship between a pregnant woman and her unborn foetus essentially different from the relationship

between a worker and his/her material product? Despite its acceptance in liberal society (as Arneson, 1992, suggests), does one object to alienated labour per se or is that objection pertinent only when applied to women's reproductive capacities?

Satz (1992) warns against the two opposing arguments, the essentialist theories that maintain that reproductive labour should not be bought and sold, and the free market approach that celebrates the autonomous chooser.

The essentialist approach that attaches social respect and dignity to reproductive labour does not critically examine the historical circumstances that have made such an understanding possible and that reflect "society's attempts to control women and their sexuality", which are essential for maintaining relations of inequality. Satz argues against positions such as that of Anderson's on the surrogate's alienated labour, which assumes a sacrosanct, natural bond between the mother and the foetus. Many women do not feel such a bond, an essential point that must be made in the light of feminist arguments for abortion, which would be incompatible with the argument based on the primacy of the 'maternal instinct'.

In response to arguments that see surrogacy as baby-selling and that criticize the idea of the mother's rights over the baby, which is evident in the surrogacy contract, Satz draws parallels between surrogacy and adoption. She argues for an 'open' model that regulates the arrangement, that respects a change of mind on the part of the surrogate, and that provides detailed information about the medical procedures as well as the attendant risks.

For Hochschild (2009), "The gestating that the surrogate does is the back stage work that is not visible in the child that is seen as and raised by the couple. The work that was invisible otherwise in the "private" now comes out in [a] commercial way[,] yet the attempts to keep it under wraps with workers whom it would be easy to keep under wraps and who would not be your equals".

Where others have denounced surrogacy arrangements because of the consequent alienated labour that is instrumental in creating the disposability of wombs, Hochschild argues that 'surrogates do the emotional labour of separating themselves from the baby they carry, and from the part of their body that carries that baby.' For her, it is this 'emotional labour of estrangement' that needs to be visibilized and accounted for.

Nussbaum, on the other hand, highlights the need to critically assess the reasons why certain occupations related to women's sexual and reproductive capacity are stigmatized. She asks whether the beliefs such as commodification and control of men over women's bodies, as have been cited earlier, result of reason or prejudices? While Nussbaum looks at the example of sex work, we may find her inquiry into the beliefs and practices pertaining to the taking of money for the use of the body, as well as her inquiry into the options available to poor working women, to be just as pertinent in the case of commercial surrogacy.

For Nussbaum (1998), the most urgent issue is that of employment opportunities for working women and their control over the conditions of their employment. The debates over commodification, ethics, and morality must not be separated from the reality of working-class lives. Historically, anxiety that has been expressed about the use of the female body in certain occupations like female singing and dancing has stemmed from conservative and class-privileged positions that denounced these women as immoral. The views on commodification

thus need to be scrutinized, since they can be embedded in class prejudices that are unjust to working people.

Nussbaum compares various kinds of women's work, such as factory work, nursing, and teaching, and argues that the exploitative terms under which women are employed in these occupations, and the effects of stereotyping women that may be consequent to these practices, are also characteristic of sex work. However, feminist responses, far from seeking prohibition, have often not articulated concerns about these kinds of women's work that we see voiced in the context of sex work. Similarly, concerns about women's autonomy and agency, and the possibilities of women entering into exploitative work arrangements, are not voiced as vehemently as they may be when responding to women's involvement in sex work or commercial surrogacy. This raises the question about how the terms of reference in our commitment to feminist principles have altered in the two cases.

Sharp (2000) further draws our attention to a Eurocentric propensity to privilege 'ethical' abstract universals over localized 'moral' concerns. There is a need to contextualize our understanding of practices such as this and to grasp the processes that enable these practices to flourish. This can be understood through a critical ethnography, on the one hand, and through the dynamic of international political economy and trade, on the other hand.

In her feminist ethnography of surrogates in Anand, Gujarat, Amrita Pande (2010) uses the theoretical framework of reproductive labour, thus extending feminist scholarship on nannies and domestic workers to women engaged in commercial surrogacy. Reproductive labour typically refers to activities such as household purchases, cooking and serving, laundering, and providing care, activities from which white upper-class women in the United States have historically freed themselves by purchasing the services of women of colour (Glenn 1992 in Pande 2009a). Pande argues that surrogates in India, who are renting out their wombs and providing gestational or nurturing services, must also be seen as engaged in care work and reproductive labour. Yet their experience is atypical because there is a high degree of stigma attached to what they do. This stigma stems from many factors. Not only does surrogacy bring into focus the bodies of poor women, but it is also associated with an 'immoral commercialization of motherhood', and is often equated with sex work in the public imagination.

Reflecting on surrogates' narratives, and comments on their work and choices, Pande points out that surrogates seem to resist the stigma attached to their work by articulating a difference between themselves and others who are equally needy but who are seen as less 'moral', like sex workers. Such narratives aim to preserve the sense of self-worth of surrogates. Yet by emphasizing the goodness of their husbands in allowing them to do this work, surrogates are also over-compensating for their temporary role as breadwinners. Many also downplay their decision to become surrogates, and instead emphasize the role of a higher power or God in their lives. However, the surrogate's identity as a mother clashes with her identity as a worker, and the same narratives that serve to reinforce the surrogates' image as dutiful and selfless women in the service of their families also undermine their role and image as independent wage workers. Based on the findings of her interviews with surrogates, Pande points out that many surrogates seemed to resist the commercial and 'disposable' nature of their position by establishing, or by claiming to have established, a 'special' relationship with the intended parents. However, such relationships would make remuneration structures informal, and

would also make it difficult for surrogates to negotiate the terms and conditions of their employment as workers.

The tension between the mother identity and the worker identity is an important theme in Pande's work. She highlights how the perfect surrogate – cheap, docile, selfless, and nurturing – is not found ready-made, but rather is created through relations of production.

“When one's identity as a mother is regulated and terminated by a contract, being a good mother often conflicts with being a good worker, which makes the perfect surrogate subject rather difficult to produce . . . At each stage of the disciplinary process, the mother-worker duality is manipulated in ways that most benefit the mode of production, from the recruitment of guilt-ridden mothers to the disciplining of poor, rural, uneducated Indian women into the perfect mother-workers for national and international clients” (2010: 970).

Pande illustrates this argument with the example of recruitment tactics, contract and counseling processes, and the functioning of surrogacy hostels. Recruitment tactics often target women who are desperate for money to provide for their children, to get their daughters married on time, and so on; a surrogate should be a good mother to her own children before she can build on that to be a good mother-worker to another's child. As such, “being a mother is not just a medical requirement for a woman to be recruited as a surrogate but also an insidious mechanism to control her as a worker” (2010:976). Through counseling and training, the surrogate is constantly made aware of her disposability (as a worker), but is also expected to love the baby she is carrying (as a mother). The surrogate should not see what she is doing only as a business (she is a mother, after all), but must hand over the child without creating any problems or violating the terms and conditions of the contract (she is a worker most of all). Further, the surrogacy hostel works not just to impose discipline and surveillance, but also to generate self-discipline and self-surveillance. It facilitates detailed regulation, which would not be possible in cases where there is a separation between home and work (2010:983).

Even as Pande situates her understanding of surrogacy within the framework of reproductive labour, she points out that surrogates and their families do not see what they do as labour. As such, stigma and gendered work equations interplay to suppress the development of a worker identity among surrogates.

As Shah (2009) pertinently points out, “Control of sexual and reproductive labour primarily in the service of the patriarchal, monogamous, heterosexual family has meant its total devaluation in the market. Along with the notions of chastity and naturalness associated with the domestication of all such labour has meant a complete stigmatization of it when done anywhere outside of marriage”.

These processes of constituting new subjectivities are seen to take place in the context of the growing popularity of surrogacy as an option for working-class women, and of the scale achieved by the industry in a short span of time. The nature of labour in developing countries like India in an international regime of globalization and liberalization has made the flourishing of this industry possible.

A paper based on a previous research study by Sama (2010) concluded that the chief reason for India becoming an international centre of the ‘baby business’ is its cost advantage

vis-à-vis developed countries. A surrogacy arrangement, including IVF, costs about \$11,000 (approximately Rs 5,00,000) in India, while in the United States surrogacy alone, excluding ART charges, costs \$15,000 (approximately Rs 6,75,000). In the UK, an IVF cycle costs about £7,000 (approximately Rs 5,00,000) and surrogacy costs about £10,000 (approximately Rs 7,00,000). Like any other market, the ART market also deploys common strategies to generate demand, such as offering packages, schemes, and concessions; inflating success rates; and undertaking aggressive advertising through the use of attractively designed websites, brochures, wall advertisements, street hoardings, bus stop signs, and announcements on local television channels (Sama, 2010).

The industry functions through actors and collaborators at various levels, in an environment characterized by lack of binding standards or regulations, where these multiple stakeholders stand to profit enormously. ART clinics are not the only players in the business of promoting 'reproductive tourism' in India. Other players include a wide array of organizations catering to clientele both at the national and international levels. These range from ART consultants, medical tour operators, surrogacy agents, the hospitality industry, and tourism departments to other organizations specializing in the promotion of medical tourism. The Indian government promotes medical tourism by offering incentives such as low interest rates for loans provided for establishing hospitals and subsidized rates for buying drugs, importing equipment, and buying land for clinics. In addition, the General Agreement in Trade in Services (GATS) includes trade in medical services, thus enabling private hospitals treating foreign patients to receive financial incentives; these incentives include the ability to raise capital at low interest rates and the eligibility for importing medical equipment at low rates of duty. As Qadeer and Reddy assert, medical tourism is an industry that thrives on cheap air fares, Internet and communication channels in developing countries, and hi-tech super-specialty medical services for people who can afford it, whether foreign or national medical tourists. It also effectively deploys and markets Indian *exotica*, and packages health care along with other traditional therapies and treatment methods (Reddy and Qadeer 2010).

To create demand, ART providers argue that with infertility being 'rampant and rising steadily' in today's world, ARTs have become the 'need of the hour'. They cite higher rates of infections and ensuing complications, particularly in the absence of adequate gynaecological and obstetric services, as factors that contribute to the high levels of infertility in India. Providers thus claim that they are merely responding to the demand of women 'desperate' to become mothers. There is an increasing medicalization and pathologization of the condition of infertility, with the industry pushing for early medical intervention.

Combined with the availability of women's cheap labour in the unorganized sector that is a characteristic of the globalizing third world economy, the 'surrogacy industry' constructs the discourse of a win-win scenario for both infertile couples and women struggling with poverty. On both the demand and supply sides, one notices the emergence of a society in which individuals do not depend on the state for any solutions.

Further, stating that such cross-border trade would be based on fundamental economic disparity, Spar (2005) highlights the skewed choices that lead women who populate the lower ranks of the labour market to opt for surrogacy and yet the bulk of the profits go mostly to brokers. Cross-border surrogacy, then, plays out through this characteristic exploitation. Spar

argues that concerns regarding global inequality have also been voiced in cases of the garment industry, environmental arbitrage, however, in those cases they have led to regulation. For Spar, prohibition would result in driving the practice to another region or even underground. Instead, state authority should be wielded to negate the possible ill-effects of surrogacy.

Hochschild (2009), however, is sceptical about how this could be accomplished. While opposing the imposition of free-market and free-choice perspectives on globalization, she argues: 'Even if surrogacy were safely regulated with the interests of surrogates well in mind, they are vulnerable to something else, inherent in the global free market system – "a race to the bottom".' While granting that legitimizing such arrangements would provide economic relief to some women, Hochschild contends that it would nevertheless not create an economy that would offer another way out of poverty. Contract pregnancy shares many features with other labour contracts that have been critiqued in social philosophy, making waged labour itself unacceptable. For Satz (1992), the question to ask, then, is, "What kinds of work and family relations and environments best promote the development of the deliberative capacities needed to support democratic institutions?"

Contract and Ethics

Qadeer (2009) begins her essay, 'Social and ethical basis of legislation on surrogacy: Need for debate', by listing the key ethical principles that have guided medical practice: beneficence, non-maleficence, consent, confidentiality, and patient autonomy. To these, the discipline of public health has added the principles of social responsibility and justice. Given that India's fertility industry is completely unregulated at present, Qadeer highlights concerns about the misuse of technology and the commodification of body parts, which violate the health and the rights of people involved in arrangements like surrogacy.

Qadeer compares surrogacy with human-organ donation to demonstrate that, unlike the former, the latter has been restricted to a non-commercial transaction by the state. According to her, this "distinction between human body parts donated and those rented, and the equating of goods and living beings in commercial surrogacy" is irrational. This logic obscures the difference between the product of social human labour, such as any consumable commodity, and the product of women's procreative labour, a baby. Qadeer argues that there is no way to put a value on a human baby but arbitrarily, and asserts that therefore this value has to be the same everywhere in the world, including in the third world where poor women who become surrogates provide cheap labour. She compares the situation in India with the situation in the United States, where hiring a surrogate is many times more expensive and where she is better provided for in terms of medical expenses, health insurance (including for her family), expenses for maternity care and clothing, and the hiring of an independent lawyer.

Qadeer discusses several ethical issues that pertain to surrogacy. Technologies of selection, including ARTs, have made it possible to eliminate female and/or disabled foetuses. Yet if gender, disability, and infertility are all social constructs, then how can the Pre-Conception and Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act give parents the absolute right to abort a disabled foetus? Qadeer also points out that secrecy and anonymity – so precious to surrogacy arrangements – are rooted in the social primacy, and in the perceived superiority and exclusivity, of 'blood relations'. She asks why surrogacy is being envisaged in this old patriarchal mould. Should not the process be made more transparent, with both the

commissioning mother and the surrogate mother being involved in the birthing and breastfeeding processes? Qadeer also raises ethical questions relating to compensation, health rights, and legal assistance for the surrogate. Further, she points out that the commissioning parents have the right to demand abortion, and that the surrogate does not have the right to keep the child if she so wishes.

Qadeer also points out the larger contradictions in the state's promotion of commercial surrogacy vis-à-vis its two-child norm to control population, and the problem of maternal mortality. She argues that ART providers seek regulation because they wish to safeguard their interests. They want to ensure, for instance, that surrogates are legally bound to part with their babies, and that surrogates cannot act on their own and abort their foetuses.

Qadeer makes a case for better and equal terms in the surrogacy contract, although she begins by questioning the rationality of such a contract itself. This begs the questions: If done ethically, is commercial surrogacy a legitimate and acceptable profession? Or is there a larger question of structural injustice that might be overlooked by adopting a micro-view when examining the ethical terms of the contract?

Nelson and Nelson (1989) take an altogether different view, challenging the very basis of a contract pregnancy. According to them, surrogate motherhood signifies that the two strands of motherhood, social and biological, have been evaluated such that where there is a conflict between them, the social sense is seen to override the biological. However, Nelson and Nelson maintain that parental obligation is based on the causal relationship between parents and their offspring, and not on intention. So, it is "not the *decision* to have children but rather the *fact* of having done so, which primarily creates responsibilities" (87:1989). As such, parental duties cannot be transferred to another as a matter of choice, for, in this view, it is the child who holds the claim against both mother and father. Indeed, Nelson and Nelson point out that although surrogacy seems defensible along the standard liberal lines of freedom, individuality, opportunity, dignity, etc., we must remember that the abstract individual of liberal thought looks very little like a woman or a child. Surrogacy contracts are inappropriate because they leave out the interests of the infants, who are not the contracting parties. Further, Nelson and Nelson argue that even the most 'meticulously worded' contract cannot safeguard the surrogate; this is because of the current patterns of patriarchy, the non-volitional nature of the functioning of the woman's body (pregnancy is a natural body function that the surrogate cannot help), and, most importantly, because relinquishing control over the rearing of the child is an essential element of the contract. Hence, Nelson and Nelson point to fundamental, structural contradictions that make contract pregnancies unacceptable.

Merrick (1990) similarly takes a stand against surrogacy, using a range of arguments. In discussing the social and ethical issues involved in commercial surrogacy, Merrick asks whether the arrangement constitutes the sale of the child. A typical surrogacy contract provides payment not for the service rendered, but rather for the surrender of the baby and for the termination of the surrogate's parental rights. This transaction is a sale that turns the child into a product and devalues him/her as a human being. Merrick argues that surrogacy should be banned also because it increases the possibility of the child being abandoned due to birth defects, and because it inflicts psychological harm on the players involved. It restricts the

surrogate's freedom and choices, and instrumentalizes her to serve the ends of others. The socio-economic exploitation of lower-income women by higher-income couples is clear in surrogacy. Merrick argues that surrogacy damages the structure of the nuclear family, which is a fundamental building block of society.

Merrick points out that there are no data on the psychological effects experienced by children born of surrogacy arrangements. Indeed, overall, very little data exist on the participants in surrogacy arrangements. Additionally, how would the best interests of the child be adjudged when custody battles occur in surrogacy arrangements? Can a contract legally bind a surrogate to follow a certain lifestyle, and to meet certain conditions imposed on her lifestyle? Does she have to submit to abortion if the intended couple so wishes? Merrick argues that a ban on commercial surrogacy arrangements is the only solution when one considers the total picture.

However, others argue that most such issues can be, and must be, ironed out through a responsibly termed contract. Further, the issues that cannot be resolved through a contract are perhaps bigger universal conflicts that will continue to exist in most exchanges. Hill (1990) argues that surrogacy must be closely regulated to best serve the interests of all concerned. He arrives at this conclusion after making comparisons with other models of prohibition and non-enforcement. According to Hill, prohibiting surrogacy is unacceptable because there is a great need for an alternative to the traditional means of procreation. Such a ban may also not be effective, and may serve only to create a market in 'back alley' surrogate arrangements, which render the actors vulnerable to abuse and manipulation. Hill, who is based in the United States, also argues that a ban on surrogacy would fail to meet the constitutional requirement that laws infringe on fundamental rights (in this case, the right to privacy of the surrogate and the right to procreation of the intended parents) to the least possible extent. Similarly, Hill out the option of non-enforcement of the surrogate contract. His arguments against non-enforcement are based on the need to rightfully and legally restrain the surrogate, to ensure that a custody battle does not ensue, to ensure that the child does not grow up in the functional equivalent of a broken home, and to ensure that the surrogate is bound by a contract and does not have an unfair bargaining advantage or edge. Hill cites the rationale behind the contract theory in general, that is, each party is made aware of his or her rights and obligations under the contract by establishing these prior to performance.

While making a case for the enforcement of the surrogate contract, Hill argues that even if surrogacy has certain harmful effects, it does not follow that the state should ban all surrogacy en masse because of the strong tradition of personal autonomy in matters of individual choice. Rather, legislation would serve precisely to mitigate the possible harmful effects of surrogacy, such as by putting in place systems for screening, licensing, and judicial review.

Hill proposes that mere biology should not be the basis for establishing an individual as the 'parent' of another. Rather, the fundamental basis of the parent-child relationship is intentionality. In the case of surrogacy, it is the intention and the action of the intended parents that bring the child into being. While the surrogate assists in bringing the child into the world, her involvement follows, and is contingent upon, the intention and the action of the intended parents. As such, Hill argues that intention must trump biology, genetic or gestational, when

demarcating parenthood, "Biological parents are considered legal parents in our culture not because of their biological relationship with their children, but because of what the biological relationship evidences – namely, the intention to raise the child, the means to bring the child into existence, and the ability to care for the child after birth. Where couples lack the physical capacity to bear a child but possess the more fundamental indicia of parenthood, their status as parents should be recognized and honored even above those who claim a biological relationship with the child" (Hill 157:1990).

A major motivation for Hill to support regulation is clearly so that the surrogate can be controlled and managed. This is similar to Qadeer's (2009) assertion that industry is pro-regulation not because regulations are benign, but because they are better for business.

Another motivation for supporting regulation is found in the writings of Shevory (1990). He adopts a critical legal studies perspective in analysing the surrogacy contract, and argues that such a contract pushes liberalism to think differently and more flexibly about the separation between the public and the private. Family life has generally been considered a 'protected space', beyond the rationalistic economic calculus. However, real-life family relations do not fit this idealistic, affectionate model, and they become the subject of litigation when conflicts arise within the family. Thus, Shevory argues that family litigation exposes the falsity of the myth that divides life into the two spheres of the private and the public. Within this, the issue of surrogacy pushes the question even further: Should family life be treated in/by/under law as simply another set of economic relations? Even as Shevory states that surrogacy has the potential to exploit and abuse women, he insists that it need not be so. He thus sees surrogacy as an opportunity to refashion liberalism. He concludes with the following argument, "It is a mistake to believe that policy practices which limit surrogacy will solve the inequities that surrogacy exposes. To merely outlaw surrogacy will not alter the mixture of altruistic impulse and financial necessity that encourages women into its practice. Banning surrogacy will simply reinforce the idealization of the traditional family structure. Given that the practice of surrogacy will likely be continued, with or without legal authorization, perhaps we should be optimistic and consider surrogacy as a potentially useful practice for deconstructing the walls that divide the world into seemingly immutable, but actually very fragile and besieged, family structures".

In the context of a range of ambivalent responses to the practice of commercial surrogacy, Fraser (2011) states that against the vagaries and exploitation of the market, a feminist critique that is merely a defensive project and that seeks to protect women's reproductive labour from the sphere of the market is not adequate. In protecting the supposed non-commodified essence of labour, such a project obscures the non-market forms of domination through which that labour is performed. What, then, should be the concerns and norms that direct us to regulate this market? Fraser presents three sets of questions. First, how ethical are the norms on the basis of which protection is desired? Do they violate the principle of parity in participation? Second, is the regulation structured in a way that treats women as active citizens or as passive subjects? Third, is the state regulation mismatched, in that by protecting people in one arena it exposes them to the dangers of the market in another, or is it well-framed, affording protection to all those on whose activities society relies?

Conclusion

The above survey of the literature on commercial surrogacy has reflected on and directed the nature of the enquiry of this research study and sharpened the focus of our investigation in the following ways.

Medical innovation and technology make it possible to destabilize the linear categories of biology and kinship. In this context, where there can be multiple definitions, it depends on who has the power to establish the legitimacy of one particular definition. In this context, where the idea of 'natural' biology and parenthood is being seriously challenged, and where the deployment of meanings that are being actively assigned to relationships is also being challenged, whose interests are being served by a particular deployment, particularly as seen in the case of commercial surrogacy? There are particular power configurations in a surrogacy arrangement that make this possible. The objective is to reveal these power configurations and to identify those who are marginalized by them.

Additionally, this practice poses challenges to several patriarchal institutions and practices, while the industry is flourishing, it attempts to portray such destabilizing trends to the contrary through familiar expressions and purposes making it seem acceptable. At the same time, what are the limits that are put on this perceived-to-be-deviant practice? Is there a limit to how much one can deviate? How are these limits conceptualized? For instance, who can be a surrogate? How must she behave? How is she following the norms of being a mother? Are her identity markers in sync with the ties of kinship that the commissioning parents want visibilized?

In an attempt to understand if and what different rationales exist, the focus is also brought on the ways in which the performance of women's reproductive labour is altered when introduced in the market. The practice of commercial surrogacy is located as one more aspect and arena indicative of women's reproductive autonomy. Their choices are influenced depending on how they are situated in their social and economic context. We look critically at the considerations that influence their choices, the control they have over these choices, and how they want to, and are able to, shape their lives accordingly. We also look at the institutions and structures of power within which these choices are made, the ways in which surrogacy arrangements, in their current form, are compatible with these institutions and structures of power, and the ways in which they challenge, or can help women challenge, these institutions and structures.

Keeping the above direction of inquiry, this study seeks to strengthen the current research and literature available on commercial surrogacy by examining the surrogate's position in relation to all the other actors in the arrangement and scrutinize the concrete processes of this site of (re)production. The attempt is also to look at how the various processes that constitute the practice have been evolved, by whom and serving whose/what interest. The study also looks at how compatible the current proposed policy is with the reality and the needs the surrogates and an ethical practice.

Notes

¹ Feminist writers have emphasized the patriarchal nature of reproductive technologies, which they say, use women's bodies to meet the male need for a genetic tie with the offspring. This view sees surrogacy in particular as devaluing the mother's relationship with the child in order to exalt that of the father (Roberts 1997:249 in Pande 2009b: 384).

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CHAPTER 1

Profiles of Surrogates, Surrogacy Agents, Surrogacy Centres, and Commissioning Parents

This chapter presents the profile of the surrogates, the centres providing surrogacy services, the agents who facilitate and coordinate surrogacy arrangements, and the commissioning parents who were engaged in surrogacy arrangements in the research sites.

The profiles are organized into two sections: Section A, which provides the socio-economic profiles of the 12 surrogates interviewed; and Section B, which provides background information about the above-mentioned actors and offers insights into their roles, and the nature of their interaction with the surrogates. This information facilitates the understanding of the variables that determine or influence the reasons and motivations of the actors for entering/re-entering the surrogacy industry, that influence the selection of surrogates, and that are the driving force behind the commercial surrogacy industry.

SECTION A

Profile of surrogates

This section presents the profiles of the surrogates who participated in the research and who were or who are currently involved in arrangements of surrogacy (See Table 1). It examines the surrogates' backgrounds with regard to age, education, work/occupation, income, caste, religion, type of family, marital status, location of residence, and explores if and how these criteria determine their motivations to enter surrogacy arrangements as well as the extent and nature of the negotiations that mark surrogacy arrangements.

Age

Age-related information gathered in the course of the research was based solely on the surrogates' responses. It was expected to provide a better understanding of the age at the point of entry into surrogacy and of age-related criteria for inclusion in surrogacy arrangements.

All the surrogates at the time of the interview were in the age group of 21–38 years, with all except one below 35 years. Ten of the 12 surrogates were in surrogacy arrangements at the time of the interview. Two surrogates, SP1 and SD6, had been in surrogacy arrangements four and three years prior to the interviews respectively. The maximum age at surrogacy was 34 years and the minimum was 21 years.

Table 1: Profile of Surrogates

Code	Current age (in years)	Age at surrogacy (in years)	Surrogacy location	Religion	Caste	Education	Status of surrogate pregnancy when interviewed
SP1	38	34	Jalandhar (Punjab)	Sikh	Jat (FC)	Class 9	4 years since surrogacy
SP2	28	28	Jalandhar (Punjab)	Hindu	Brahmin (FC)	Class 5	1 month after delivery
SP3	30	30	Jalandhar (Punjab)	Hindu	Ramgadi (OBC)	NA	3 months after delivery
SP4	28	28	Jalandhar (Punjab)	Christian	Maire (SC)	Class 5	3 months pregnant
SP5	28	28	Jalandhar (Punjab)	Hindu	Khetri (FC)	Not literate	2½ months on medication; ET* to be done
SP6	30	30	Chandigarh (Punjab)	Hindu	Rana (FC)	Graduate	ET done, pregnancy to be confirmed
SD1	30	30	Delhi	Hindu	Not low caste (as told by surrogate)	Class 8	3 months pregnant
SD2	30	30	Delhi (current surrogacy) Indore (first surrogacy at 29 years of age)	Hindu	NA	Class 10	5 months pregnant
SD3	30	30	Delhi	Hindu	Parsunath	Not literate	3 months pregnant
SD4	21	21	Delhi	Muslim (Shia)	NA	Class 4	2 months pregnant
SD5	34	34	Delhi	Muslim	Sheikh (OBC)	Not literate	ET done; pregnancy to be confirmed
SD6	35	32	Delhi	Hindu	Brahmin (FC)	BA	3 years since surrogacy

Source: Field data, December 2011–April 2012.

Note: *Embryo Transfer (ET) is usually done in the second or third month after the process of medication begins.

The age-related responses point to the preference for the inclusion of younger women in surrogacy arrangements. According to AgD,

If a surrogate goes in for her first arrangement at 25 years, then she can go for two to three arrangements till she is 30 years. The chances of getting pregnant are reduced after 30, and delivery is also perceived to be more complicated in older women, given higher incidences of high blood pressure, diabetes, thyroid, etc.

However, exceptions to this general preference did exist, if according to AgD, surrogates were '34–35 years old but looked younger, and were healthy' The Draft ART Bill - 2010 does not permit women below 21 years and above 35 years to become surrogates.

Marital status

All the respondents (doctors, agents, and surrogates) said that marital status was a primary criterion for inclusion in surrogacy arrangements, albeit for varied reasons. 'Being married' or,

more importantly, receiving the surrogate's husband's consent along with the surrogate's own consent was a condition adhered to quite strictly by doctors and agents. This was largely perceived as important to pre-empt the possibility of any trouble (or liability) claimed by the surrogate, or to avoid future monetary contestations by the husband, as well as to ensure cooperation towards a positive outcome of the pregnancy and towards 'easy' relinquishment. The husband's acceptance of the arrangement was also perceived as critical to avoid any challenges to the practice of abstinence, particularly in the early months of pregnancy, which was deemed mandatory in all surrogacy arrangements. Doctors also justified marital status as a necessary condition as per the Draft ART Bill - 2010.

All the 12 surrogates were married. Two of them said that they were or had been separated, although they were 'not divorced' from their husbands. SP4 was living separately from her husband, having decided to put an end to a violent relationship. She, however, was reconciled to his return for the period of surrogacy (or for even longer) as the clinic required his consent for the surrogacy arrangement:

Surrogacy arrangements were undoubtedly directed by a hetero-patriarchal construct of marriage and child bearing that permits the latter only within the former. Surrogates similarly expressed their constraints in challenging existing norms, or were willing to make reconciliations (as above), or simply drew on the power and security that 'being in a heterosexual marital relationship' provided. As SP5 said in response to a question about her stomach showing (in sometime), *"No worries. My man is with me."*

The privileging of married women is apparent in surrogacy arrangements, that seeks conformity to patriarchal norms of marriage and reproduction even as it deviates in some respects. The conformity in this case is in the interest of a successful arrangement. Consent of the husband for entering into a surrogacy arrangement, which reinforces the patriarchal logic of control of the surrogate woman's reproductive capacity/labour, is also mandated by the state in the Draft ART Bill-2010; if the woman intending to be a surrogate is married, 'consent of her spouse shall be required before she may act as such surrogate'.

Type of family

Information about the type of family was collected primarily to understand the implications vis-a-vis the type of family in the context of surrogacy; when the surrogacy becomes 'visible' in the case of a single, nuclear or joint family, and to assess the economic and social consequences of changes in the family formation as a result of surrogacy. Information about family also important to better understand the motivations and decisions behind a woman member becoming a surrogate.

For the purpose of analysis, the family was categorized into single, nuclear, and joint families, where 'single' family means that the surrogate was living on her own or with children; 'nuclear' family means that she was living with her husband and children; and 'joint' family means that she was living with other members of the extended family – mother-in-law, sister-in-law, brother-in-law, mother, father, sibling, etc. – all living together or in very close proximity. At the time of the interviews, nine of the surrogates were living in nuclear families, two surrogates were living in a surrogate home, and one surrogate's brother in-law and family lived on a floor

above her own family's home. Of the nine nuclear families, three of them were contributing financially to their parents and in-laws.

The type of family in which they lived had changed for four surrogates directly as a consequence of their surrogacy arrangements. SD2's family status (at the time of the interview) was nuclear, a shift from her original joint family, as a result of her relocation to another city for the surrogacy. SP4 along with her three children had been living separately from her husband, but asked the husband to live with her during the surrogacy. SD5, who was staying in the surrogate hostel, was living away from her husband and children, who lived in the same city, for the period of the surrogacy. SD4 was also living in the surrogate hostel along with her young daughter. Earlier, she lived with her mother after having separated from her husband.

Income

Income is one of the indicators for assessing the class backgrounds of those who went in for surrogacy arrangements. Details about income have to be analyzed along with details about various movable and immovable assets. Information in this regard, however, was not available for most respondents, and hence has not been presented here.

This section presents data about income alone, as it was described as one of the most critical reasons for the women's entry into surrogacy. Household monthly income was calculated as the cumulative amount of the average earnings of the surrogate and the husband, excluding the remuneration that they were getting every month (in some instances) for surrogacy. The average income was indicative of the approximate household income given the nature of the work – seasonal, home-based, piece-rate, etc. – in which the surrogate and members of her household were involved. (See Table 2 for details about income, categorized by the location of surrogates).

Table 2: Household Income

Punjab		Delhi	
Surrogate	Household Income (average / per month INR)	Surrogate	Household Income (average / per month INR)
SP1	4000-4500	SD1	10500
SP2	6000-7000	SD2	9000-10000
SP3	4500-5000	SD3	10000
SP4	3000	SD4*	NA
SP5	7500	SD5	4500
SP6	15000	SD6	12000

Source: Field data, December 2011–April 2012.

Note: *SD4's only source of income was her current surrogacy arrangement.

While the value of income differed substantially based on the surrogate's location, an analysis of the available data in the following chapters provides an understanding of the economic reasons for choosing surrogacy, the shorter and longer-term economic implications of the surrogacy arrangement for the surrogate and her family, including loss of current income (both of the surrogate as well as of her husband), relocation expenses, and other costs.

Children

Having child(ren) was perceived as an important indicator of a surrogate's fertility and 'healthy uterus', and therefore of her ability to carry the surrogate pregnancy to term.

The 'completion' of the surrogate's family, that is, having the desired number of children prior to entering into the surrogacy arrangement, was something that the agents took into account. According to AgP,

Because, God forbid, a problem should arise in conceiving later, they would say that I got this done, that is why I can't have children now.

Apart from their own children (See Table 3), five of the surrogates also had children in surrogacy arrangements; three surrogates had single children; and two surrogates had twins. The time frame since the birth of the surrogate's last child either prior to surrogacy or since the birth of the last child through surrogacy ranged between one to 12 years. This provides some insight into the pattern of spacing between births, with possible implications for the surrogate's health. Only one surrogate in this study, SD2, had already undertaken a second surrogacy, just a little over a year after giving birth in her previous surrogacy (See Table 3).

Table 3: Number of live births and time gap between previous childbirth and surrogacy

Surrogate	No. of children prior to surrogacy	Surrogate Births	Total no. of Live Births	Time gap between last child birth and surrogate pregnancy
SP1	3	1	4	4 years
SP2	2	1	3	4 years
SP3	2	2 (Twins)	4	3 years
SP4	4 *	PC	4	7 years
SP5	3	PNC	3	6 years
SP6	1	PNC	1	NA
SD1	2	PC	2	12 years
SD2	2	1 (previous), PC currently	3	10 years prior to surrogacy, 1 year since first surrogacy
SD3	2	PC	2	NA
SD4	1	PC	1	NA
SD5	5	PNC	5	NA
SD6	1	2	3	3 years

Source: Field Data – December.2011 - April 2012; PC – Pregnancy confirmed; PNC – Pregnancy not confirmed yet; NA – Information Not Available

Note: * SP4 currently lives with three children (1 daughter and 2 sons). She had given away her second son when he was eight months old to a child-less couple. Facing the new born's illness while she was separated from her husband and in financial difficulties, she was unable to afford treatment and gave him away so he could be cared for well.

As per the Draft ART Bill - 2010, a surrogate may have a total number of five children (successful live births), including through surrogacy. While the information gathered from the interviews showed that this may not be adhered to very strictly, the rationale for having the 'five children' estimate in the Draft ART Bill - 2010 is unclear. While the limit on the number of children is

generally claimed to be a safeguard put in place to protect women's health, it raises questions about what, therefore, should be the recommended number of children, and whether this limit should be stipulated by the state at all in all cases, or whether it should be stipulated only in surrogacy arrangements? More importantly, in the interest of the health of women can these so called safeguards be seen as a solution given by policy when they do not better the situation of the surrogates at all? The estimate of five children needs also to be located in a context where state policies promote the control of fertility (particularly the fertility of women) and exercise control over the number of children (for example, the two-child norm) in non-surrogacy situations.

Residence

Details of residence were collected to examine and map the movement by surrogates to different locations within and across cities and towns as well as to understand the reasons for such moves - both temporary and/or permanent - and their economic implications. Locations (of residence) were also important for understanding how agents and clinics gained access to surrogates as well as to how surrogates gained access to clinics.

Of the 12 surrogates, five were residing in Delhi, six in Punjab, at the time of their surrogacies. Of the six respondents in Delhi, SD2 had migrated from Indore to Delhi with her husband specifically for the surrogacy and lived in rented accommodation for the period of the surrogacy arrangement. Two surrogates, SD1 and SD3 were originally from Bengal and Bihar respectively and had moved to Delhi some years prior to the surrogacy arrangement with their husbands and children, seeking better economic prospects and work. SD4 and SD5 were residing in a surrogate home for the period of surrogacy. SD6 was in Delhi during her surrogacy and had since moved to Ranchi (Jharkhand) and was at the time of the interview exploring the possibility of entering into another surrogacy arrangement.

Table 4: Location of residence

Code	Permanent Residence	Surrogacy location	Code	Permanent Residence	Surrogacy location
SP1	Jalandhar, Punjab	Jalandhar	SD1	In Delhi for 8 years (migrated for work from West Bengal)	Delhi
SP2	Bababakala, Punjab	Jalandhar	SD2	Indore (residing in Delhi for the duration of surrogate pregnancy)	Delhi, Indore (first surrogacy)
SP3	Ludhiana, Punjab	Jalandhar	SD3	Delhi (originally from Bihar)	Delhi
SP4	Kapurthala, Punjab	Jalandhar	SD4	Delhi	Delhi
SP5	Kapurthala, Punjab	Jalandhar	SD5	Delhi (migrated for work)	Delhi
SP6	Chandigarh, Punjab	Chandigarh	SD6	Delhi during surrogacy (Currently in Ranchi)	Delhi

Source: Field data, December 2011–April 2012.

In comparison, in Punjab, all the surrogates resided in their own homes throughout the surrogacy period. Four of them did not reside in the same city/area as the clinic where they had undergone or were undergoing surrogacy, but resided in neighbouring towns and villages.

One surrogate was originally from Himachal Pradesh but had moved after marriage as her husband was living in Punjab.

Some of the surrogates had moved for the entire period of their surrogacy either to another city or within the city to a surrogate home or hostel. Few surrogates planned to shift from their current residence to other, less familiar locations within their cities or towns in order to avoid interference or to evade questions by neighbours, particularly when the pregnancy became visible.

Religion and Caste

Collecting and analyzing information about religious and caste identities was necessary to understand the trends in the selection of surrogates based on them. These criteria were usually laid down by the commissioning parents, often based on their own identities.

While there was no conscious attempt to include predominantly Hindu respondents, they nevertheless formed the majority of surrogates in this purposive sample. Eight surrogates identified as Hindu, two as Muslim, one as Christian, and one as Sikh. Among the surrogates who were Muslim, one stated she was a Shia and the other a Sheikh (Other Backward Caste - OBC). Two of the surrogates who identified as Hindu belonged to the Brahmin caste (Forward Caste - FC). The others identified as 'Rana' (FC), Khetri' (FC), Parsunath, Ramgadi (OBC), and Maity (Scheduled Caste - SC). One surrogate said she was 'not from a low caste.'

Although the surrogates were from diverse religious backgrounds—Sikh, Muslim, Christian, and Hindu (a majority)—this does not imply that such identities are irrelevant to their entering the arrangement. DP2 said,

There was a surrogate who belonged to a low caste and she was rejected on that basis. [The commissioning parents said] We don't want a low- caste surrogate, or someone with a dark complexion or someone who is not good to look at.

Such demands were made despite the surrogate being involved only in gestation with no genetic link between the surrogate and child and regardless of the counsel they had received against such practices:

They have all sorts of demands, but then we tell them that the surrogate has nothing to do with all this. So we do have to counsel [them]. But then they do sometimes reject surrogates.

(Do they sometimes ask for a surrogate of the same religion?) No. I have not encountered that. With me there have been demands about caste.

(High caste?) Yes. But the doctor had explained [the situation] to her. And I also said that what do you have to do with the caste.

(She was a high caste? And she wanted the surrogate from her own caste?) No, not from her own caste. They see how women work in houses and say that we don't want someone like this. But mostly, if you explain to them once or twice, they understand. I say that I am also from that caste. There is only one odd patient who asks for this. Otherwise they are concerned that she should have proper hygiene.

(Do they pay more?) Of course.

(How much more?) 50,000 maybe or one lakh, not more than that.

Source: AgP's interview

These decisions were also justified in the context of the health of the surrogates, with commissioning parents drawing on existing biases by referring to connections between caste and religion, on the one hand, and fertility and lifestyle, on the other hand. DP3 commented,

Even if it is not her genetic material, patients may demand [it]. They think of the blood and [the] environmental factors that may affect [the child].

According to AgD, commissioning parents from certain religious and caste backgrounds preferred surrogates from backgrounds similar to their own. According to him,

NRIs can source eggs and surrogates here from the same caste and religion as theirs. They may or may not get this abroad.

He cited this as the reason for their decision to access services in India, specifically Punjab. Although he felt that these trends were gradually changing, the responses by agents and doctors largely reaffirmed the existing stereotypes about, or perceptions of attempts to conform to and reinforce existing social hierarchies and prejudices concerning fertility, marriage, as well as systems of caste and religion.

Education

Information on education levels was collected in order to examine the implications for information transaction vis-à-vis the contract, the medical protocols, the decision-making process, etc.

With regard to formal education, two of the 12 women in the sample were graduates; three had studied until the tenth class, and three surrogates had completed the fifth class. Three surrogates had not received any formal education. No information was available about the educational level of one surrogate.

The current sample reflected low access to education, with three surrogates having received no formal education at all. There was no dramatic variation between the research sites. Even among surrogates with higher levels of education, gaining access to information and maintaining communication was a challenge, given that a major part of the arrangement was transacted in English, that is, signing consent forms, implementing other protocols, and, in some cases, communicating with commissioning parents. This has serious implications for the giving and receiving of informed consent and for the surrogates' participation in informed decision making.

Work / Occupation

The surrogates were often involved in different kinds of work in order to make ends meet. Many of them were engaged in informal, seasonal occupations or piece-rate work from home.

Three of the women had never been employed prior to the surrogacy. Five of the surrogates were involved in garment work—stitching clothes, embroidery, and *sitara ka kaam* (stitching sequins). Of the remaining surrogates, SD3 was a peer educator with a non-government organization (NGO) and worked with women, particularly sex workers, facilitating their access to health care. SP4 was a cook working as part of a crew providing catering services for

Table 5: Nature and status of employment of surrogates and husbands

Code	Occupation / Status of Employment		Husband's Occupation/Status of Employment	
	Prior to surrogacy	During/after surrogacy	Prior to surrogacy	During/after surrogacy
SP1	Garment; Stitching (10-15 yrs)	Discontinued (unable to following surrogacy)	Driver (private taxi service)	Same; invested in a car from the remuneration for surrogacy
SP2	Housewife	Same	Mason	Same
SP3	Garment stitching from home; not regular, sometimes for neighbors	Stitching work; planning to buy a machine with specialized unction (for 'overlock')	Auto Driver	Same - now he drives Chhota Haathi (local vehicle)
SP4	Cook (3 years- makes rotis at weddings, seasonal - only in winters); domestic worker (regular)	Unable to do any work	Daily wage worker in the catering business - "Halwayi" (for weddings) (seasonal)	Same
SP5	Serves tea in an office in a coach factory (6 years). Earlier as labourer in the village	Same	Supervisor in a coach factory	Same
SP6*	Housewife	Same	Service ('office job')	Same
SD1	Placement agency ("place girls in big offices" or domestic work) Previously Patient care (ran a nursing bureau, placing nurses for patient care), earlier garment export factory work ('sitara ka kaam', measurement)	Discontinued work Considering domestic work - as a cook after surrogacy	Patient care	Same
SD2	Garment stitching (piece work from home); earlier papad-rolling work at home	Continued stitching	Garment; embroidery (factory)	Unable to find work in Delhi due to relocation
SD3	Peer educator at an NGO; Assisting people (mostly sex workers) in getting treatment and medicines for HIV, STIs, UTI	Continues in a limited manner - coordinates over phone. (Asked to discontinue by the Commissioning parents)	Export factory worker	Same
SD4	Garment work; stitch sequins in women's shirts	Discontinued work after one month due to pain in eyes and headaches.	Separated from husband	NA
SD5*	Housewife	None	Cook	Same
SD6	Housewife; earlier tuitions or dancing classes. Worked as personal assistant to doctor in the hosp ital where she was a surrogate for some months; Has tried to sell a kidney (unsuccessfully)	Assistant to the doctor after surrogacy; currently looking for surrogacy opportunities	Hotel Manager	Same

Source: Field data, December 2011–April 2012.

Note: * Women engaged in care work of their families and household with no employment outside home.

weddings and she also did domestic work (washing and cleaning in people's homes). SP5 worked in a government office (but in a private capacity), serving tea and doing other such chores. Information about spouses' work was available in the case of some surrogates (See Table 5) and included mason, driver (auto, private taxi service), cook and/or *halwayi*, supervisor in a factory, embroidery worker, worker in an export firm, and hotel manager.

Surrogates and their spouses were engaged in similar kinds of work; largely casual, irregular, and seasonal, and highly dependent on the vagaries of the labour market. Those employed in garment work, for example, were mostly involved in home-based, casual, and piece work. SP3 sometimes stitched clothes for neighbours for whatever payment they were willing to give, while her husband was an auto driver. Her husband's employment, however, was an irregular source of income and he would often shift jobs, which had resulted in financial difficulties and debt, further exacerbated due to a death in the family.

The situation of SP1 was similar; her husband was a taxi driver while she had done garment piece-rate work from home for many years till she became a surrogate. SD1 had also taken up stitching work but had discontinued it since it led to her straining the eyes and headaches.

SD2 and her husband had been involved in garment work prior to the surrogacy. She did piecemeal rate, home-based work and her husband worked in a garment factory. Before that she did papad-rolling, also from home. According to SD2, there was not much income in garment work. Her husband originally worked in a paint factory that closed down and he was without any regular work for two or three years. To make ends meet, both of them learnt to stitch. During her first surrogacy, SD2 continued stitching for most of the pregnancy. During the second surrogacy, due to relocation to Delhi, it was very difficult for both of them to find work.

SP4 was engaged in multiple jobs at the same time. For seven years she worked as a cook at weddings, but this was a seasonal source of income. She supplemented this with domestic work, such as cleaning utensils and washing clothes which was her regular source of income though with lower wages. She had done this work from a very young age, supporting and accompanying her mother, also a domestic worker. SP4's daughter, at the time of the study, used to work in the house where her mother usually worked, whenever her mother (SP4) was unavailable or unable to do so.

The nature of work in which the majority of surrogates and their husbands were involved was a crucial factor that prompted them to consider surrogacy as a means of supplementing their income. Two surrogates also said that they preferred surrogacy to doing domestic work. According to SP2,

People in houses can accuse you of stealing from them. They can accuse you of anything. Then we can't repay them. I have heard this happens. I have never done it [domestic work].

SP1 said that a number of women from Jalandhar, Punjab, who were domestic workers were opting for surrogacy arrangements. SD5 was looking for domestic work when the surrogacy agent in her neighborhood approached her for surrogacy.

Trajectory of work of a surrogate

SD1 hails from a village in West Bengal. She had studied till class 8. Her husband owned a grocery shop in the village. She used to assist him in the shop and sometimes sold vegetables in the local market. Finding themselves in a critical situation where both of them had to undergo surgeries and had to pay off debts incurred following the medical expenses, SD1's husband decided to sell the shop, their only source of income. SD1 decided to migrate to Delhi, following many others from her village. Leaving the children with relatives and using up all their savings the couple moved to Delhi at the persistence of SD1 so she could search for work while her husband recovered. In Delhi, SD1 started working as a domestic worker. Before starting this work she had been informed that it was a two-room house, but turned out to be a much larger house with four floors and 15 rooms where she was expected to clean bathrooms, wash clothes, clean utensils, and also take care of a child and attend to an older woman. The salary offered, however, was not increased and finding herself unable to physically keep up with the amount of work SD1 discontinued the work. Having worked a fortnight, she was not paid by her employers or the agent who had facilitated her placement in the home.

Unable to find work and with all their savings exhausted during this period on rent, food etc., SD1 and her husband were considering returning home, when a neighbor arranged for SD1 to work at an export garment factory work shed. She was paid Rs 1,500 for this work and soon arranged for similar jobs for her husband and her sister (who had followed her from her village). Over the year, SD1 shifted jobs (stitching, embroidery, measurement) between different garment factories whenever offered a higher salary by Rs. 300 or Rs.400 eventually reaching Rs.3500. She would often supplement the income from factory with piece-rate work from home in the evening. Once her children had come to live with her, she switched jobs and was placed in a patient care job at a private nursing home where she worked for two years. While SD1 found the pay satisfactory and the owner helpful, in supplementing her income as well as aiding her training in nursing; she quit the job due to extremely long hours and unpredictable work timings, with no leave offered. Following this, SD1 worked at two hospitals in South Delhi at a lower salary, for two years, after which started her own nursing agency, earning commission for placing nurses for home care of patients. However, during a stay back in her village she incurred severe losses and had to shut down the agency. During this time she came to know of surrogacy, while she was planning to open another agency in partnership with three other people.

Three of the surrogates had to stop working completely during their surrogate pregnancies as due to poor health conditions. One of them had to restrict her work because this was requested by the commissioning parents. SD3, who worked closely with sex workers as a peer educator, was asked to discontinue her work; the commissioning parents did not want her to visit hospitals, which was central to her work. However, she continued to work, coordinating matters over the telephone as against being physically engaged in the task. In the case of SP4, who also could not continue to work during pregnancy, her 14-year-old daughter used to go instead for domestic work which SP4 had taken on, after school.

Two of the surrogates had been in surrogacy arrangements prior to the current one, and two surrogates were planning to do surrogacy in the future too. SD2, for example, was in her second surrogacy arrangement. The first one had been successful and the commissioning parents from that arrangement had requested SD2 to get into a surrogacy arrangement again after she completed her current one. Two surrogates had donated eggs previously, while two surrogates had experienced unsuccessful surrogacy attempts previously.

Most surrogates and their spouses were in the informal work sector, characterized by exclusion from the organized labour market, low wages, home-based work, insecurity of tenure, lack of benefits, and poor working conditions with implications for the health of workers. Given this scenario, surrogacy was seen to provide an option for enhancing one's financial security.

Selection criteria for surrogates

The selection criteria for surrogates described by the commissioning parents, doctors, and agents in the course of the research are presented here. They include physical attributes such

as height and skin colour and other traits such as caste, religion, age, and children. Surrogates were also expected to be docile and not possess a *kadwa swabhav* (bitter/rude disposition). In addition, medical fitness, pertaining particularly to reproduction, was mandatory.

The commissioning parent stated,

She should be simple, [even if] not middle class, lower middle class [would also be acceptable]. But the features should be good. Everything should be good. The living standard, a little bit, should be good.

'Healthy' and presentable appearances, 'hygienic' lifestyles and respectable married life, served as a basis for excluding certain women, where suspicion was often attached to their caste or class identities in appropriately caring for the child. DP3 said,

First of all, she should be fertile. She should already have children. Second, she should not have any medical problem. She should not have a problem holding the child, like a cyst (rasoli) or any such problems. Her uterine cavity should be healthy. And she should not have any genetic problems. No risks. She should not be HIV-positive. We do tests and we screen them.

According to DP2,

The surrogate should be young and have children of her own. She should have her husband's consent for surrogacy and should be medically fit. She shouldn't have any infectious disease and should not have any genetic problems.

Any criterion that additionally demonstrated an absence of a genetic link between the child(ren) and the surrogate or demonstrated an overt connection (such as a similar blood group) indicated suitability. DP3 affirmed that there were different demands for the kinds of surrogates sought by commissioning parents: 'Yes, like religion. Or A,B, or O positive blood group, to match with that of the husband.'

Apart from such preferences, an agent pointed out that if a woman had undergone sterilization, it was an added suitability. Sterilization makes impossible the genetic link between the child(ren) and the surrogate, and was seen as a guarantee to avoid contestation regarding the claim over the child (discussed further in Chapter Four).

According to AgD,

If they [surrogates] have had a [sterilization] operation (nasbandi), it is a good thing, implying that in case of sterilization there was no possibility of a genetic link between the surrogate and the child, which settles all doubts for everyone.

The socio-economic profile of the surrogates detailed above explores the identities of these women, their background and helps us understand the context of their choices in life. At the same time it also indicates the preferred markers and the boundaries that the industry draws for particularly reasons in selecting women, often excluding those from most marginalized communities and circumstances.

SECTION B

This section presents brief profiles of other actors in the surrogacy industry – commissioning parents, surrogate agents, and doctors/surrogacy centres. It provides an overview of the range of actors involved in arrangements of surrogacy and flags preliminary issues for further analysis.

Profile of commissioning parents

Information about the profile of the commissioning parents was drawn largely from the responses of doctors and agents. This was not central to the inquiry, and only one commissioning parent was interviewed in Punjab.

The surrogates invariably had minimal information about the commissioning parents, while the backgrounds of the surrogates and their husbands, their lifestyles, etc., were open to deep scrutiny, reiterating the skewed power dynamics in the surrogacy arrangements.

According to the doctors and agents, the commissioning parents who opted for surrogacy were usually couples who had not had any success through IVF or Intra Cytoplasmic Sperm Injection (ICSI) or those who had experienced repeated miscarriages. Such couples generally opted for surrogacy in the end. Commissioning parents were Indians, non-resident Indians (NRIs), and sometimes foreign nationals. Based on the limited information provided by the surrogates, it was possible to conclude that seven of the commissioning parents of the surrogacies were NRIs, of which four were Punjabis currently living in Canada, the US, and the UK. Of the remaining four commissioning parents from India, two were from Punjab and two were from Delhi. One surrogate had not met the commissioning parents yet and had no information about their background, location, etc. There were variations between Delhi and Punjab, with the former having a wide range of commissioning parents, extending from locals to NRIs to foreign nationals, while the latter was accessed primarily by commissioning parents who were locals, people from neighbouring states, and people belonging to the Punjabi diaspora, largely from the UK, Canada, and Australia.

SD6 described an offer from a Japanese couple that she had turned down as they had wanted her to stay with them for the period of the surrogacy. SD2's commissioning parents for her first surrogacy was a Gujarati couple from the UK, who had requested SD2 to be the surrogate for their second child following her current surrogacy.

In Punjab, the NRI commissioning couples were mostly Punjabis, especially in cases requiring donor ova. According to DP3, Jalandhar in Punjab, home to more than 15 IVF centres, had particularly witnessed a boom in the numbers of NRI commissioning parents. The commissioning parents' choice of the locale for surrogacy was determined by the presence of relatives and /or was based on the promotional strategies and advertisements employed by the centres with regard to high success rates, state-of-the-art infrastructure, and ability to source donors and surrogates from ethnicities corresponding to those of the commissioning parents.

According to DD1,

For surrogacy, it is the foreigners who come, whether it is from Europe, Canada, or Israel. They all come for surrogacy here, because surrogates are not available in their country as cheaply as they are here.

While a large majority of the commissioning parents were married heterosexual couples, single commissioning parents, although rare, also approached centres for surrogacy. DP3 shared,

Actually, the patient was divorced within a month or two of marriage and had been single since. She was more than 45 years of age. She came with her sperm donor, and the eggs were her own...She wanted to get a surrogacy done because she didn't have much time since she was working.

While there were age restrictions for surrogates, similar criteria were not applicable in the case of commissioning parents. DP1 observed that couples came for surrogacy despite being of very advanced age, as they had lost a child(ren) and were desperate for a child, especially a boy to maintain the wealth within the 'family' or to carry on the family's name.

Profile of surrogacy agents

In the course of the research, two agents (see Box 3 and 4 for profiles) were interviewed. In addition to these two agents, surrogates, in their narratives, referred to six other agents who had been involved and who had facilitated their surrogacy arrangements. Nine of the 12 surrogates had become part of surrogacy arrangements through the intervention of agents,

Profile of surrogacy agent

AgP, 36 years old, identified as a Hindu Valmiki. She has studied till 12th class and works as a lab technician in a hospital. She is married and has three daughters and a son. Her husband is a registered medical practitioner (RMP). AgP is also very active and deeply involved in women's micro-credit groups, of which there are 500 in her area. She claimed to have good relations with the women in her village. She entered the arena of sourcing egg donors and surrogates through a colleague in the hospital who put her in touch with an IVF and surrogacy centre in Jalandhar.

She has been involved in getting egg donors for the hospital for about three years and began sourcing surrogates a year ago. She has mediated about five cases of surrogacy so far. She is currently associated (to varying degrees) with five IVF and surrogacy centres in Jalandhar. She continues to work as a lab technician and has negotiated convenient working hours with the hospital.

including two surrogates whose surrogacy arrangements were coordinated by a medical tourism agency that was largely involved in the facilitation of transnational surrogacies.

Agent's role(s) in surrogacy arrangements

The role of the agent in the surrogacy arrangement was not limited to merely facilitating the recruitment of the surrogate, although this was central to the agent's responsibilities. Recruitment involved the identification of the surrogate as per the given selection criteria and then convincing her and her family to be part of the surrogacy arrangement.

The agent assumed the important role of a negotiator with regard to monetary transactions between the different actors in the arrangement, and was involved in facilitating the contractual agreement. The agent was also involved in closely monitoring—overseeing and supervising—the surrogate's medical and diet regimen, work routine, etc., in motivating the surrogate not to digress from the directions and expectations of the commissioning parents, and in encouraging the surrogate to follow the doctor's advice, throughout the period of surrogacy. The agent also helped the surrogate with the administering of injections if required, with identifying rented accommodation when relocation became necessary, and with facilitating travel to and from the surrogacy centres. The agent also facilitated meetings between the commissioning parents, the doctor, and the surrogate, and also attended these meetings.

Information transaction, negotiations with regard to remuneration, etc. were perceived by agents as their domain, and all efforts were made by them to keep control over these areas.

Perceptions about surrogacy agents

The agent–doctor–surrogate relationship epitomizes the power dynamics at play in information transaction and of the power balance; this being largely in favour of the clinic providing surrogacy services and doctors. The presence of the agent was perceived as minimizing the involvement and accountability of the doctor or the surrogacy centre to merely intervention in the medical sphere. The agent was perceived as someone who would be responsible for all aspects of the arrangement, including the contract between the commissioning parents and the surrogates.

Surrogacy Agent's Profile

AgD, 36 years old, identified himself as a Rajput Thakur. He is based in Delhi. He had studied till the fifth grade. He had a long work history prior to his entry into the surrogacy industry, including in a well-known petroleum firm as a trainer (contractual), a gas agency, and an export company. He was engaged in an informal capacity with a clinic for procuring referrals when he was approached by the doctor to arrange for surrogates. AgD's social skills and his wide network of contacts, coupled with his keen sense of the market, impressed the doctor, who asked AgD to find surrogates for his clinic. In the last six years he claims to have mediated about 25-30 cases on an average per year.

The role of the agent was perceived as the perfect answer to questions about medico-legal accountability, the process of recruitment, the drawing up of the contract, etc. DP3 commented on the expanding numbers of agents and their contribution to changing trends:

Earlier patients had to look for their own surrogates. Or maybe the hospital staff would know someone who was ready to be a surrogate. But now there are many agents. Even doctors prefer them.

Additionally, given the absence of regulation of the surrogacy industry, surrogacy centres, doctors, and agents and/or consultancies have created a structure or template that is largely designed to serve their own interests, designed for their own benefit and protection, rather than that of surrogates.

Profile of surrogacy centres

Information drawn from interviews with four doctors (Delhi-1, Punjab-3) from three centres providing surrogacy services, is presented here.

The three surrogacy centres presented common features as well as some differences. Factors such as the promotional and advertising strategies used, the profiles of commissioning parents (locals, NRIs, foreigners), the charges for surrogacy and the remuneration for surrogates determined the typology of the centres. Although the sample was not large enough for quantitative substantiation, the information drawn from the responses pointed to trends and typologies pertaining to centres and surrogacy practices. The three centres differed in the extent of the surrogacy services that they provided. One centre was a tertiary-level trust hospital that provided multi-specialty services, including ART and surrogacy services based in Delhi. The second was a nursing home that provided gynaecological, dental, orthopaedic, including infertility and ART services. The third was a fertility centre that claimed to provide services concerning all aspects of infertility. This fertility centre was also linked to a *gurudwara*

Background of a fertility centre

The fertility centre located in Punjab, was started in 2008. While the centre is recent, it highlights / boasts of a historical connection to 'services' for infertility linked to a religious institution.

Legend has it that the founder and religious leader, was approached by a woman who was unable to conceive. His blessings enabled her to conceive. Since that time, for hundreds of years, the place has been approached by those who are unable to conceive a child. Along with the blessings, now there is also an infertility clinic, established by the son of the current leader of the religious institution. He offers 'blessed treatment'. The people who visit the institution and its branches, in nine other locations spread over Punjab, Delhi, Uttar Pradesh, and Uttarakhand, are guided to this clinic for assistance for dealing with infertility. The centre offers a free residential facility for local people and for non-resident Indians (NRIs). For NRIs, the centre provides 'five-star' rooms where they can stay free of cost. The centre also offers subsidized treatment for those who cannot afford it, made possible through donations collected from its various branches across different states and countries.

(Sikh temple) that was historically a space for couples who came seeking blessings for, and solutions to, their infertility problems. The second and third centres were based in Punjab. All the three centres practiced gestational surrogacy only. The second centre had not received any enquiries for at least five months and the respondent did not have information pertaining to the period beyond this time frame. While the Delhi based centre received commissioning parents mostly from India and also some foreign nationals from Europe, Canada, Israel, the third centre was accessed primarily by Indian commissioning parents, particularly Punjabi NRIs (mostly from Canada and England). The commissioning parents were mostly those connected with the *gurdwara deras/communities*.

In the Delhi centre most surrogates were brought by commissioning couples, the Punjab centre depended largely on surrogacy agents to identify and locate potential surrogates. The centre used varied strategies for the promotion of their services – through websites, community based camps, agents, etc.

This chapter provides an overview of the various players in the surrogacy industry, and the concerns and challenges it raises, to be deliberated further in the following chapters.

CHAPTER 2

Entry Into Surrogacy: Motivations and Negotiations

This chapter examines the paths that lead to the entry of women into surrogacy – the sources of information available to surrogates, the kinds of strategies used and negotiations made in the process of making the decision to become a surrogate. The chapter is divided into two sections. Section A details the varied sources of information and the extent of this information with which surrogates enter the arrangement, discusses the motivations and life situations that led the surrogates to consider surrogacy as an income source, and examines the processes and factors that informed the surrogate’s decision to become a surrogate.

Section B examines the surrogate recruitment processes – the manner of recruitment, the nature and role of agents in this process and the strategic networks used and built for contacting and approaching an increasing number of women who would become surrogates.

SECTION A

Sources of information about surrogacy

The objective in this section is to understand with what level and kind of information surrogates enter the arrangement that often shapes their decision and expectations. Surrogates from Delhi and Punjab had heard of, or read about, surrogacy from varied and multiple sources which included women in the neighbourhood, surrogacy agents, women / family members who had been egg donors or surrogates, popular media (films and television programmes), and magazine advertisements for potential surrogates.

Some surrogates came to know about surrogacy because someone in the family, in the neighbourhood, or in the village had been a surrogate or had donated eggs. As SD3 said, “*Ladies get to know about such things from each other.*” Similarly, SD4 said, “*I used to hear of this from everyone where we stay.*”

These sources of information point to the manner in which potential surrogates are accessed, through neighbourhood chains of contacts. SP2 said that a person from her village told her about egg donation. Two popular Hindi films, *Chori Chori Chupke Chupke* (2001) and *Filhaal* (2002),¹ featured prominently in the interviews with surrogates, with four of them citing these movies as their initial sources of information. SP6, who was approached by an acquaintance of her husband’s to be a surrogate mother, said that her first exposure to the idea had been from the movie *Filhaal*, which she had seen before she was married. The films in some ways turned into sources of misinformation. A surrogate whose husband had also seen the film, featuring

conception through sexual intercourse between the surrogate and the commissioning father, was against the surrogacy until he was convinced otherwise by the doctor. Media depictions also led to certain expectations with which surrogates entered the arrangement. The surrogates compared these cinematic portrayals with their own experiences with surrogacy. SP4, for instance, had specific expectations regarding how her role would be valued and building a relation with the commissioning parents, which in reality were not met.

Thus, the ideas gleaned from the portrayal of surrogacy in the media could be different from the way in which the process actually unfolded for the surrogates. The way in which surrogacy actually takes place was not always understood clearly or anticipated through the information gathered initially from these sources.

Television was also a source of information on surrogacy as well as ARTs. In the course of the study, members of the research team chanced upon a television programme on a Punjabi local TV channel that focused on ARTs. The programme showcased an ART clinic, with the doctor in charge describing the various techniques and procedures, offering clarifications about the medical procedures, and highlighting the services available, their success rates, etc. The promotional show sought to target potential customers, as well as surrogates, addressing various queries about the IVF techniques.

Although the nature and extent of the information received from these sources was not probed in detail, these played an important role in the surrogate's decision-making process about entering a surrogacy arrangement prior to accessing information from surrogacy centres and doctors, which was often a second step. This is discussed in the subsequent sections.

Motivations

As discussed in the previous chapter, the surrogates were engaged in low paying, seasonal and informalized work. This usually translates into uncertainties and financial difficulties. The remuneration for surrogacy—the amount, the nature of payment (lump sum), and the time span over which the amount is received—emerges as a central reason for becoming a surrogate.

While considering surrogacy, women often talked about their everyday hardships and difficulties in making ends meet. In two cases, surrogates were single mothers, separated from their husbands. SP4 and SD4 had separated from their husbands and had young children to support. While the former wanted to buy a house instead of staying in the rented place where she lived with her children, at present. SD4 wanted to be independent of her mother's support and to invest in her child's education. SD5's husband was a daily wage worker whose income was not sufficient to cover the family's expenses. SP4 described the desperation that she and others like her felt,

It is money that gets you to do everything. One has compulsions at home. Everyone is sitting with a lot of tension at home. No one does it because they enjoy (shauk nahi hota) bearing someone else's child. When there are compulsions, this is what god gets you to do. No woman bears a child and gives it away out of interest.

SD1 highlighted the lack of support in raising children and securing their future apart from the jobs that were available to her and her husband. However, while the kind of work they are engaged in, ensures their survival and sustenance, it offers nothing more that can secure their families' future or provide better opportunities.

Who will help us out? We have put our children in an English-medium school. The most important thing that came to my mind is that we have to educate our children. So it is just that. I have this dream, since I couldn't study and we are so miserable. My children should be able to go forward, with blessings from you too. With English, one can meet [good, decent people]. Whatever I couldn't get, my children should. That's why I came here. I have no troubles over my sustenance (khana-peena). I can work anywhere and get my food.

Given the nature of the occupations in which the surrogates and their husbands were engaged, it was not possible to earn the kind of money in the short duration that surrogacy promised. AgD commented that surrogates would have had to work for years to earn a comparable amount as offered by a single surrogacy arrangement, noting that this was a vital factor in arriving at the decision to become a surrogate. The gap between the estimated annual income and the income promised to/ received by the surrogates was substantial. Only one surrogate had received remuneration that was lower than her family's annual household income for the corresponding period. SD6 said that she did not realize at the time that the payments being made to surrogates were much more, and had gone ahead anyway as she needed the money for the purchase of land. According to SP1, it was poverty and desperation to earn money that led women to become surrogates, egg donors, and even sex workers. However, she drew a moral boundary between herself and other surrogates, citing her motivation as sympathy for the plight of the commissioning parents (their *majboori*), persistence, and her husband's persuasion,

They [commissioning parents] used to call from abroad again and again. They used to say, "We have a lot of problems. We don't have a child and we want one of our own."

Surrogates detailed the following reasons and requirements that prompted them to opt for surrogacy.

Immediate financial needs

Many of the surrogates faced emergent needs and financial problems that they or their families were unable to address with their usual sources of income or assets. Surrogates spoke about finances required for debt repayment incurred by the family due to sudden events such as deaths and accidents. SD2's joint family house (that is, the house of her in-laws) was mortgaged in lieu of a loan. This loan was incurred when her father-in-law borrowed money after her brother-in-law had an accident. As the eldest members of the family, her husband and SD2 were expected to mobilize the money to repay the loan and redeem the house. SP3 was also in a similar situation, and she and her sisters-in-law were considering egg donation and surrogacy. According to SP3,

In our home, Munna's father [her husband] doesn't have that much work on his hands. And, as you know, if there is a death in the family, then there are expenses. So there was debt. We had to take loans for doing all the work [performing the last rites for the deceased] . . . The family was saying if it happens (it would be good), since there was no money.

While SD2 and SP3 decided to become surrogates to salvage the family out of debts, another surrogate, SD6, SD6 had decided to become a surrogate the first time because her husband wanted to buy land and needed money. She was now seeking a second surrogacy arrangement in order to put together money for the marriage of her younger unmarried sister. SD6 said,

Let me tell you honestly, I have a younger sister to wed. My parents are dead and we are three sisters. She is our youngest, and is studying in Lucknow. My sister and I are married. She is also trying to raise money for the wedding, but she can only do so by hiding it from her in-laws and everyone else. The groom has too many demands that we can't meet. We need around seven lakhs [rupees]. My husband has been very kind. He has already been paying for her tuition, hostel, food, etc. in Lucknow.

Thus, their positions and roles in their families – as older daughters and daughters-in-law, as members of joint families – and their commitments towards the natal family and the associated responsibilities were the reasons for their entry into surrogacy. SD2 and SD6 felt responsible for raising money to help their family, and SP3's family saw surrogacy as a possible solution to their financial problems and urged her to consider it.

Aspirations for children's future

Securing the future of their children was a common aspiration expressed often by the surrogates during interviews. The surrogates insisted that they were undertaking surrogacy for the sake of their children. SD2 wanted to invest the earnings from her second surrogacy in her children's education. This desire to give her daughter a better life than the one she was herself leading is echoed in the narrative of 21-year-old SD4, who had studied till class 4,

I thought about my child. I will educate her. She will also be able to read, write, work on computers like you. I want this for my daughter. Not like me.

However, SP3, who had delivered twins through a surrogate pregnancy, lamented that the 'sacrifice that she had made for a year' would not be known to her son. On the one hand, the surrogates did not want anyone to know about the arrangement, while on the other, some of them, like SP3 for instance, voiced a desire for acknowledgement from their children about the 'sacrifice' that they had made for their sake in an attempt to secure their future. This theme is explored further in Chapter Six.

The emphasis on undertaking surrogacy for selfless reasons served to justify the decision. The decision to become a surrogate was, however, a carefully considered and deliberated decision, often involving family members and other surrogacy actors, as the next section demonstrates.

'To be or not to be'

Surrogates voiced their initial dilemmas and confusions about becoming surrogates and described how these issues were resolved. SP4 took up to a month before she came to a decision about becoming a surrogate.

She [agent] also said nothing will happen, I will take on your responsibility. I said I am scared, something will happen. My operation has been done, but she said it [the surrogacy] can still happen. I wasn't convinced. I called her after a month.

SP4's sister-in-law had been a surrogate and in terms of care and remuneration the arrangement had been satisfactory for her. This positive experience coupled with the reassurance from her agent led her to overcome her misgivings. She then sought clarifications regarding the medical interventions that would make conception possible in her case, having undergone sterilization.

SD5 also had doubts, but these were eventually clarified by her agent, and the doctor was able to convince her to become a surrogate:

I was confused and faced some dilemmas. How will it be possible [how will she conceive]? Will I have to sleep with anyone? The doctor explained that it is for someone's happiness and the bhabhi [agent] had earlier explained the procedure to me.

SD6 had doubts and fears as she 'did not know what it meant'. So she refused to go in for surrogacy initially. Then she spoke with the commissioning mother who asked her to meet the doctors, after which SD6 agreed. SD1 also mentioned her conversation with her doctor:

Doctor sahib had told [me] this that if you eat well and take care of yourself and give a child like this, you are helping people and the nation. It will be a good thing. God will also bless you. Doctor sahib persuaded me. So I said okay.

Thus, information provided by doctors helped allay the surrogates' fears and confusions about the procedures. The doctors, in addition to validating the information provided, also seemed to significantly influence the decision to become a surrogate. Doctors emphasized the altruism of surrogacy, convincing the surrogates about their critical role in helping not only those who were childless and also in aiding the nation in its development. Portrayal of child bearing as a means of 'helping the nation', and the benevolent potential of this capacity, was employed by different actors for convincing the surrogates. The confusions and anxieties of the surrogates were allayed by the doctors and the agents who gave assurances that they would be available and take care of any risk or adverse situation, if it should arise through the course of the pregnancy. The assurance thus provided was meant to address and dispel the specific apprehensions voiced by the surrogates. However, the surrogates' queries related to the medication or to the process of pregnancy were fairly limited, often a result of relating surrogacy to their earlier experience of childbirth.

Persuading the husband

In entering the arrangement, the husband's consent is pivotal, making it a mandatory requirement stated by all actors. AgD said that earlier he used to first approach the husband

about the arrangement and seek his approval and consent, after which he would talk to his wife. Increasingly, however, he pointed out that the surrogates themselves talk to the husband and explain the arrangement. In some situations, where the husband was reluctant, the agent and/or the doctor talked to him. AgP stated,

Some people say that this is 'do number ka kaam' [underhanded/illegal work]. We say it is not like that. Nobody gets to know whose sample [sperm] it is, so it's okay. So sometimes gents [husbands] say that we will come along. I take them and show them there is no such problem.

SP3 described how the agent convinced her husband,

He [husband] was also thinking how will it happen? He didn't know. So she [agent] told him that everything will happen as directed by the doctor. Like there was a movie made, which had Salman Khan in it. She told [him] that it did not happen from a [physical] relation but through a medical process. So my husband agreed.

SP2 said, "At first, he [husband] did not agree. He found it hard to believe. I explained to him that it's [done] through machines. There will be no problem."

Strong reservations against surrogacy often stemmed from the assumption that the surrogate would be required to have sexual relations, leading to comparison with sex work. The absence of sexual intercourse in surrogacy was emphasized while persuading the surrogates and their husbands, as it was a key factor in the decision about becoming a surrogate. That the entire process was performed through 'medicines' and 'injections' was a vital fact that was used to convince the husbands to agree to sign the agreement. The distancing of surrogacy from sex work is thus used as a means of easing the fears of surrogates and of their husbands.

Surrogates also described their experiences in convincing the husband. SD1 pragmatically told her husband that surrogacy was the only means they had for securing a better future for their children. She said,

I explained to my husband as well that whatever is in (our) fate will happen, so just give your signature and don't tell me so many things. He still said he can't give it. He was being so difficult. I said, 'You will have to give it, for my sake (tumhe meri kasam) . . . The agent is saying that if the signature is not there, then it will not happen. You have an I-card, I don't. So he agreed.

SP4 was married at a young age and had faced violence and abuse from her husband, from whom she was now separated. However, she needed him to sign the contract, and her surrogate pregnancy needed the legitimacy of marriage. She said that otherwise, that is, without the presence of her husband, she would have to deal with questions about whose child she was carrying and so she approached her husband and asked him to accompany her in the visit to the doctor and sign the agreement.

However, the husband could also play a more proactive role in the woman's decision to become a surrogate, as in the case of SP5 and SP3. SP5 had refused the offer of surrogacy, but the agent then approached her husband to convince her,

I said I won't do it. She (agent) said do it, someone will have a child in the house. They will be happy. I refused. Then my husband talked to her. She explained it to him. He talked to the madam [doctor], about a lakh or two. Then he said do it, someone will have a baby in their house.

SP3's first surrogacy arrangement did not materialize and she was asked to approach the hospital again. It was her husband who urged her to go to the hospital again and undertake surrogacy. Thus, the husband was coaxed into giving his consent in some instances and was proactive in other instances, but the husband's consent and signature were necessary. This conforms to and bolsters the hetero-patriarchal construction of pregnancy strictly within the bounds of marriage, so the husband becomes a party to the negotiations. The husband is supposed to sign the contract and not merely give his consent verbally. The doctors/hospitals want to ensure that no issues or objections can be raised by the husband later on. Thus, the women whose husbands disagree or refuse to sign the contract are unable to undertake surrogacy, thereby imposing a limitation on the agency and decision-making ability of the surrogate.

Locating surrogacy in women's work

Along with the surrogates' narratives of their poverty and helplessness, it is also important to examine their decision to undertake surrogacy within the larger context of women's work. Surrogacy brings the traditionally domestic activity of giving birth to a child into the realm of the market. Chapter Six elaborates upon the nature of the stigma attached to surrogacy, and consequently the prejudice faced by surrogates. The fact that this work is stigmatized is an important factor when unravelling the surrogates' decision to be involved in it.

The informal sector that employs a large number of the women in India is characterized by meagre pay, no social security, and long hours of tedious work. The exploitative conditions in the sector have been further exacerbated by the structural adjustment policies adopted by the government nearly two decades ago. In this context, surrogacy appears as one of the existing options of mostly informalized work for women.

Responses to the question of whether surrogates considered surrogacy as a form of work were mixed. According to SD2, *"This is definitely work. I do understand it as work but do not consider it as 'hard work'. One has to use one's body (mehnat wala kaam nahi, bas shareer ka thoda kaam hota hai)."* Thus, SD2 attached a lower value to the 'efforts/labour' involved in a surrogate pregnancy but noted the use of one's body. However, the other surrogates did not concur with SD2's opinion since they did not conceptualize surrogacy as a form of work. Their opinions reflected the conventional understanding of what is perceived as work. The work that is traditionally assigned to a woman, be it housework or reproductive labour, is invisibilized and devalued. Discussing their decision, the surrogates compared surrogacy with the other kinds of work available to women like themselves. While SP4 noted that the remuneration for performing *kothi ka kaam* (domestic work) is less, other surrogates spoke about their perceptions. SD5 said, *"I said I have never worked in homes, I don't like it. I can do this, I will like it."*

SP2 said:

When you are in need (majboori), it's fine. Majboori can make a person do anything, but this is fine. Compared to other kinds of work, this work is okay. Like [some women] have to do domestic work, women go out and work in houses. This is better than that. Why? People in houses can accuse you of stealing from them. Anything they can accuse you of. Then we can't repay them, na. I have heard this happens. I've never done it.

The statements of SD5 and SP2 clearly point to the choices they have made regarding surrogacy after weighing the conditions of work and the income they would earn. Their statements remind us of the deplorable conditions of work that are inherent to the informal economy.

SD2 remarked that she was getting paid 11 rupees for stitching the same pair of trousers for which she had got 25 rupees a few years ago when fewer women were involved in this activity. She wondered if a similar situation would arise when more and more women entered surrogacy arrangements.

The women had weighed their decision to undertake surrogacy by seeking more information and by consulting family members, doctors, agents, and other surrogates for information and advice. They had considered the money that surrogacy offered then for carrying a baby to term, along with the other options of earning money at their disposal. Many of the surrogates and their spouses are part of a workforce that operates without any economic or social security, or legal protection of rights (See Table 6 for details pertaining to work).

SECTION B

Recruitment patterns and chains

A surrogacy arrangement was sought either through an agent, or through approaching the hospital or doctor directly, or through responses to advertisements. In SP6's case, the commissioning mother, who was a distant relative of her husband's, had approached her. Apart from SP6, one surrogate directly approached the hospital and one responded to an advertisement, while the remaining nine surrogates were recruited through agents.

Recruitment networks for surrogacy as well as egg donation have largely spread through word of mouth. Egg donation preceded surrogacy in the case of four surrogates. SD1 was first approached for egg donation. However, she decided against donating oocytes since she felt that it led to high blood loss and she had already undergone surgery to treat a breast tumour. Four out of the 12 surrogates interviewed, had donated oocytes before becoming surrogates.

AgD started speaking to women about egg donation and surrogacy at the behest of a doctor. The first surrogacy that he coordinated was that of his wife, "Yes, one needs to give an example. The response is better when one gives an example. Then slowly people started coming."

This is what AgD had to say about the initial period,

It was very difficult at first, but now it is simple because it has become a chain system. One surrogate tells others. One comes back

with four or five surrogates on an average. Like this one. She was doing nothing, but a woman staying next door did it and told her. She was motivated and has been an egg donor and is now doing surrogacy. She now says that she wants to tell people once hers is successful. And that will be additional income.

Agents were selected on the basis of their contacts within a certain locality, for their ability to convince people to become surrogates or donors, and for their skills in mediating the arrangement. The two agents interviewed in Delhi and Punjab had extensive contacts within their respective communities. Owing to his work as a marketing agent, AgD had developed a network of contacts in the hospitals as well as within the community, whereas AgP was well known within the community because of her association with women's micro-credit groups and her job as a lab technician (see Chapter One for details of the profiles of agents).

AgP started looking out for women to do egg donation as part-time work. She said she used to feel embarrassed to speak about surrogacy. However, she taught herself to persuade other women,

When I go to talk to them, I tell them that you will get money and that you will also do something good for someone. I say that this love [for children] that God has given us, everyone should be able to experience that. How we feel in our hearts, that this is our child [sic]. You get married and then after three or four years everyone wishes to have a child. If someone doesn't have [a child], then we can give them one. There is someone's welfare [bhalayi] as well as money in this. So they [surrogates] get convinced. [I] have to meet them a few times.

The idea of fulfilling another woman's desire of motherhood by performing an act of *bhalayi* (goodness, benevolence) was an important part of the persuasive pitch to which the surrogates were subjected. The agent's narrative shows us how she invoked the love that a woman was meant to feel for her child and how she emphasized that some women were denied the joy of maternal love and hence needed to be 'helped'. This construction of motherhood as being a 'natural' longing among women, and of surrogacy as an altruistic deed, was employed to influence women.

The idea that motherhood was a woman's destiny and that helping a woman fulfil this destiny was a noble task was a commonly used rationalization. SD4 said, "Well, I thought someone who does not have a child will get it. I will get their good wishes/blessings [dua]." According to SD5, "It is God's grace and we also get others' good wishes (dua bhi milti hai) from those who don't have a child."

The surrogates repeatedly cited it in the course of the interviews as a way of justifying their decision to undertake surrogacy. They then developed notions about the acknowledgement and recognition that they deserved from the commissioning parents for doing them a good turn, an expectation that stems from this altruistic rationale for undertaking surrogacy.

Three surrogates from Delhi observed that everyone in their locality knew about surrogacy. The agents operated in localities within their neighbourhood. In cases like that of SD2's, who had shifted from Indore, a room was arranged by the agent in a location in his neighbourhood. Likewise, the agents helped other surrogates relocate to areas in their neighbourhoods.

A recent and growing trend is that of the agents paying a commission to the surrogates for putting them in touch with other potential surrogates or donors. This commission is paid for every successful egg donation, embryo transfer, and it ensures that surrogates seek out other women and put them in touch with the agents. Hence, a pool of women who are willing to take up this work and look out for other women is created. SD1, SD3, SD2, and SP4 spoke about how recruiting other women for egg donation and/or surrogacy was a means of additional income for them. SD2 described her plans after returning to her hometown from Delhi, where she had moved for surrogacy, *"When I go back to Indore, I know a lot of women. I will explain it [surrogacy] to them properly since we are on good terms."*

The area of functioning for the agent was not limited to one city. One of the agents interviewed was sourcing surrogates from Delhi as well as from other cities like Indore. The surrogates living or working in the different areas become links in a chain, allowing the agent to gain access to other women from the community. SD2 was recruited through such a process, when AgD made a trip to Indore and visited her to talk about a potential surrogacy arrangement based in Delhi. Now SD2 plans to link with other women in her hometown, Indore, for egg donation or surrogacy.

Not all surrogacy arrangements were mediated. The first surrogacy of SP2, SD6, SP6, and SD2 took place without the mediation of an agent. SD6 responded to an advertisement in Delhi, SP2 went to a hospital in Jalandhar, and SD2 did her first surrogacy in Indore. SP3 was approached by an agent, but after the arrangement with the first couple failed to materialize, she approached the doctor directly after a few months, and entered into a surrogacy arrangement with another couple.

SD2 observed that it had become difficult to become a surrogate without an agent because if one approached a doctor directly in Delhi, (s)he would refer the woman to an agent. A doctor from Punjab also agreed that he found it easier when an agent was involved; he thought that the agent provided accurate information about the potential surrogate, took care of everything related to the contract, and arranged the meeting between the surrogate and the commissioning couple. As DP1 said,

[When the] agent arranges for a meeting between the patient and the surrogate, I find it easier. The agent takes proper care of the surrogate and gives accurate information. Surrogates sometimes do not give the complete information.

For the surrogates, the agents were their primary, and at times their only source of contact and information during the entire process. In the case of doctors, the agents verified the information pertaining to, and the background of, the surrogates and handled the mediation between the couple and the surrogate. As SD2 commented, *"I guess even the doctor does not want to take responsibility."* And DP1's remark echoes the same reasoning or conclusion, *"We just do the IVE, that's it, nothing else! I don't have to find out anything about her. Medically she is fit to conceive, that's it. Not more than that."*

The agents were thus perceived by the doctors and the surrogates alike as shouldering the 'responsibility' of the arrangement, and these arrangements were increasingly happening through agents. The surrogates had ambivalent responses. SD1 avoided answering questions

about the agents and only stated that the agent in her case had been helpful and had arranged for everything. Even SD3, who was interviewed in the hospital like SD1, refrained from making any comments about her relationship with the agent. However, other surrogates expressed their anguish about their agents, especially when interviewed in a setting where they were more comfortable, like their own homes. SP3 dismissed any reason offered as an explanation for the presence of the agents,

I don't think an agent should be present. Whoever wants to get this done, can go directly to the doctor like I did. This agent person takes money for himself or herself first. The money gets cut from ours . . . The agent just gets you to talk to the doctor and the doctor will say the same thing to us.

SP4 mentioned having to go for hospital visits without her agent,

[The agent] is supposed to come along. But she goes by herself from here and then calls me after reaching the hospital and tells me that she is there and that I should come. I get dizzy. I feel like having someone with me when I go.

Apart from negotiating the remuneration and arranging the hospital visits, the agents also monitor communication with the commissioning parents. SP4 said,

The doctor told me that the commissioning parents are coming on the 26th and that they will take me [out] with them. I told [agent] and she says I will also come with you. As if I will just run away with them and not take her.

Nevertheless, AgD talked about the requirement of agents in the surrogacy process. This was in response to a question about the Draft ART (Regulation) Bill and Rules 2012,

It is written that you will be arrested if you take commission. Whereas, if you want a surrogate, where will you look for one? Or those who do not want to reveal that they are getting surrogacy done. It is difficult for them. They will approach an agency. And if the agency is illegal, then even you will be fearful about what will happen. It will be easier if the agency is legal. If you get a surrogate from an agency and there is a problem, she gets it aborted and runs off to her village. Who will be responsible? The doctor will not take responsibility, but there has to be someone who does, right?

Thus, AgD projected the agent as someone who would not only seek out surrogates but also as the person who would be held responsible for them. This statement indicates that the agent was accountable to the commissioning parents and that his 'responsibility' was to ensure the safe delivery of the baby. The agents play a crucial role in the process since they mediate every aspect of it. While the agents create an unequal relation and can exercise power over the conditions of the arrangement for the surrogate, they themselves belong to the same socio-economic background as the surrogates and are supposed to shoulder all the responsibility for the arrangement. Given that they consider themselves accountable to the commissioning parents, they add to the lopsided power dynamics between the actors involved in the surrogacy arrangement.

The surrogates had gleaned ideas about surrogacy from people in their vicinity and from the media. The decision to choose surrogacy as a means of earning money was directed by the economic context of the surrogates, the various pressures that they faced, their own aspirations, and their deliberations with family members, husbands, doctors, and agents. The doctors and the agents, apart from clearing doubts and allaying fears regarding the procedures involved in a surrogate pregnancy, also emphasized the altruistic aspect of this arrangement in order to persuade the surrogates. The entry into surrogacy ushers the surrogates into a process full of challenges and difficulties. These are presented and discussed in the following chapters.

Notes

¹ *Chori Chori Chupke Chupke* is a story of a couple who hires a sex worker to undertake a surrogacy for them. The husband (Salman Khan) impregnates the surrogate (Preity Zinta) who then refuses to give up the baby, but relinquishes the child towards the end.

Filhaal is a story of two friends, one of whom decides to become a surrogate (Sushmita Sen) for the other (Tabu). The pregnancy leads to complications in their relationship and also in the relationship of their respective partners.

CHAPTER 3

Medicalization

The surrogacy arrangement entails subjecting the surrogate's body to long-drawn-out and significant medical interventions. While aspects such as the benevolence and generosity of the act of surrogacy and financial gain for the surrogate are repeatedly highlighted, the medical procedures and their implications are completely invisibilized. This chapter looks at the complex medical regimen and its various implications through the experiences of surrogates. The chapter is divided into two sections. The first section explains the medical regimen. The second section looks at the implications and the multifaceted experiences of the surrogates through their narratives.

SECTION A: THE MEDICAL REGIMEN

This section explores in detail the process of medical intervention that is undergone by surrogates during the surrogacy arrangement. The focus is on aspects such as tests, medication, procedures, and regulation of behavior, on the one hand; and on rationales provided by doctors and agents for certain decisions and for choosing certain technologies in the course of the treatment; on the other hand, assessing the extent to which these choices are supported by the process of informed consent on the part of surrogates.

Medical history and investigations/examinations

The process of preparing the surrogate's body for the IVF technique is begun only after her medical, especially obstetric history has been considered and only after several tests have been conducted to ascertain her 'fitness' for carrying the pregnancy to term. Prior childbirth is a prerequisite for the surrogate for entering into the arrangement. The suitability of the surrogate's body for this pregnancy is evaluated by a thorough examination and by various tests to check her hormone levels and uterine lining, and to ensure that she does not suffer from any disease that would make her 'unfit' for the surrogate pregnancy. According to DP3,

She should already have children. Second, she should not have any medical problem. She should not have a problem holding the child, like a cyst or any such problems. Her uterine cavity should be healthy, and she should not have any genetic problems. No risks. She should not be HIV positive. We do tests and we screen them [surrogates]. We have to take their history first. We have to talk to them, and we have to check them. Through ultrasounds, there should be no problem [sic]. If needed, we do [a] hysteroscopy.

While surrogates were made to undergo several tests, they were rarely informed about these, if at all. Most of the surrogates interviewed for this study were unable to describe either the number or the purpose of the tests conducted beyond providing minimal details. (Refer Annexure I for details regarding the information to be sought from the surrogate as listed in the Draft ART Bill - 2010).

A few surrogates in Delhi reported that the following tests and diagnostic technique were done: blood test, urine test, and ultrasounds. They described these tests and techniques in varying terms, but never with any surety about the purpose or need for them. SD3 said, "*Tests were done to check if there is any disease or not, and [an] ultrasound was done to check if there is any sort of problem in the uterus.*"

SP3 shared,

They did all these tests of the whole body like some operation. I don't know since I was unconscious for two–three hours. When they took me to the operation theatre, then I found out. They said nothing will happen; you will be out in five minutes. When I went in, I was given an injection and told nothing about what they were going to do. Even at home I was not informed that something like this will happen. The agent also had not said anything. Suddenly they said the test needed to be done immediately. I only got to know later that it was a big test, scanning from inside. When I became conscious afterwards, then I was in this big room. I had thought it would be something normal, like an injection. They had not told me this.

As is evident from SP3's account, she was unaware of both the purpose of the test and the actual procedure that she was made to undergo, "*He [agent] did not tell me to do anything. Whatever tests had to be done, he got them done.*" In none of the cases were the results and the reports pertaining to these tests shared with the women. They were simply informed that they would be moving on to the next stage, that of preparing the body for the embryo transfer (ET). In case there was a condition that needed to be treated, they were given the relevant medication or were asked to seek treatment elsewhere and to come back once they were 'healthy'.

Not surprisingly, from this point on, all decisions pertaining to the surrogacy were taken mainly by the clinic, by the commissioning parents, and by the agent (if the arrangement was mediated), with the surrogate being sidelined from being part of these decisions. According to SD2, "*. . . In the beginning, my blood and urine tests were conducted and everything was fine in the report. Thereafter, the treatment went further.*"

In cases where the women were found to be suffering from any kind of deficiency-related condition such as anaemia, they were prescribed medicines and were subjected to further medical interventions to ensure that their bodies were 'ready' for further processes and procedures. AgD stated,

Some keep having fever frequently, which is caused by anaemia, but they get better. Some are weak. I know that if we do ET, it won't be successful. I give them medicines and things and get their treatment done. Make them fit and then get them into surrogacy.

SP3 underwent all the required tests, but after the papers were signed, she was rejected by the clinic on the grounds that there was some problem with her uterus. However, later she was informed that she had tuberculosis. She got her reports checked at another hospital and took medicines for six months for treating the tuberculosis. Following that, she contacted the doctor from the infertility clinic again with the intention of entering into a surrogacy arrangement.

Anemia and tuberculosis were the starkest manifestations of the harsh realities of the lives of many surrogates. The lack of access to even basic health facilities for the surrogate otherwise was ironically 'managed' and 'balanced' through the availability of sophisticated and hi-tech medical care when she entered the surrogacy arrangement. This clearly demonstrates the contradiction that surrogacy presents even at a very preliminary level. The investment in making the surrogate's body 'healthy' was therefore accompanied by its own politics, wherein all efforts were geared towards the ultimate aim of ensuring the birth of a healthy baby without any complications. In this context, the surrogate's body, not surprisingly, was merely a means of achieving this end. Even the detection of tuberculosis as in the case of SP3, was only possible when she underwent the screening procedure for surrogacy, and she was thereafter treated for the disease.

Decisions in 'treatment procedures'

This section examines the procedures that form part of the 'treatment' and the decisions taken regarding the care of the surrogate during the pregnancy, delivery, and post-pregnancy periods. It looks at the rationales provided by doctors and agents to surrogates. It also assesses the information provided to surrogates

IVF/ET Surrogacy over Traditional Surrogacy

A surrogacy arrangement can be broadly divided into two types:

1. Traditional where the oocyte of the surrogate mother is used and (artificially) inseminated with commissioning father's or donor sperm. In this case, the surrogate anticipates a relatively normal pregnancy and birth with no major hormonal manipulations.
2. IVF-ET where both the egg and sperm are fertilized outside the body in a laboratory and the embryo is transferred into the uterus of the surrogate. This kind of surrogacy also opens up the possibility of donor gametes being used, and the surrogate experiences multiple hormonal interventions. In this case, the surrogate has no genetic link to the child. All the doctors and agents interviewed said that only gestational surrogacy was carried out, in keeping with the provisions of the Draft ART (Regulation) Bill and Rules 2010, which clearly prohibits traditional surrogacy and only allows gestational surrogacy.¹

This arrangement entirely discounts safety issues of the surrogate. Many couples could have a baby with just the father or a donor so as to protect the surrogate from unnecessary risky procedures like IVF. In practice, according to the providers, the choice of IVF over insemination is often guided by the desire to pre-empt any contestation over the child by the surrogate. DP3 explains,

In most cases, we use the patient's [commissioning mother's] egg. We prefer not to take the surrogate's eggs, and to use her

only for surrogacy, because if we use the surrogate's eggs, it can create problems for the patient [commissioning parent] later. She [surrogate] may or may not give [up] the child.

The lack of a genetic link made possible through IVF technology is presented to surrogates as evidence of the lack of biological connection to the child, and thus as grounds for surrogates having no claim on the child. The proposed legislation to regulate surrogacy in India also clearly states that the surrogate has to relinquish all her rights over the child. According to AgD,

The doctors also explain it to them [the surrogates]. [They say] We will not take anything from you. No egg or sperm. Also, if they have had a sterilization operation, it's a good thing.

AgD indicated that if the surrogate had undergone sterilization, and there was no possibility of the child having any genetic link to her, it was perceived as an added advantage. This settled without a doubt that the surrogate could not be the genetic mother of the child. This is perceived as crucial given that the idea of the natural mother is pluralized in the context of surrogacy, since there can be three different contesting claims made by the commissioning, gestating, and genetic (in the case of donor ova) mothers. Whether the gametes of the commissioning parents were used in the IVF technique or not, the fact that the surrogate's gametes were not used becomes the grounds for dismissing her link to the child. (This is discussed further in Chapter Four).

Almost no information was provided to surrogates about the procedures nor about the techniques that they underwent, apparent from the lack of details and description about the medical procedures that they experienced.

Yet the surrogates displayed a greater level of knowledge about whose gametes were to be used in the procedures rather than the procedures themselves. This was evident from the fact that the flow of information was heavily influenced by the interests of commissioning parents and doctors in ensuring a successful birth and relinquishment, and this prevailed over any considerations of ethical protocols or of informed consent from surrogates.

Multiple cycles

The general success rate of implantation in IVF is not high, and may not lead to pregnancy in a single attempt. Surrogates were often put through a number of cycles before a successful pregnancy took place, culminating in a successful childbirth.

Among the surrogates interviewed, SD3 underwent two unsuccessful cycles and ET before she conceived after the third attempt. SD1, who had a similar experience, observed,

The first time around the ET fails. It mostly comes out as negative. Around four-five of them have come [out as] negative. SD3's was negative, was negative. My first time came out negative. And there was a girl who stayed nearby, hers also came [out] negative. I have observed [that] the first time [it] always comes [out] negative.

The following observation by AgD confirmed that repeated cycles are a common feature of IVF procedures and therefore of surrogacy arrangements despite the attendant risks and complications,

So in this package, I tell them to do the pickup and give semen samples. Mostly foreigners do this and they don't stay here. They do it in advance or if they are not successful, then we use a donor. Then it is taken, [the] embryo is fertilized, and transfers are done. Till it is successful, we keep getting it done. At times, if it is successful in one go, it is their loss and our gain. So it is like a kind of an insurance company. The first few times, it is a profit. If it is more than four-five times, it is a loss.

The agent explained that the carrying out of multiple cycles was an accepted part of the package offered to the commissioning parents, where multiple cycles were guaranteed until the time of successful implantation. A surrogate, then, may have to undergo repeated cycles of stimulation, medication, and ET. Surrogates mostly were not informed of the actual procedures and did not understand that the failure of successful conception was likely, given the limited success rate of the technology. Additionally, instead of providing information explaining the low success rate, surrogates were also often told that their ability to take care and their willingness to comply with or follow the directions given to them determined whether the cycle was successful or not. This leads the surrogate to regard herself as a causal agent and thus responsible for failure. This was seen in the case of SD1 and SD3.

Given the lack of information about the possible effects of medication and the IVF procedure on their bodies, multiple cycles were presented to the surrogates as a preferred convention in practice to ensure success, but without highlighting the possible increase in the accompanying risks. This aspect has not received any attention in the proposed Draft ART (Regulation) Bill and Rules 2010, which does not regulate the total number of IVF cycles that a surrogate can undergo.

Multiple embryo transfer and foetal reduction

In an earlier study conducted by Sama, 'Constructing Conceptions: Mapping of Assisted Reproductive Technologies in India', it was found that multiple embryos were transplanted to 'improve' the success rate. The study highlighted the risks of multiple pregnancies and of multi-foetal reduction (Sama, 2012, p. 123). Multiple embryo transfer can lead to multiple gestations or pregnancies which in turn can lead to situations where the surrogate has to undergo foetal reduction, whether in the interest of guaranteeing the birth of one child or due to the preference of commissioning parents regarding the number of children they want to have. The possible risks of multiple pregnancies are increased chances of miscarriage, obstetric complications, premature deliveries, and birth complications. Foetal reduction may cause bleeding, perforation, infection, premature labour, and loss of all foetuses. These, however, do not find place in any discussions before surrogates undergo these procedures. (Sama, 2006, p. 127).²

DP2 similarly stated that the low take-home baby rate or carry-home rate was often the reason for transfer of multiple embryos, "*Ideally two, not more, should be transferred. Sometimes three, but not more.*"

More than one embryo was transferred in the case of at least five surrogates interviewed for this study. The surrogates were not informed of this. Only three surrogates were informed about the possibility of multiple gestations, following the transfer of multiple embryos.

SD6, SP3, and SD3 found out that they were carrying twins during the course of their pregnancy. According to SD6,

They will not say how many transfers they are doing. Then the result will come and they will tell how many children are there. (SD1)

They had transferred four eggs (embryos) inside me and I was not told about it. One day, I got a call asking me to visit the hospital. They told me that one of the children did not have a heartbeat and that one has to be taken out by surgery. I was very scared. I didn't understand how you could take one out. What if something happens to me? I called my husband, but before he could reach, they had taken me inside for the surgery. That night there was too much pain in my stomach. (SD6)³

It is evident that SD6 was informed neither about the transfer of multiple embryos nor of the reduction, and that there was no question of her consent having been sought. AgP stated, “Mostly doctors, whether its donor or surrogate, don't tell them the technique. (Why not?) If someone asks they will tell, but no one asks.”

Not only was information not provided to surrogates and nor was their consent sought in the first place, but the lack of any processes of seeking informed consent was further justified by putting the onus on surrogates. Since it was the commissioning parents who were considered the ‘patients’ in the case of surrogate pregnancies, the question of acquiring the surrogate’s consent was bypassed or ignored time and again, and information was shared only with the commissioning parents.

In the case of SP3, it was the husband who was involved in the decision making,

They did not tell me about this, but the parents had talked to my husband. They told him that they had kept two eggs (embryos). He said that was not an issue. So they had spoken to my husband and he had said that was fine. They talked with my husband while I was sitting inside. I did not know about this.

While two doctors acknowledged the greater risk in multiple gestations, it was clear that the surrogate’s fertility is seen only in two contexts: through the lens of the interests of the commissioning parents and the doctors; and as something that was strictly confined to, and controlled within, the institutional constraints of marriage, and largely with the surrogate’s husband having a strong voice in such decision making. Seeking the opinion of the surrogate—whose body, after all, is being subjected to multiple births—is completely disregarded.

The Draft ART Bill - 2010 acknowledges the side-effects of ART procedures on mother and children, and lists multiple gestation, ectopic pregnancy, spontaneous abortion, and ovarian hyper stimulation syndrome as the main complications. It also states that no more than three embryos for IVF-ET at one sitting should be transferred, except under exceptional circumstances

(such as in the case of elderly women, poor implantation, advanced endometriosis, or poor embryo quality), which should be recorded (Refer to Sama's Policy Brief for a critical analysis of the provisions of the Draft ART Bill - 2010). The Draft Bill however, does not elaborate on the risks for children. It is important to mention here that children born through ART procedures face greater risk of genetic or congenital abnormalities.

Selection of embryos and Sex selection

The practice of selecting embryos as part of the procedure was confirmed by the doctors interviewed. However, different opinions were expressed regarding the basis of selection. Selection on the basis of sex was denied by all the doctors interviewed, although they mentioned that commissioning parents frequently asked for a male child. All the doctors interviewed said that these requests were common, but emphasized that sex selection was illegal and that such requests were not entertained.

You can't do that [sex selection] actually, but people keep coming for that. Everyone wants to have a male child, but we don't do that . . . In their young age, they amass property, and then there is nobody to look after their property. So they come because they want a child who can look after the property. (DP1)

DP1 said that many of the requests he gets are from aging couples who have either lost or do not have children. They are especially desirous of having sons and they opt for ART procedures or surrogacy as an arrangement for securing a male heir. According to DP3,

They [commissioning parents] may ask and may say they want a boy. But since the technique for sex selection is banned, we have to say no.

While the practice of sex selection is illegal, the possibility of pre-selecting the sex cannot be ruled out⁴. The lack of any regulatory framework regarding ARTs and surrogacy further complicates the situation. Additionally, information gathered from the doctors regarding such practices itself comes with a qualification that it cannot be verified. In an earlier study conducted by Sama, it was found that despite a similar denial by ART providers, sex selection was nevertheless being practised (Sama, 2010, p. 123).

However, apart from embryo selection, other instances of possible sex selection in the practice of surrogacy were also mentioned in interviews with a couple of surrogates. SD2, who had yet to deliver the child in her second surrogacy, had already been approached by the agent for entering into a third arrangement in which the commissioning parents' demand for a male child would be accommodated by sending SD2 to Thailand, where the surrogate would undergo a sex-detection test and consequently a sex-selective abortion, towards bypassing the impediments of the legal framework in India.

The agent was asking me about a family in Thailand. I will have to stay in Thailand for two months. They will do the treatment there and in two months it can be found out if it is a girl or a boy. And I will get two lakhs and the [cost of the] travel will be on them. They want a boy, but it [sex selection] isn't allowed here. (SD2)

While sex selection was categorically denied, selection against disability and disease was discussed without any hesitation. Selection of the 'best' and the 'healthiest' embryo was presented as a part of the standard IVF procedure.

When four–five embryos are made and are ready, we give the patient the best embryos. We put in two–three of those. (DP3)

We have done our first PGD today. PGD is pre-implantation genetic diagnosis where from each cell embryo we take out one or two cells. And we will be sending it to a laboratory in Mumbai to get the chromosomal analysis [done]. And only the normal embryo, which does not have Down's syndrome, will be put back into the patient's uterus. (DD1)

Unlike sex selection, selection to prevent disability was seen as desirable and as part of the process, raising strong concerns regarding social responses to disability in general and to the issue of disability rights in particular. It is evident that the industry can strengthen a eugenic trend in controlling reproduction. Along with seeking surrogates who suit their caste, religion criteria (See Chapter Two), the services rendered to the commissioning parents catered to the idea of producing a 'desired' child.

Controlling birth - caesarean section

Just as in the case of most ART deliveries, in the cases of surrogacy arrangements too, the deliveries through caesarean section were disproportionately high. There were many reasons for this, such as the doctors and the commissioning parents not wanting to take a chance with the delivery, the commissioning parents wanting to be present at the time of delivery (including in the case of NRIs, where they lived outside India), and the increased possibility of multiple pregnancies, push for C-section deliveries. According to DP2,

Deliveries aren't normal, because everything is planned, you know. We don't want anything to happen to the baby. And it is explained to her [surrogate] beforehand that she will have to undergo a C-section.

The most used justification for choosing caesarean section – prioritizing the health of the child and ensuring a safe delivery – was itself doubtful because of other practices, such as controlling labour and fixing the time of birth according to the wishes of the commissioning parents. In the case of SP1 and SP3, the birth of the child was delayed so that the commissioning parents could be present for the delivery.

Out of the five surrogates who had already given birth, four had undergone caesarean sections at the time of delivery, and only one had a normal delivery. Caesarean-section deliveries were becoming common practice, clearly increasing the risks for surrogates. As SD2 opined,

My chances of normal delivery were high, but nowadays doctors in order to hike their fees force people to go in for caesarean, and so I also had to go in for caesarean. Although the madam [doctor] said it was because of the baby's health, but there was still some time before the due date.

The surrogates described the effects of undergoing a caesarean operation. SP2 and SP3 both had two children born through normal deliveries, and in their surrogacy arrangements gave birth through c-sections. After the births, both experienced pain in the lower abdomen near the sutures for three or four months. SP3 developed swelling in her legs and experienced heavy vaginal bleeding. She was given medicines for a month to control the bleeding,

Usually, the bleeding is normal. It happened with these two [her children] normally. But this time, there were big, big pieces from inside [blood clots]. I got scared that may be they did not clean inside or something. I talked to the doctor again after 15 days.

The table below presents the responses of the surrogates to questions about the medical procedures that they were to undergo/had undergone. The three aspects covered are:

(a) Whether the surrogates know how many embryos have been transferred and whether they were informed about it; (b) Whether they were informed about the preference of a caesarean delivery; (c) Whether they knew whose gametes were used.

Table 6: Medical Procedures

Surrogate	Status of pregnancy when interviewed	No. of embryos transferred / knowledge about embryos	Caesarean delivery- Whether informed or not	Whose gametes were used
SP1	4 years since delivery	1/ informed of multiple embryo transfer	No mention made	Commissioning parents' gametes
SP2	After delivery	1/ not informed	Not informed, had a caesarean	Commissioning parents' gametes
SP3	Has delivered the child	2/ The commissioning parents had informed surrogate's husband	Informed that since it was twins, delivery will be caesarean	Commissioning father's sperm and commissioning mother's or donor egg
SP4	3 months, ET done	2/ did not know, informed during a scan	Not informed but she felt that they will do the operation as there are two children	does not know
SP5	2 and half months	does not know	—	doesn't know
SP6	ET done	does not know	was not told	Commissioning parents' gametes
SD1	3 months, ET done	1/ not informed	Not informed	doesn't know
SD2	5 th month (second surrogacy)	2/ told before transfer and one child was born, (first time)	Informed about a possible caesarean	Commissioning father's sperm
SD3	3 months, ET done	2/ they did not tell me, found out through ultrasound	Informed about a caesarean	Egg- commissioning mother's, sperm- does not know
SD4	2 nd month	—	—	Commissioning parents' gametes
SD5	2 nd month, ET done	—	Not informed but thinks it will be a normal delivery since she has had five normal deliveries	—
SD6	3 years since delivery	4/ did not know	—	—

Source: Field data, December 2011–April 2012.

Note: In cases where there is no response, it is because the question could not be asked within the duration of the interview.

It is noteworthy that the while few surrogates were not informed about c-section and the transfer of embryos, a far greater number of surrogates seem to be aware of the fact that their own oocyte was not used. Thus, while selective information is reiterated according to the convenience of the clinics and the parents, the general lack of information about the actual medical process, which the surrogates undertake resonates in the experiences that the surrogates articulated.

Breastfeeding

Most surrogates were given injections to stop them from lactating after giving birth. SD6 was given the medicines after the delivery, but it was too late because she had already begun lactating. This resulted in severe pain and discomfort for her; her husband contacted the doctor who then prescribed medication.

The surrogates were informed that they would not be breastfeeding the child. Out of the five surrogates who had given birth, four of them did not breastfeed the child(ren) and were given medication in the form of pills or injections to stop them from lactating. SP3 was the only surrogate who breastfed, although only for the initial two or three hours, after which she did not see the child. According to DP3, *“In most cases, they do not make the surrogates breastfeed because the surrogate’s love for the child may grow.”*

AgD stated,

I tell the surrogates that you don’t breastfeed, you will be given an injection. If you have milk, you will want to see the baby, but you will not have milk, you are like a normal patient. The urge to see the baby will also become normal.

The decision to not allow the surrogate to breastfeed is aimed at preventing her from developing any kind of emotional bond with the newborn and thereby to also circumvent the possibility of her claiming any rights over the child. The surrogate is supposed to hand over the child immediately after birth to the commissioning parents and to relinquish any rights vis-a-vis the child.

Furthermore, the injections and pills used to prevent lactation have serious side effects, ranging from dizziness and nausea to hair loss, etc. There is also the possibility of breast engorgement, an extremely painful condition, which may arise if the woman who is lactating is not allowed to breast feed.

Opinions are divided on this with regard to the child’s right and feminist contestations. While those who argue for breastfeeding, see this as a compromise with regards the rights of the child, opposition to this emerges from further glorifying motherhood, biological ties and the prior information with the surrogate of this being a completely contractual pregnancy with no places for emotions. The possibility of both physical and psychological effects of not being able to breast feed the child can neither be negated, nor undermined. (Please also refer to the section on Experiences and Implications).

Post delivery care

The doctors mentioned that the surrogates were treated for any problems they may have if they approached the hospitals. However, in the cases of surrogates who had delivered, there were no proactive steps taken by the doctors/clinics in following up with the surrogates. It was usually the surrogates who approached the doctors in case of any problems, with or without the support from the commissioning parents, which varied in each case.

AgD claimed that his practice was distinct from that of other agents in the context of post-delivery care,

People give diet for only 9 months. When you deliver, it's not like it is over. She has to return to the normal state, like she was when I first take (her for surrogacy). I take medicines from the couple, whatever is needed after delivery also. For the next 2, 2 ½ months.

Yet in all cases, it was observed that the medical regime, the dietary aspects and the other needs of the surrogates were catered to till the birth of the child and severely compromised later on. Further, currently there were no clear and standardized mechanisms to ensure post delivery care, compromising the health rights of surrogates.

Number of surrogate pregnancies

The number of times a woman can enter into surrogacy arrangements is decided on the basis of her health, her age, and the number of children she has. AgD described having arranged three surrogate pregnancies for a single woman. According to him, the following considerations were taken into account in assessing the number of repeated surrogacy arrangements that a woman could enter into:

Surrogacy, yes, two times, three times. Since it hasn't been very long for me, it's been six years since I entered [the surrogacy industry] and have been expanding my work since then, for three and a half or four years. So in four years, it was done three times [with one surrogate]. Now, someone who has done it twice might do it for the third time or for the fourth time, but her age should not be too much. If she does it at 25 years, then she can do it two–three times till she is 30. After 30 there are very few chances. If they are 34–35 years old but look younger, are healthy, then it is fine. Delivery is a problem for a surrogate who is older – with chances of blood pressure (BP), sugar (diabetes) and thyroid.

At least three surrogates—SD2, SD3, and SD6—were seriously considering entering into surrogacy again. SD2, who was interviewed when she was already carrying her second child through surrogacy, had decided to do it four times, spacing each pregnancy at one-year gaps.

Regulation of lifestyle

The prescription of medication, injections and procedures that the surrogates have to undergo as the 'treatment' is accompanied by a set of directions towards regulating their lifestyle that becomes a significant part of the surrogate pregnancy. Various aspects of their daily lives such

as their diet, sexual behavior, mobility and work become the object of scrutiny and prescription towards ensuring the carrying of pregnancy to term successfully with the birth of a healthy child.

Restricting sexual activity

Restrictions were imposed on surrogates regarding their sexual activity with their husbands. The rationale provided by the doctors and agents was primarily that after the transfer of embryo to ensure that it is successfully implanted and the surrogate does not conceive through her husband. According to DP2,

They want their own biological child that is why they go in for surrogacy. Otherwise, they would go in for adoption straight away. Either one of the parents, for e.g., the male, if his sperm count is normal then they'd like a biological child, even if the egg is from a donor. The male partner prefers that his sperm is used.

DP2 mentioned that abstinence was also preferred to avoid transmitting of any diseases. In order to ensure abstinence and anticipating problems that a woman may face in the event of conception and pregnancy, DP1 explains that the husband's consent becomes a pre requisite,

When she conceives, the husband and wife can't have (sexual) relations, they have to be separate. So they should know this. There was one whom I had refused; she was mentally prepared and all the tests were done. Then I asked about her husband and she said that she had a fight with him, so he doesn't know.

The prescribed duration of abstinence however differed, and ranged from all nine months (SP3) to one and half months after transfer till the pregnancy was positive (SD3) and in SP4's case, it was three months. SP1 who was asked to abstain after the ET also encountered violation of the same protocol by the doctor in a clinic in Punjab, in the interest of the latter,

Doctor had told me one thing, they say that we shouldn't have sex. But she said if I am unable to conceive with the procedure, you can have your own child, I will not tell them.

The control over the surrogate's sexual behaviour was motivated by the concern of both the commissioning parents as well as the doctors to ensure conception through transfer. From SP1's account it was evident that the overriding concern was to ensure successful conception and greater success rates.

Negotiating abstinence from sexual relations with their husbands was perceived as difficult by surrogates. Since there was no way of confirming that this requirement has been adhered to, it led to greater suspicion on the part of the agents, doctors, and commissioning parents. In a surrogacy hostel in Delhi, this concern was addressed by simply not permitting the surrogates to stay with their husbands, as was the case with SD4 and SD5. In the case of SD6, the commissioning parents insisted that she and her husband should not have sex and insisted that she and her husband be given medication to prevent any conception between them. According to AgD,

There can be no monitoring at night. Although there is an affidavit along with the agreement about avoiding physical relations, but they (commissioning parents) don't trust easily. I also can't but I am helpless. I tell them (surrogates), for a one-time thing (sex), you will incur loss worth lakhs and I leave it at that.

SP4 shared, "Once he [husband] did it, I thought as if the doctor is saying that one child is left now. I told him [husband] now you will not come near me for three months. He doesn't come now."

SP4 and SD3 reported that although they were sexually active in the beginning, they ceased sexual relations because they experienced anxiety as a result of heightened concern expressed by the agent that this may cause some problem or harm to the foetus. SP1 and SP2 reported that throughout the pregnancy they did not have sexual relations with their husbands.

Regulating diet and physical activity

For the healthy growth of the foetus and to reduce any risk to the pregnancy, the surrogates were asked to consume specific foods according to a prescribed diet. Surrogates reported that they were particularly asked to frequently have foods such as fruits, juice, curd, almonds, vegetables, coconut water and also asked to have only home cooked food. According to SP5,

She (commissioning mother) said 'eat good things'. Fruits, which I do eat. My husband gets them. She asks me to eat meat, fish. She asks me to eat everything and never keep yourself hungry. - don't say 'I won't eat this or that'.

AgD stated,

Lot of things are to be avoided. Lot of food and drinks are not allowed. No papaya, not too much oil and salt in food. No strong tea. Milk is also reduced. No problem if you eat non-veg. If not, then the diet is given accordingly so the iron and all is fulfilled.

To regulate the diet, in most cases, a part of the payment would be assigned for the dietary consumption, or often the commissioning parents or their relatives would meet the surrogates and provide them with fruits, etc.

The surrogates were also asked to rest and keep their physical activity to the minimum and told to rest. According to DP2, "We tell her [the surrogate] not to exert herself. Some of these surrogates are poor, they are working ladies. So we tell them to take extra bed rest, good diet."

SP1 shared, "The doctor said you mustn't do any work; you have to take care of this child like it's your own. There is risk." Restrictions were placed on the surrogates for doing their household chores and also continuing with any other work that they maybe engaged in within or outside the house. Two surrogates were asked to discontinue their work when they entered into the arrangement. In some cases, the commissioning parents asked the surrogates to hire domestic help and provided money to ensure that they would be able to do so. SD2 (in her first surrogacy), SD6, and SP3 were paid by the commissioning parents to hire help.

The surrogates were also asked to commute to the clinics for appointments in cars/taxis. SP3 shared,

The doctor asked us to come by car. They are twins so it might be risky. So after five months they [commissioning parents] also asked us to travel by car; they said that they will pay for it.

In Delhi, SD1 and SD3, who had entered the arrangement through the same agent, travelled in a taxi that was arranged by the agent, who would also accompany them for all their appointments.

Constant supervision and surveillance

There was a strong apprehension among doctors and commissioning parents that the surrogate may not comply with following the routine of medication and injections or other prescriptions regarding behavior as discussed above. DP3 explains the necessity of closely watching over the surrogate,

A surrogate is supervised more. Mainly, they should not try to be clever/over-smart. They should take proper, healthy food and medicine. Other patients do it because they want the delivery to happen. But with surrogates, we don't know what she is thinking in her mind. Does she even want to deliver, or will she miscarry?

The role of the agent becomes pivotal in such a situation. According to DD1, the payment especially in case of NRIs or foreigners, made to the agent was primarily to take responsibility of the surrogate,

Constant supervision is necessary because if the surrogate aborts her pregnancy or something happens it is the monetary loss for the agency. So they (agents) need to make sure that she's eating, taking medicines which have been prescribed. Why will I not look after my own pregnancy? If I have to give away the child, good or bad; these are low education level, these women might have cared only so much for their own pregnancies... now they are surrogates for a rich parents who has come from abroad so they will look after them since, they are prized patients.

According to AgD,

They (commissioning parents) ask "how is the child in her stomach", so there is no mistake which can lead to their baby being aborted. There should be nothing wrong.

The surrogates' socio-economic backgrounds and 'low education levels' were seen as implying a certain negligence regarding the pregnancy and become the ground to justify the surveillance to keep up with the 'desired' standards of a pregnancy prescribed by the commissioning parents. There was also suspicion about the surrogate as not caring about the child since it is not her 'own'. In the face of insistence by commissioning parents, who were considered 'prized clients', the agents exercised control and extended surveillance over all aspects of the surrogates' lives to avoid any monetary loss by displeasing or dissatisfying their clients.

Enforcing regulations: Ways of monitoring

In cases where there was involvement of the agent, the extent and degree of successful monitoring was greater than cases without, where the control was either exercised by frequent reminders by doctors or commissioning parents over phone or in person.

AgD had devised several ways of supervising the surrogates effectively, often by making other actors in the arrangement as well as those who were a part of the surrogates' daily lives the source of enforcing restrictions. He encouraged the surrogate's husband and children to make sure that she did not physically exert herself and that they help out with work at home. According to him, a good strategy was to visit the surrogates at their residence without informing them in advance. He also encouraged the commissioning parents to visit the surrogate 2-3 times a week and gauge her condition themselves. AgD arranged for the surrogates to reside in his own neighbourhood and identified surrogates themselves as effective agents for extending surveillance and monitoring each other,

If one surrogate stays next to the other, they give information about each other. If they (surrogates) live nearby, then wherever they buy their food, we tell them that she is our surrogate, you don't give them certain things. So even if they (surrogates) ask for something by mistake, they (shopkeepers) say this is not allowed for you.

Creating extended networks of surveillance, severely curtailing the surrogate's autonomy over her body and choices regarding sexual behavior, eating habits, work options and mobility takes the form of accepted convention of medical practice, outside the clinical setting. Therefore along with an intense medical regimen, a controlled and strictly monitored pregnancy and lifestyle becomes an integral part of surrogates' lives in the interest of a healthy live birth of a child, in which the interest of the various actors are invested strongly.

It is revealing that the interests guiding the actors in the surrogacy arrangement did not accommodate considerations of the surrogate's health; risks to her body and to her health were disregarded in the rush or willingness to accommodate the wishes of the commissioning parents. For instance, doctors were willing to accommodate the desire of commissioning parents to be present at the birth, even going to the extent of delaying birth. Further, the surrogates were expected to open up all their spaces and lives for supervision by the agent and the commissioning parents. In contrast, the latter did not consider the surrogate as rightfully deserving of knowing about the arrangement and procedures, while at the same time, expected surrogates to be obedient and to adhere to each and every direction.

Medical practice that was motivated by concerns other than safeguarding the health of the surrogate can often affect the surrogate's health in various ways (this is explored in the subsequent section), and escapes any supervision and regulation.

SECTION B: EXPERIENCE AND IMPLICATIONS

As mentioned above, the rigorous medical routine was not without significant implications (both immediate and long term) that surrogates experienced in different ways. This section examines and unpacks these realities.

The situation is also explored through the interaction of surrogates with other actors, such as the medical staff, the agents, and the commissioning parents, both within and outside the hospital setting, while undergoing the required medical procedures.

Exclusion from the process and hospital setting

The nature and the level of information provided to surrogates and the process of securing their consent, or rather the lack of it, have been discussed in the previous section. This section examines how these processes were embedded in the surrogates' position in the hospital setting and the dynamics of their interaction with the other actors involved in the arrangement.

Surrogates described how they were excluded from any communication, while the other actors – agents, doctors, and commissioning parents – had direct links to each other. Surrogates highlighted their minimal contact with doctors. While the typical doctor–patient relationship itself is asymmetrical along the lines of knowledge–power, dependence, and lack of reciprocity, this asymmetry is further amplified in the case of a surrogacy arrangement. Surrogates found themselves further marginalized because their socio-economic status was a deterrent to communication, coupled with the fact that it was the commissioning parents who were considered the 'rightful' patients.

For instance, the only interaction that SD1 had with the doctor was in regard to fixing appointments. 'The doctor only says "SD1, you have to come today"', she shared. SD2 said,

Here the thing is that you can neither talk to the doctors nor to the couple [commissioning parents]. You have to keep your thoughts to your own self. Whatever they say, you have to do it. Madam said, 'Do this, do that.' And you have to do it. You can't talk freely. She [doctor] just asks, everything is fine, is there any problem, eat this, eat that. They will ask about all the things that they are concerned with as part of their work. The rest comes in the report. The doctors look at the report in front of them. They won't share an experience with a human, but they will do it with a file and that is it. They won't look at you. They will look at your file. 'How are you? Do you feel fine? Are you eating? Is the movement okay?' . . . That is all they say. Even if you try to talk to them, they will say, 'I don't just have one patient to see, I have many.' They are all meethi chhuri [sweet knife]. . . Madam doesn't have any time. It is a fixed timetable. Right now, in this hospital, then that. Here, if there is a new patient, there is no one who can explain anything to you. They only talk to the family [commissioning parents], as if it is them and not us who are pregnant.

Reflecting on her exclusion from the process, SD2 observed that the primary issue as far as the doctors were concerned was the 'health' of the foetus progressing towards a successful delivery. The 'patients' that the doctors were catering to were the commissioning parents, and not the surrogates. The surrogate's identity was reduced to the pages kept in a file and was largely perceived as an appendage to the commissioning parents. She was regarded as someone who would otherwise not have been able to access the services of the medical establishment, and was treated in a decidedly inferior manner. This asymmetrical relationship clearly revealed the power dynamics at play.

The remoteness and alienness of such a setup, on the one hand, obstructed the flow of any information to the surrogate, to her disadvantage, and, on the other hand, further isolated her in a context where she was compelled to hide her identity as a surrogate from all the other people in the spaces she inhabits.

Surrogates in the clinical setting experienced a general atmosphere of intimidation to open communication. In such an atmosphere, it was improbable that surrogates themselves would seek information. Asked whether she desired any further communication with the doctor, SD1 said that she could not ask too many questions, *“With these people, if you talk too much, it doesn’t look good.”*

SD1 was only too aware of the class bias that shaped medical practice in general, and surrogacy in particular. Accessing the services of a private hospital in a posh Delhi locality was something she would not have been able to do without entering into the surrogacy arrangement. She was intimidated by the sense of exclusion arising from the unequal treatment meted out to her. This was evident in her assuming that the doctors or the staff would not welcome any communication from her, especially her asking them questions. The medical ethical protocols of securing the surrogate’s consent were meant to be followed in this forbidding and alien setting. This raises serious doubts about the possibility of gaining consent in a free and equitable manner, given the hindrances and disadvantages faced by surrogates.

Drawing a contrast between Indore and Delhi, the sites of both her surrogate pregnancies, SD2 explained why she preferred a setup such as that in Indore,

Here there is only one doctor. There, there were four–five. The main doctor was very busy, so you could get your name written down and she would meet you then. There were other madams for sonography, other tests. There was another doctor who would make very good conversation with you. Here, no one is bothered. There, they would put you through to the doctor immediately. For them, it wasn’t like the surrogate was different. For them, everyone was the same. And madam would talk to the family the same way, about the same things that she would speak to me about. For her, it was about the patients.

SD2 preferred the Indore hospital over the Delhi facility because in Indore, she was not treated differently from others, and was seen and respected as anyone else. In contrast, in Delhi, her identity as a surrogate and her socio-economic background resulted in her being assigned an inferior status in the hospital.

Access to doctors

Furthermore, access to doctors was also often mediated by the presence of the agent, if there was one involved in the arrangement. Often it was the agent with whom the surrogate had the most contact and with whom she communicated most frequently. Agents told surrogates to inform them if they had any problems or concerns, which would then either be attended to by them or conveyed to the doctors. Agents, presented themselves as a bridge between the medical establishment, the commissioning parents, and the surrogates.

SD2 effectively shows that concerns about the exclusion of surrogates from the entire process were difficult to address,

These are all small matters. You can't tell them to the agents. They have so many women who come to them; this is their work. AgD has not come to visit me for a long time. He doesn't come. He just talks on the phone. If there is a problem, I tell him.

The concerns of surrogates were often dismissed as 'small matters'. In the power relations between the various actors in the surrogacy arrangement, and the various spaces in this arrangement, surrogates were assigned a specific (and inferior) position, which was determined by the clear class prejudice that governs the entire arrangement. Hence, the worries and anxieties of surrogates were not seen as qualifying as real 'problems' that either the doctor or the agent needed to address. Furthermore, the agent, who was the only contact person for the surrogate, may also not always be available to hear her concerns, thereby amplifying her isolation.

Despite the impression given, agents did not act as neutral third parties. Their main concern was to guarantee a successful pregnancy culminating in birth. The conditions in which surrogates worked become 'small matters', and the agent's role was to control, monitor, and check events to avoid any adverse condition. The agent's role was not to be an effective link in the chain of communication. Indeed, the communication that the agent enabled was rather one-sided.

SD1 observed the agent, the doctor, and a relative of the commissioning parents talking when she was at the hospital for her appointments. On being asked whether she had inquired from the agent what the others were talking about, she said:

No. I have not asked them. They will wonder why I am so curious or what my motive is. If I ask him that, he will say I do all your work, what medicines, etc., [are required], everything I take care of. So why are you asking this?

Similarly, AgP controls communication between the doctor and SP4. She fears that any attempt to talk to the doctor directly would be regarded with suspicion by the agent, who could then ask SP4 whether she trusted her. AgP's personal relationship with the agent, who was part of her community, made it harder for her to do so. However, often the agent was the only channel of communication for conveying the concerns of the surrogate to the doctor. The agents in the above cases evaded any responsibility of providing information to surrogates, or of enabling communication between surrogates and doctors or commissioning parents. They saw their roles mainly in terms of a stated personal relationship, whereby the demands and queries of surrogates were made to look like unwarranted suspicions, and the surrogates' right to know was denied or dismissed.

SD1 added that inside the hospital it was not possible to communicate with anyone. About the possibility of communicating with other surrogates present there, she remarked:

You can get into trouble if you ask too much. The most you can ask is where are you from. Asking more than that can get you into trouble.

Her responses and her demeanour during the interview at the hospital were in sharp contrast with those she had exhibited during the interviews conducted at her residence in Delhi. She remarked:

You tell me, how I could say anything in front of the doctor? Where there is the doctor, the sister, the agent, the people who will be taking care of the delivery, how can I talk in front of them? You spoke to me, took my number, and then have come here to speak to me. Otherwise how could you have come so far? Nobody can talk around the doctor, agent, etc. If you are also an agent, you will also not allow me to talk so much.

SD1 described the secrecy that surrounded the practice in general and the invisibilization of the surrogate in particular. This was ensured by both doctors and agents, so much so that surrogates were expected not to talk to anyone. It was important to note that surrogates interviewed in Delhi had more information about the procedures and other aspects of the arrangement, largely due to their communication with other surrogates, if any, in their neighbourhood. Under the supervision of the agent, however, such an exchange of information was discouraged. The reason for ensuring and reproducing the surrogate's isolation and silence seems to be to obstruct another channel of gaining information about the process, to avoid the possibility of the surrogate raising questions, and to prevent any adverse consequence that this may have on the surrogacy pregnancy, which by its very nature was considered precarious.

The doctors are saying that there is only one child now, but I feel there are two. I have a lot of faith in my god. It comes on TV in the morning, the pastor's programme (Bandagi), so in the end I thought he was talking only to me. I was his eyes, and I felt like he was looking into my eyes and telling me 'You will have children, they will be healthy, and they will be girls. You will recover well.' I have medicines, but god has told me that I will be okay and that there will be twins. The doctors' reports will be proved wrong. That day [after the delivery], I will call you up and tell you that I had faith in my god.

You don't trust the doctors?

No, only god. My god has given me food, support (sahaara) for my children and me.

And why don't you trust the doctors?

It is just that tomorrow if they operate, they can take out anything else from inside. (SP4)

In the case of SP4, the distancing from the medical establishment and the entire process led to an acute distrust against the medical staff and total exclusion. She kept her concerns to herself and sought support only through her spiritual devotion; the result was that of total disengagement. Despite these feelings of distrust and alienation, SP4 had to continue to adhere to the instructions and to follow the prescribed procedures mapped out by the other actors in the arrangement.

The hospital setting, as was evident from the cases discussed above dis-empowers the surrogate in multiple ways, weakening her ability to negotiate the terms of the arrangement and compromising her ability to exercise any control over what her body had to undergo, thereby making it difficult, if not impossible, to make an informed decision. This position of the surrogate was influenced by the dynamics of class that played out between the various actors, and was strengthened by the inhibiting atmosphere of secrecy that surrounds the practice.

Heavy medication

The surrogates interviewed at both the sites commented frequently on the medication regimen that was prescribed for them. Since most of them were not informed of this prior to their decision to enter into the arrangement, and because often assurances were made that the surrogacy pregnancy would be like their earlier ones, surrogates had no idea about the levels of medication they were required to take; this was not something that they had considered at the time of entering into the arrangement.

SP3, SP4 and SD1 compared their earlier pregnancies with their surrogacy pregnancies. SD1 described her surrogate pregnancy as one during which she had to have many more injections and medication, and have many more check-ups and tests done.

SP4, who had not received any medication during her earlier pregnancies and who had resisted taking injections even then, expressed her frustration at having to take a large number of injections for the first time.

All these medicines are making me irritated. I said enough, but they say I have to take a lot of them.

SP3, after giving birth to the child, had contacted the doctor when she experienced pain and weakness. However, she did not go to the hospital when he asked her to come and take a prescription of medicines from him.

I am frustrated with medicines now. It was too much already. I am tired of taking medicines.

Surrogates underwent a demanding prescriptive medical regimen while possessing minimal information about it as well as its ramifications and effects. A situation in which no explanations were provided to them either about the purpose of the dosage or the frequency of medication, and where they could not communicate their discomfort effectively nor ask questions. Further, contrasting the experience of surrogacy with the experiences of their earlier pregnancies, they were unable to understand the expectations on the part of doctors or commissioning parents of strict adherence. This sometimes led to their aversion to medicine, to their resistance to comply with instructions, or even to their seeking treatment after the surrogacy pregnancy, in cases of complications, the consequences of which are unknown to us within the scope of this study. Further, no long-term research study is currently available on the post-pregnancy effects in a surrogacy arrangement in the Indian context.

Effects on the body

The possible effects of medication on the bodies of surrogates and any associated health risks were not discussed with surrogates. In all cases except one, doctors did not offer any information

about any possible consequences. In some cases where surrogates sought information about this from doctors or agents, they were reassured that there would be no consequences that were particular to their specific pregnancy. The portrayal of the pregnancy as 'normal' created the impression that there would be no effect on the health of surrogates, particularly resulting from the use of IVF procedures or medication.

I asked if I would face any life risks. He [agent] told me that nothing would happen. (SD3)

I was told no problem would arise, everything would be like the time of [the birth of] your own child. (SP2)

Similarly, on discovering that she was carrying twins, SP4 expressed concern about the effect of this on her health. The agent told her, 'It does not matter. It will be fine.' In such a context, surrogates could not possibly anticipate any effects or problems that they may face afterwards. They were required to simply resign themselves to the situation, undergo the procedures, and bear the unexpected pain and complications stoically. The possible impact on their bodies and the effect on their health were neither considered while making the decision, nor did these considerations figure as meaningful factors when it comes to the remuneration and longer term health coverage. SP2's situation was an exception. She had not anticipated any problems, thinking that the surrogacy pregnancy would be like her previous pregnancies. She was told by the doctor that an IVF pregnancy was different from the other, normal pregnancy and that in the former there is a much higher risk of miscarriage, but the explanation for this was not provided. SP3 was merely told, "It all depends on you".

The surrogate was pacified but without being given any detailed explanation about medical decisions or procedures. The purpose was to ensure that she does not do anything to reduce the chances of implantation or to risk the successful delivery of the child. In all cases, the doctors did not bear any responsibility or liability. Surrogates were told to adhere to instructions, which were presented as imperative for a successful pregnancy leading to a live birth.

The surrogates reported various effects on their bodies resulting from the procedures and medication starting from the time before the occurrence of the ET until after the birth of the child. It was observed that when the interviews were conducted in the hospital or under the supervision of an agent, the surrogates generally gave the impression that there were no ill effects on their bodies and that they faced no problems or discomfort. It was only when the interviews were conducted at their residence, or in the case of SD6 over the telephone, that they gave a more elaborate and frank description of their experiences.

The surrogates described the daily routine of receiving injections as particularly arduous. The injections, whose administration was reported to be extremely painful, also led to the formation of lumps in the body at the site where they were administered. The surrogates described the formation of *gilti*, or the tightening of skin and the formation of lumps. SD1 also experienced discolouration of skin in places after receiving injections.

SP4 experienced stomach ache, nausea, and the formation of excessive saliva from the time the process was initiated. She was informed by the agent that this situation would continue for three to four months. On expressing anxiety over this, she was prescribed more medication, which only served to increase her nausea. SD2 experienced loss of appetite and indigestion. She was given medication for increasing hunger,

I eat very few rotis. If I eat something, my body feels very heavy and [I] can't sleep at night then. That is why I don't eat at night. I just have Horlicks in the evening around six. It is very difficult to digest food in this condition.

For the first three months, I had a lot of trouble. I was in pain since there was injection after injection for three months. There is the gel one. Only after seven–eight days does the pain subside. I took three and then kept aside the rest. I was in tears and did not want any more injections. Already with all the injections there was no place left and then this injection had a thick needle. Imagine the pain. Earlier, AgD's wife used to come to inject them, but later I told her not to take the trouble; my husband will do it in the house. Otherwise, I would have to do it compulsorily.

SD1 also preferred to administer the injections herself. On the other hand, SP4, who stayed in a village outside Jalandhar, was asked by AgP to administer the injections herself. SP4, who found it very difficult to do so, forgot that the syringe was still lodged in her waist. She noticed it the next morning when she woke up, after experiencing heavy bleeding.

It can be seen that surrogates negotiate the experience of having to undergo intense pain in various ways. The injections, whose administration was extremely painful, were given under no proper medical supervision. While the agent was responsible for administering the injections, there seemed to be more flexibility in the above-mentioned cases, because none of the agents gave the injections nor was any agent present at the time when the surrogates administered them. In the case of SD2, she avoided having to take the medication and sought to escape the pain. In the case of SP4, she suffered a great deal, hampered by her obvious lack of knowledge, which could have led to dire consequences for her health and life.

SP3 and SD3, both carrying twins, after the fourth month, faced difficulty in moving around and in sitting and standing up as the 'stomach had become very heavy'. SP3 could not even squat to use the toilet.

SP1 reported that ever since her surrogate pregnancy she has experienced weakness, headaches, fever, weight gain, and bloating, so much so that many of her relatives remarked that she was unrecognizable. She also suffered from urinary incontinence. SP1 did not experience any of these changes in her earlier pregnancies and had assumed that they were the result of the medication given to her to delay the birth of the child awaiting the arrival of the commissioning parents.

The thing is that all the other children were born on time, and I had no problems. They used to give me injections to delay the birth of this child. But the child could not be held in. Now I have headaches often, even fever. I had double pneumonia. Never before had I gone through any problems. (SP1)

The above detailing of the various effects on their health as described by the surrogates was in stark contrast to the impression given to surrogates by doctors or agents that the surrogacy pregnancy involved no consequences or risks. Many adverse effects on the health of surrogates

were the consequence of the medication, procedures, such as caesarean operation and the prohibition on breastfeeding. This raises serious questions about the kinds of procedures that qualify as ‘medically indicated’ and why the successful birth and the delivering of the child to the commissioning parents should be achieved at the cost of the surrogate’s health.

Table 7: Health consequences experienced by surrogates

No.	Age	Surrogate	Health Problems Faced	Remarks
1	38	SP1	Weakness, become fat, cannot wait to go to the bathroom, headaches, double pneumonia	Delivered a child four years ago, delayed birth of the child by giving injections
2	28	SP2	There is suffering (<i>kashit toh hota hai</i>), like my back hurts	Delivered a child
3	30	SP3	Swelling in feet, weakness Usually, bleeding is normal. It happened with these two [her children] normally. But this time, there were big, big pieces from inside. [I was] given medicines and got better. Bones have started hurting, <i>gilti</i> , in the third–fourth month. Stomach very heavy	Twins delivered
4	28	SP4	Mostly I keep sleeping, lying down all day. I used to sleep like this during my elder daughter’s time. Sometimes I have a stomach ache and sometimes there is a lot of vomiting. I spit a lot. All these medicines are making me irritated, <i>gilti</i> , feel very dizzy	ET done
5	28	SP5	–	–
6	30	SP6	–	ET done, pregnancy not confirmed
7	30	SD1	<i>Gilti</i> , dizziness, weight reduced. During my own pregnancy, I used to do all the work. This child has been conceived differently, hence you have to work less	ET done
8	30	SD2	Put on weight, stitches hurt. For a couple of months, I felt less active than normal. Body suffers because of Caesarean. If I eat something, my body feels very heavy and I can’t sleep at night. Then it is difficult to digest food in this condition. Body feels heavy. At times I feel like ‘finishing’ myself. Weight has reduced	One child delivered, c-section, now second surrogacy
9	30	SD3	SD1 says: SD3 is going through a lot of problems. She can’t sit or stand. It is too much of a difficulty	Carrying twins
10	21	SD4	–	–
11	34	SD5	–	ET done
12	35	SD6	Used to have aches in my body and stomach from the first day. The child was born with a lot of trouble. I had got an infection in that area after three–four months. They gave me an injection so I don’t lactate, one hour before discharging me. But the milk had been formed. It hurt very much later when I was home	Delivered a child three years go

Experiencing restrictions and surveillance

Surrogate pregnancy was regarded as a precarious pregnancy by many of the actors involved in the arrangement. The surveillance to which surrogates were subjected was the result of the precautionary attitude adopted by the other parties in the arrangement based on the perception of a heightened risk posed by surrogacy pregnancy.

The surrogates interviewed for this study revealed the existence of various levels of possible surveillance in the two sites, Punjab and Delhi. Surrogates in Punjab resided in their own home during the pregnancy. Of the four surrogates, three had entered into the arrangement without the involvement of an agent. While surrogates received directions and instructions, physical surveillance by the doctor or the commissioning parents was not possible. In contrast, in Delhi, all except one surrogate resided in the same neighbourhood as that of the agent or in a hostel that had been arranged for them, so as to make it possible to supervise their activities daily or periodically. According to SD2,

They only care about their baby. They ask how I am, am I eating and drinking properly. Yes, I am doing all that. All this, I don't say anything negative. Like [the question] 'Are you eating?' Yes, I am. 'Are you eating fruits?' Yes. So it's not like I will go buy fruits for 100 rupees every day. 'Are you drinking coconut water?' Yes. So one says this even if I may be taking it once in eight days. The doctor says, 'Drink juice, eat curds.' I cannot eat the month's diet in a day, right? Why don't you try and stay in a family of four and figure out the expenses. Now if a person used to [eating] two rotis has four, will this not upset her stomach? I will eat what suits me. I am following the diet and [taking the] medicines they are asking me to take. Now, they are tense about the baby being healthy, but take it easy. My reports and ultrasounds are showing that everything is fine. Then why get tense? Till the time the baby is with me, I will take care. It is not like I will not. I eat vegetables. I also have two children, and have taken all precautions. It is not like I will not [take] care and all that.

SD2 indicated that this overriding concern for a safe and healthy pregnancy could be incongruent with the surrogates' own lifestyles, and yet they were expected to strictly follow instructions and observe precautions. For instance, it was not possible for surrogates to meet the demands concerning diet for several reasons, such as affordability, physical capacity, and frustration at having to follow a restrictive routine.

Among the surrogates in Delhi, SD6 did not have an agent involved in the arrangement. The commissioning parents were based in Delhi and would come to meet her often. During the course of the pregnancy, SD6 had to shift residences,

Once we shifted, we called her to tell her. She came and started fighting with us, saying, 'If something were to happen to my child' (agar mere bachche ko kuch ho gaya na). My husband also got very angry.

The demands made by commissioning parents and doctors thus often seemed unreasonable to surrogates. Yet, if surrogates did not follow instructions, they were seen as irresponsible or untrustworthy. Constant suspicion and great concern for a successful birth led to the surveillance of surrogates by commissioning parents, agents, and doctors.

Surrogates sometimes resisted such complete control over their lives by others in the surrogate arrangement. SD2, who found many of the restrictions placed on her impractical, said;

It is not like they will come and check. Don't work and rest. Now if I don't work in my house, who will?

The expectations of commissioning parents were often contrary to the needs of surrogates in their daily lives, and attempts were made to ensure that the commissioning parents' expectations prevailed.

SD2 was given money by the commissioning parents to hire domestic help. However, she regarded this as unnecessary because she had done the housework during her earlier pregnancies. Additionally, she felt that since she could easily manage on her own, she could choose to use that money as per her needs.

Sometime back I had a fight with the agent. He said the doctor had scared him by saying that if the child shifts downward, the child might come out sooner. In such circumstance, no money will be given. So I became very angry. I went to madam and said I want to get an abortion done. Then madam made me understand that there is nothing to be scared of, that I should not abort it [foetus], and that she had not said anything like that. She told me not to worry and that I will be paid. She said if you are careful, then everything will be okay.

In this case, the threat of non-payment became another tool for creating fear, for enforcing 'discipline', and for ensuring compliance on the part of surrogates.

Implications for everyday life

During pregnancy

The effects of the medical procedures, coupled with the regulation of behaviour to which the surrogates were subjected, have far-reaching implications for their daily lives.

SP4, who had otherwise been very active in her day-to-day life, was now unable to eat anything, suffered from lethargy, slept most of the time, and was almost bed-ridden. She expressed great anxiety about her condition.

There is a lot of anxiety (ghabraahat). [I wish] That it should just get over quickly, so I can gain my health back. I am not able to stand up these days. If I do stand up, I feel very dizzy.

[Did this happen earlier, at the time of your other pregnancies?]

No, never. When my daughter was born, I would keep sleeping. When my sons were born, I would work a lot. I would never get dizzy. I used to move around, go to work. Now I can't go to work, can't go out. I am just lying inside all the time. At times I feel like 'finishing' myself. I used to do a lot of work. Ask my mummy. I made food, went to school and cooked there, then made tea and then got dressed.

After two attempts, she had to discontinue working as a domestic worker and cook. SP4's daughter then began to work in her place in the house. She now depends on what her daughter and her estranged husband can bring in during the months of the pregnancy.

Besides physical pain and discomfort, her condition has affected her psychologically as well. The confinement and immobility that she was compelled to face are matters of great concern for her. Her frustration has been deepened by the loss of earning capacity and dependence on others.

SP1 gave up her stitching work during the pregnancy, as asked by the commissioning parents.

They told me not to pick up any heavy things, because it is through the donor that the child had been conceived. There could be any problem or harm to the baby. I didn't do any work, not even stitching. Since then I have left that work. I can't do it anymore. Earlier I could make two–three thousand. Now my back hurts a lot. It has had a great impact.

After delivery

Both SP3 and SD2, after giving birth through c-section, experienced pain, which surfaced especially when they were engaged in doing any work. Swelling in her legs and pain after the stitches prevented SP3 from lifting heavy objects. She also had to discontinue her stitching work.

I used to work very fast, but now I am not able to do it. I tire very easily. My body is no longer what it used to be. (SP3)

Similarly, SD2 was unable to keep up her usual level of activity during the first two months. Yet the housework needed to be done. 'I did not let my body feel weak. I did all my work. You have to do it,' she said.

SP4, who had not yet given birth, was already anticipating the effects of a Caesarean.

I hope the doctor doesn't give me any takleef [doesn't trouble me] and that I may stay with my children, all fine and healthy. I don't know what the doctor will do. They will do the operation and then I wouldn't be able to do any 'heavy' work [that causes strain]. If it is a normal delivery, I will be fine. Otherwise the 'heavy' work that I can do now, I won't be able to do afterwards.

During the course of the pregnancy, surrogates received extra care and were instructed to keep their physical activity to the minimum. This was in sharp contrast to the post-pregnancy period during which the same level of care was generally not extended to surrogates. Further, it was difficult for surrogates to resume their earlier level of activity and work after the restriction on physical activity during the pregnancy.

The cost of a successful delivery, then, was paid by the surrogate in various ways, such as the effects on her health and on her body, her household income, and her lifestyle and activities.

These concerns were not taken into account in deciding the terms of the arrangement and the remuneration offered to the surrogate. Besides, the surveillance and monitoring of the surrogate's lifestyle and activities was equated to medical treatment. This raises questions about what constitutes a healthy pregnancy and who can afford to have one, since the level of care and the kinds of precautions that were prescribed for the surrogate were not what she observed or received during her own pregnancies. The imposition of restrictions on her diet, sexual behaviour, mobility, and other work options, coupled with the expectation of complete compliance, means that the surrogate's rights to her body and her right to privacy were severely compromised.

Choosing 'risks'

In the context of the monitoring of the pregnancy and the effects of this on the lives of surrogates, it is important to understand what guides surrogates' choices and how the experience influences their motivations.

So will you become a surrogate again?

I am giving it a thought, but at times I just don't understand whether I should get it done or not. On the one hand, Caesarean is not a good thing, so my body suffers. Women generally turn away from these things.

You don't have a problem?

I was scared earlier, but I have no problem.

What did you think would happen? What were you scared of?

So many people. There are two–three doctors, two–three helpers, and women. You are surrounded from all sides. (SD2)

SD2, anticipating her third surrogacy arrangement, reflected on her experience until now, the changes her body underwent, and the potential risks of the pregnancy. She had planned her fourth surrogacy arrangement as well.

The body cannot support [itself] beyond a point. Now with stitching, I need glasses. Soon I won't be able to do it, and then what will I do?

Similarly, SP3 expressed her ambivalence about the effects of surrogacy on her body as she grew older. She was considering entering into another arrangement. She wanted a separation from her husband, and surrogacy seemed to be her only option in the context of financial support and the responsibility of supporting her children.

SP2 had decided not to become a surrogate again, since now her children were growing up and it would be difficult for her to hide the surrogate pregnancy from them. The fear of facing stigma from within her family discouraged her from entering into surrogacy again.

SP1, on the other hand, had decided not to enter into another arrangement. The arrangement, for various reasons, was not as satisfactory as she had hoped. The commissioning parents did

not fulfil the promises they had made regarding the benefits they would provide her, such as arranging for employment for her son, and had completely distanced themselves from her. Additionally, her health deteriorated, adversely affecting her ability to work.

SP4 had taken one month to decide about entering into the arrangement.

I thought that life and death is in the hands of god. Whatever is written will happen. If life is not written, then [I] have to go to God.

Even though SP4 did not have information about the procedures and about any other effects or risks involved, she perceived that there could be severe consequences nevertheless, considering even the eventuality of death. Three months into the pregnancy, her deteriorating health and immobility were causing her great anxiety.

It should just get over quickly so I can gain my health back. I am so worried because if anything happens to me, then my children will be miserable.

Her decision to become a surrogate was driven by her determination to provide for her children and to safeguard their future. Now she was equally anxious to end her surrogate pregnancy without compromising her health.

The surrogates' decisions to enter into surrogacy arrangements, were influenced by a constant negotiation and weighing of 'risks'. They were guided by what they perceived as a greater and imminent risk to their lives.

So next time you do it, how do you want it done?

I will want health insurance. You have to take a little care of your own self as well.

For SD2, it was important that the commissioning parents bore the responsibility and expense for her health and general care. Given her experience of a caesarean birth and her second surrogacy (which was in progress at the time of the study), she was aware of the consequences and risks involved. Nevertheless, she had decided to undertake two more surrogacies to secure the future of her children and to pull her family out of debt.

The women had entered into surrogacy mainly to escape the burden of poverty; their situation further compromised by the lack of information and the unanticipated effects of surrogate pregnancy. Surrogates assessed what they perceived as 'risks' in their lives and chose to enter surrogacy, weighing their familial responsibilities and financial compulsions against these risks to their health and lives.

Conclusion

In this context, it is important to analyze the policy for regulating this industry and unethical medical practices, question whose interests are being protected, and ask what anticipated conflicts and complexities the law chooses to address. As Qadeer (2009) emphasizes, "current policy framework which is the Draft ART Bill - 2010 offers inadequate protections for the surrogate, especially in terms of the risks she undertakes. The procedures required for the

surrogate's medical care should be standardized, fully articulated and not left vague in the policy. The financial support for her maintenance should also be clearly articulated and different possible obstetric events taken into consideration. The financial consequences of complications of pregnancy, morbidity, and death should be the burden of the commissioning couple".

The provisions of the legislation with regard to the number of live births, foetal reduction, etc. raise many concerns, while it is silent about prevalent practice of c-sections as the mode of delivery, post delivery care, morbidities and other critical aspects, that increase the potential for serious health problems for surrogates. In addition, without clear limits on the number of IVF attempts that may be made, and without specific limits about the duration over which these IVF attempts may be made, the implications for the surrogate's health increases significantly (Refer Annexure IV).

Further, the imposition of many harsh restrictions on the surrogate's personal behaviour and movement ought not to be allowed as a matter of contractual agreement. Lack of informed consent is also a glaring problem overall, and this must be addressed in the proposed legislation vis-a-vis surrogacy. Therefore, the medical regimen, the resulting effects, and the experiences of surrogates pose questions that are deeply political and that have significant implications at the policy level. These issues need to be addressed urgently to protect the health and rights of the surrogates.

Notes

- ¹ 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), (Draft) The Assisted Reproductive Technologies (Regulation) Bill and Rules - 2010.
- ² *ARTs and Women: Assistance in Reproduction or Subjugation?* (Sama, 2006). For a more detailed and systematic description of the risks and side effects of ARTs, see also *Constructing Conceptions: Mapping of Assisted Reproductive Technologies in India* (Sama, 2012).
- ³ According to the ICMR guidelines, "No more than three oocytes or embryos may be placed in a woman in any one cycle, regardless of the procedure/s used, excepting under exceptional circumstances (such as elderly women, poor implantation or poor embryo quality), which should be recorded". Indian Council of Medical Research (2005). National Guidelines Accreditation, Supervision and Regulation of ART Clinics in India. New Delhi.
- ⁴ In an earlier study conducted by Sama and published under the title *Constructing Conceptions*, it was found that despite a similar denial by ART providers, sex selection was nevertheless being practised (Sama, 2010, p. 123).

CHAPTER 4

Relinquishing The Child: Contract, Contact, and Control

A successful commercial surrogacy arrangement culminates in the relinquishment of the child by the surrogate to the commissioning parents. The multiple actors who are involved in the arrangement are deeply invested in it, so that the need to ensure relinquishment becomes a matter of great importance. The technology creates a disruption in a linear bond of kinship between parents and child, complicating the idea of a biological link that is not restricted to a single person. There are uncertainties regarding the surrogate's perception of the pregnancy and the child, as well as the commissioning parents' expectations regarding when the child should be given away, what kind of contact would be established between them, the child and the surrogate. As a consequence, in discourse and in practice, efforts are made and care taken to ensure a smooth process of relinquishment. While examining the various processes that have evolved as part of the practice, this chapter focuses on how various actors in the surrogacy industry have contributed to the creation of a particular subjectivity of the surrogate, how the terms of the arrangement are set in a legal contract and its significance, and how surrogates respond to this process, and how they understand and often seek to forge, relations with the child and with the commissioning parents.

Contract

Generally, surrogacy arrangements are formalized through a contract. Out of twelve, ten surrogates had signed a contract or an agreement; the other two being the ones whose pregnancy had not been confirmed yet. The contract is the only legal tool that sets the terms of the arrangement. Thus, it becomes imperative to examine under what circumstances it was drawn up and what purpose it serves, whether there is parity between the signing 'parties', and how and what kinds of contestations it seeks to prevent and address. The importance of signing a contract, and the significance of its enforceability is, in a very lop-sided manner, grounded in minimal involvement on the part of the surrogates. The surrogates refer to this process as merely 'signing papers' and, with little or no information provided or deliberation involving them, it does not figure as a crucial step in the arrangement for them. Thus, the contract that is signed becomes a tool in the hands of the other actors, such as commissioning parents or agents, towards securing particular interests, directing the nature and outcome of the arrangement in ways favourable to them.

The Drawing up of the contract: No legal counsel for the surrogate

The contract or agreement is between the two 'parties' – the surrogate and her husband and the commissioning parents. The contract is drawn up by the commissioning parents or by the agent.

In one medical establishment, the managing director, who was also the doctor in-charge of the surrogacy arrangements, drew up contracts for both the commissioning parents and the surrogates to sign. No legal aid or counsel was made available to the surrogates, nor were they asked if they needed it arranged. There were no negotiations or discussions over the terms of the contract, and the surrogates were simply presented with 'papers' and told that they were required to sign them.

SP1 signed the contract drawn up by a lawyer hired by the commissioning parents. When asked whether she had thought of hiring a lawyer too, she replied, "*We didn't think we needed one. We had faith in them [commissioning parents].*"

Most of the communication between the actors was verbal. The surrogates' interactions with the commissioning parents was marked by a discourse of altruism. SP1 had been contacted by the commissioning parents repeatedly for over a month, during which they expressed their desire for a child. Assurances regarding payment and any other expectations that SP1 might have regarding the outcome of the arrangement, such as securing employment for her son, were also given. The entire process progressed in a decidedly informal manner and was couched in an altruistic discourse. In such a context, the space for voicing, considering, and addressing uncertainties, doubts, and the possibility of disagreements itself was compromised.

In most situations, the surrogates may also not have anyone available to counsel them or with whom they could discuss the entire process of being part of such an arrangement, given the general preference for anonymity. In the case of SP1, an acquaintance and a doctor known through the commissioning parents, acted as a middleman. Despite the surrogate's personal association with them, she was not informed or advised about any considerations or issues that needed to be deliberated. The involvement of people known to her personally worked to her disadvantage, creating a false sense of security. The entire arrangement proceeded in an informal manner and later the surrogate found herself dissatisfied by the outcome, but unable to do anything since the contractual obligations did not address her expectations from the arrangement, only assurances had been given that the commissioning parents would fulfill them.

Additionally, surrogates often may not be able to anticipate matters of conflict or the need for clarifying certain terms, given the limited information made available to them, and may encounter situations as they occur subsequently. For SP4, acquiring any kind of legal aid or help would not have been possible in the first place,

I have no money for lawyers! Right now I don't work. Everything rests on my husband.

The possibility of entering into a fair contract is doubtful when the two 'parties' enter the arrangement on an unequal footing. SP4 did not possess the resources required for bargaining successfully or for seeking counsel in the same way that the commissioning parents did, in order to secure their own interests. Indeed, in SP4's case, entering the arrangement further weakened her financial state for the period of the arrangement. Unable to continue with her work otherwise, and not being paid any monthly or periodic instalments by the commissioning parents, she lost her independent source of income for the duration of the pregnancy and relied only on her husband's income.

SD2 had undertaken two surrogacy arrangements, and in both cases she and her husband signed the contract drawn up by and in the presence of the lawyer representing the commissioning parents. Each time, the content of the contract that was conveyed to them entailed focus on their complete relinquishment of the child and that the surrogate or her family would not pose any objections. Entering the arrangement through an agent the second time, there was no direct negotiation between the surrogate and the commissioning parents. Negotiation, between the surrogate and the agent, as in this case happened over payment, was not covered in any contract since the agent did not feature as a visible contracting party.

In the absence of any affordable legal aid and counseling that can be accessed by the surrogates, the contract was drawn up by the lawyers arranged for by the commissioning parents. In this scenario, only the interests of the commissioning parents would be presented and safeguarded in the contract. The question of legal aid for the surrogate then becomes a crucial one, in a situation that is disadvantaged both due to lack of resources as well as information. While the contract gives the arrangement its legal sanction, such a mechanism can be very remote for surrogates in terms of accessibility. This is reflected in SP1's experience. She stated that she had no faith in law, which she felt was placed at a great distance from her life, and that she would never approach a court of law for any redress. In such a context, making legal provisions truly helpful for surrogates requires a degree of institutional support and proactive legislation that provides access and aid to surrogates along with information about various aspects that require careful attention and consideration on their part.

Signing of the contract

Nine surrogates reported that they, along with their husbands, had signed the contract. The surrogate was not considered or given legitimacy as a signatory by herself, her husband's signature featured as a mandatory requirement for the contract, and thus requiring her to be represented as a married couple.

This condition effectively excluded any woman who was single, separated, divorced, widowed, or who, even if married, wished to enter surrogacy without the explicit consent or approval of her husband. This was seen to prevail more in Punjab, however, than in Delhi. The possibility of accommodating surrogates away from their homes in a residence arranged by the agent or in the hostel reduced the possible chances of conflict that the surrogates residing in their own homes as in Punjab were more likely to face.

At a centre in Punjab, after the doctor and the commissioning parents between them decided that SP4 would be the surrogate, even though estranged from her husband, she was asked to bring him along so that he could sign the agreement. SP4 was told that the process would be taken further only after spousal consent was obtained and confirmed.

SP4 had chosen to separate from her husband, who had a history of alcoholism and abuse. She supports her three children and also her sister by taking on domestic work and cooking. As the sole breadwinner and the head of the household, her decision to enter into a surrogacy arrangement was an independent decision motivated by the need to fulfil her responsibilities and to safeguard the interests of her children. Yet, despite the fact that the decision to become a surrogate was her own, and that she was willing to enter into the arrangement on her own,

she was expected to acquire her husband's consent as well, her choice or decision being deemed inadequate. SP4 had to approach her husband, and offered him a part of her payment to secure his consent and his signature on the agreement. This resulted in a compromised arrangement for her, in which she was consequently subjected to humiliation by her husband. It was the interest of the commissioning parents to avoid a possible conflict with the husband, and thus posing any kind of risk to the pregnancy or the baby, that prevailed over SP4's desire to be able to exercise her own autonomy.

Securing whose interests?

In all cases barring one, the surrogates were not informed about the actual clauses and the content of the contract. The 'papers' were drawn up in English; a language that most of the surrogates could neither read nor understand. The only information about what the agreement stated was provided to them verbally by any one of the other actors involved in the process – agent, commissioning parents, or doctor. The agreement was neither translated into Hindi nor any vernacular language, nor read out, leaving the surrogates with no knowledge of what they had actually agreed to undertake or perform or deliver.

Two of the surrogates said that there was mention of the remuneration in the contract, as had been told to them, but they were unaware of the exact provisions regarding payment. What was conveyed to the surrogates and their husbands in all cases was that the document stated that the surrogates agreed to give up the child(ren) after birth.

In her first surrogacy arrangement, SD2 had signed some 'papers' after the birth of the child, the content of which was explained to her as,

The signature meant that we had given the child to the couple and that no one could raise any objection. That we had no rights over the child.

According to SD3,

The agent explained after reading it [contract] that the child I will deliver is a responsibility, so that until the time I do not give birth to the child, I cannot go anywhere and I have to give it to them on time. Like it is suspected that out of love for the child, the surrogate lady may run away, so that is why it is important to sign [the contract].

Thus the contract is not a result of negotiation between two informed parties. Nor does it address various aspects of the surrogacy arrangement. Terms of payment, medical procedures, healthcare or insurance, redress in case of violation, do not find space in this document as per the understanding and information given by the surrogates. Drawing up an agreement was driven solely by the concern that no contestation of claim regarding the child should arise. Apart from the security of a signed contract that the commissioning parents procure against any contested claim over the child, the act of 'signing the papers' becomes a tool to impress upon the surrogates that they cannot backtrack from their commitment. What should be a negotiated agreement catering to the needs of both the 'parties', in reality is turned into merely a disciplinary tool for the surrogate. As AgP shared, "I have to tell them that your signature is taken and that if you refuse later to give up the child, then there will be a case against you."

Hardly geared towards gathering the surrogate's informed consent, with no discussion over the terms in the contract, the surrogates were often unaware of its significance and consequences at the time of signing. Yet the same contract possesses legitimacy and has the legal force to make the surrogate liable and to compel her to act according to the terms laid down. The commitment demanded from the surrogate under the terms of the contract is decidedly lopsided; the document secures the rights of the commissioning parents while completely neglecting the rights of the surrogates.

Table 8: Details provided by the surrogates regarding the signed contract

Surrogate	Signatories to the contract	Information provided at the time of signing the contract regarding its content
SP1	Surrogate & husband + commissioning couple	To finalize the arrangement and guarantee that she will give up the child
SP2	Surrogate & husband + commissioning father + doctor	Only the clause requiring her to have the child and to give it up was mentioned to her. Does not know if money was mentioned in the contract
SP3	Surrogate & husband + commissioning couple + doctor	Mention of money transaction (details not known to her) and surrogate's guarantee that she would give up the child
SP4	Surrogate & husband + couple (not sure about wife)	Guarantee that she would give up the child, no mention of money
SP5	No agreement signed yet	
SP6	No agreement signed yet	
SD1	Surrogate & husband	Nothing regarding the content was explained to her.
SD2	Surrogate & husband + commissioning couple	Told that it is a declaration stating that she is willing to have their child for them, that she will carry out her entire responsibility, and that she has no qualms about giving up the child. No mention of money in contract; only verbal assurance
SD3	Surrogate & husband	Contract was in English which neither she or her husband could read. The agent explained, it stated that she cannot go anywhere till the birth of the child, after which she will have to give up the child to the commissioning parents
SD4	Surrogate & aunt	Does not know the content of the contract
SD5	Surrogate & husband	Does not know the content of the contract
SD6	Surrogate & husband	Was told that she would be given money only after the baby was born. No mention of anything else, such as 25% of payment at the time of ET or extra payment in case of twins

Source: Field data, December 2011–April 2012.

The efforts made by various actors to ensure relinquishment have to be located in the prevalent social meanings and norms. Unlike the situation under other commercial arrangements, in the case of surrogacy, the meaning attached to the mother-child bond does not cohere with the meaning assigned to the usual relationship between the worker and her product; the surrogate has to separate herself from, and surrender the result of her labour, as is the case in other commercial activities, which is generally widely and uncritically accepted in capitalist society. Thus, conscious attempts are made by the other actors involved in the 'production' to ensure a complete relinquishment.

Counseling: Towards what end?

Counseling services for surrogates were unavailable in all the medical centres that were visited as part of the research study. None of the surrogates understood the concept of counselling when asked about it. On further elaboration of the concept, they said that no single person was assigned specifically for such a service at the hospitals, and that it was the doctors or the agents who spoke to them. The surrogates were also asked by the agents and the doctors to contact them if and when they had any problem. The ‘counseling’, in this respect, was not a service provided from the beginning of the surrogacy process insofar as it was designed to help the surrogates in understanding or coping with the process. Indeed, it took the shape of informal interaction and was directed towards the specific goal of creating a particular subjectivity of the surrogate to ensure her compliance with the instructions given to her, as well as strengthening her resolve of giving away the child. At various junctures throughout the pregnancy, the agent or the doctor would give the surrogate limited information or brief explanations towards this end; this will be explored in the subsequent sections.

This interaction between the doctors, agents and the surrogates is not motivated by the interests of the psychological health of the surrogate or to enable better communication with the commissioning parents that might be desirable. Instead it turns into a process of creating an experience of alienation by the surrogate, directed heavily towards enabling a smooth relinquishment of the child and thus a successful arrangement.

Denying breastfeeding and contact with the child

All the surrogates, except one, did not breastfeed the child after birth. It was explained to them that it was better for them not to breastfeed since this would prevent them from developing a bond with the child.

According to AgD, the surrogates often have queries about breastfeeding, meeting the child after birth, and maintaining contact with the commissioning parents. In his practice, AgD informs all the surrogates that they will not breastfeed the child and will be given medication to stop lactation, and that the child will be taken away after delivery while the surrogate is still unconscious.

If you have the milk, you will want to see the baby. But if you do not have the milk, you are like a normal patient. The urge to see the baby will subside.

The explanation for the practice of discouraging surrogates from breastfeeding, and even making it a standard practice to give them medication to prevent them from engaging in this activity, is to prevent surrogates from developing a bond with the child, thereby making it easier for the separation and relinquishment to take place. It is believed that breastfeeding will lead to surrogates developing affection for, and closeness with the child, and this bond is seen as resulting in their reluctance to part with the child. These views also stem from popular imagination and perceptions. It is important to note that ideas about the mother-child bond and its meanings have been constructed differently in varied contexts. The industry has created a language and visuals of the joys of motherhood and that infertile couples can now experience them too. Yet, when it comes to the surrogates the same existing bonds have to be eroded. On

the other hand, historically, women have also been employed as 'wet-nurses', where their labour was not seen in relation to their motherhood or any such bonds with the child. Thus meanings are assigned in particular contexts and situations depending on how women's reproductive labour is employed and for what purposes.

This inconsistency in the deployment of meanings can also be located in the way that breastfeeding is seen as an activity that is valued insofar as it ensures the health of both mother and child. State-sponsored campaigns encourage breastfeeding for both maternal and newborn health. However, such a concern is not even voiced in an industry that comprises medical establishments functioning as service providers. The possible merits of breastfeeding for the newborn or for the surrogate post-birth, or the surrogate's choice in the matter are neglected and the consideration that is accorded priority is that of weakening the link between the two and of securing the relinquishment of the child.

Similarly, all contact between the surrogate and the child is discouraged after birth, so that in most situations, surrogates are not permitted to hold the child, or to even see the child, or the amount of time that they spend with the child is curtailed.

AgD in his practice leaves that decision to the discretion of the commissioning parents. The duration and extent of contact between the surrogate and the child after birth is then perceived as a matter of benevolence on the part of the commissioning parents, suiting their needs and what they choose to permit in individual cases, and not as a matter over which the surrogate should be consulted.

It is at their [commissioning couple's] discretion. I don't have any objection to that. Most people say that if we show them [surrogate] the baby or let them hold it, their connection with the baby will increase. So they don't want to. Some couples decide, you deliver, take the money, that's it. The NOC [No Objection Certificate] is given in the embassy and they get the exit visa. Within two months, all formalities are completed. Birth certificate is made, passport is made, then the visa application is made after the DNA test. After that, the surrogate is called to the embassy and asked if her amount is paid and she gives an NOC.

Gestational only

Successive attempts have been made to delegitimize the surrogate's bond or identification with the child, among which defining motherhood through a particular understanding of a biological link is a widely used strategy. According to AgD,

Surrogates are donors also, but in surrogacy we do not use her [the surrogate's] egg. If she is the surrogate and we take her egg for a transfer, then it will become her baby, right? Then she may claim [the child] later. If she is clever, she will do it later, when the child is older. If the child does something (achieves something), she may be advised by some people or it might strike her to go claim the child.

Here we see a particular deployment of 'biology' where it is the genetic link that is given legitimacy over the gestational link in order to extend the claim over the child, thus undermining

the surrogate's role and dismissing her rights to the child. Is there an objective 'truth' about whether genes should count as the sole link to the child over blood and gestational labour? The point to note here is not the importance assigned to what can or should be seen as the legitimate or superior marker of identity, but rather to recognize that the attempt to create this marker is driven by certain interests alone. Whether it is the commissioning parents' gametes or the donor's gametes, there is a particular 'truth' of 'biology' defining parentage at work here, one that serves to secure the claims of the commissioning parents. This conflates directly with the interest of the industry as well, seeking to satisfy its consumers and guaranteeing no legal or any other tussles on the one hand, and being a commercially much more lucrative option, bringing in higher revenues due to higher costs of IVF technology, on the other.

Regarding the surrogate's claim on the child, another agent, AgP, states that to avoid any contestation over the child in case of multiple births, irrespective of the surrogate's link to the child, the fact that the child is not conceived from her husband (the sperm used is either that of the commissioning father or an anonymous donor) is used to undermine any claims she might make,

We tell them earlier itself that whatever happens is in the couple's fate. We tell them whether it is one or two or three, it is theirs. Even if you were to keep it, you would be the mother, but there would be no father.

It is evident from AgP's rationale that there is no monolithic notion of biology that can be an indicator of parentage, and that it is used in the surrogacy arrangement merely as a tool of control. Even when acknowledging the surrogate's link to the child, and that she could be considered a mother, AgP alludes to the existence of other social restrictions such as those of bearing children within marriage and contending that since the child would not be "biological" child of the surrogate's husband and thus there being no grounds for her keeping the child.

The desire to avoid any contestation over the child leads to medical decisions about opting for IVF over IUI (artificial insemination), even though the latter is a much less invasive technique that requires only the sperm to be injected into the surrogate's egg. IUI does not require the high level of medication and technological intervention that IVF does, and the risks to, and the effects on, the health of the surrogate are substantially lesser.

In the face of such explanations that are offered, the surrogates responded to these interpretations and ideas in different ways.

[What if you had done surrogacy with your own egg? Would you give up the child? Or do you think there is some problem with this?]

Yes, of course, I would give it up. I have no problem with this. If tomorrow I become an egg donor and if I don't have a problem with that, then why would I object to doing surrogacy with my own egg? People are just scared that if the child is half theirs [surrogates'], then they would try to make a claim on the child. The families don't want it. (SD2)

The rationale provided by the doctors for dismissing the gestational link clearly does not hold legitimacy in the eyes of all the surrogates. The surrogates do not perceive the use of oocytes as their only possible connection with the child. (This will be explored further in the next section.) According to SD2, the desire of the commissioning parents to maintain secrecy about the fact that they have opted for surrogacy leads to a general preference to maintain minimum contact with the surrogate after the birth. The attempt very often is to create a distance between the surrogate and the child as well as with the commissioning parents. For instance, during the pregnancy, SP1 was assured by the commissioning parents that they would bring the child and visit her, but she was requested not to disclose to the child the fact/truth about the surrogacy. Eventually, however, the commissioning parents broke all contact with her.

Possibilities of pluralizing kinship?

How surrogates understand their relationship with the child

The surrogates form their own views and perspective on their pregnancy, their role in the surrogacy arrangement and their relation with the child, variously appropriating and sometimes resisting the rationale provided to them by the other actors involved in the arrangement.

It is only that I have given a place. It is only a womb (ek koak hai bus), nothing else. It is someone else's, so I don't think about it. Like that film [referring to the film Chori Chori Chupke Chupke]. That is her own; this isn't mine. (SD4)

In consonance with the doctors' and agents' articulation, SD4 defines her role as that of providing the womb, while establishing no ties with the child. Further, she draws parallels with the plot of a popular Hindi movie in which the child is conceived after the husband and the surrogate engage in sexual relations, leading to a conflict over the child. On that ground, identifying the child as the surrogate's in the film, she rejects the same identification in her own case.

It is important to note at this point the context of SD4's interview, which was conducted at the surrogacy hostel under the supervision of an agent. The extent to which the rationale provided has been internalized by her is questionable given the expectation of particular responses in the presence of the agent.

SP1, on the other hand, remarked that irrespective of what the others may say, during the pregnancy, the child doesn't feel like it belongs to the commissioning parents.

SD2 was given injections to stop her from lactating so she could not breastfeed the child.

If you do not feed it [child] from the beginning, then the milk isn't formed. That is why they ask you not to keep in touch, since at times you feel like it, and the baby does too. That will cause a problem with the family, so right after the baby is born, they keep it.

SD2 explains the logic behind such a decision, which is motivated by the desire to protect the interests of the commissioning parents. However, she does not internalize or accept it,

See, no lady will think that it is someone else's child till it is with her. No lady will think that.

(Even if the oocyte is hers)?

Yes, whatever is said, while one knows it [child] is to be given, for nine months it has been in one's womb like our own baby. I make myself understand that it is to be given. But until it is in my womb, I will do everything that I did for my own children. It is my own, with all the care that I take.

For SD2, irrespective of all the explanations that are provided to her delinking her from the child to forge a separation between the surrogate and the child, the fact of carrying the child establishes relatedness.

In most cases, the child is handed over almost immediately after the birth. After the child was born, it was brought to SD2 to hold.

I said it is better to be away from the baby. She is someone else's. So why do something that will hurt me later? But the baby's real mother remains the one who gave birth to her. So the birth certificate had my name as the mother.

There is a simultaneous negotiation to create a distance from the baby at the same time as there is a negotiation to create an identification, emphasizing SD2's relatedness to the child.

I took care of the child just like I took care of my children. There can never be any difference in a mother's love, even if you have to give it [child] away. Love remains the same. Whatever feelings I had during my children's time, I have the same feelings this time around as well. Yes, definitely, [it is true] that you have to give her away. And I have to give away [the child] with happiness and not in sadness. And that is how it was.

SD2 emphasizes that while the association with the child can withstand any effort at separation, or any explanation provided for this separation, nevertheless the separation from the child is undertaken and achieved very concretely and consciously. This effort becomes part of the labour that the surrogate performs in this arrangement.

SD1 said,

I thought why think of it as another's child? One might as well think about the child as one's own. When the child goes to them [commissioning parents], then we will think of it as theirs. Right now, we are the ones who think how to walk, what to eat, what to do. If we think like that, then only we can give the child.

For SD1, the bond with the child is built on the care given by the surrogate.

SP3 described her reaction when she was told that she would not be allowed to breastfeed the baby,

I was very shocked. You develop love for the child, just like when my children were born. Even now I wish I had kept one [child]. Afterwards, we had even told them that give us one girl. But they didn't agree to it. I felt very attached to them. The day they took the

children, I had started crying. It happens, you develop feelings. I had them for nine months in my stomach. You can feel when they are playing inside you. This much I wasn't even able to feel at the time of my own children; they were born one at a time.

SP3 and SP4 both expressed a desire to keep one of the twins that they were carrying. SP3 asked the commissioning father if she could keep one child but he did not agree.

Regarding the role of surrogates and the parentage of the child, SP3 said,

The child is not from one, not two, but three people. One is commissioning father. Then there is the egg donor. And the third one is me, who has nurtured the child in the stomach for nine months. The blood that is nurturing him, that is mine, right? So there are three components from three people. For the plant to grow, you have to nurture it. It is my blood that is nurturing the child. The lawyer said that there is no law. It has not been decided who the mother is; both can be. (SP3)

According to DP3,

I don't think she [surrogate] has a right over the child. She might have a relationship with the couple later, and enquire about the child. They are not worried. They already have children. They are not doing this for children, but for the money.

DP3 pointed out that the surrogates enter the arrangement not to have another child but for monetary reasons, and that the probability of a case where the surrogate might want to keep a child is quite low. From the varied responses of the surrogates it can be surmised that despite the attempt to create a single definition of motherhood, and to establish a link with the child, surrogates come up with their own rationalizations in support of, or in opposition to it, very often reclaiming their roles. SP3, like other surrogates, resisted a singular understanding of kinship, according her gestational labour and 'nurturance' the same importance as a genetic link. This resistance emerges in response to the attempt to dismiss the surrogates' role and to alienate them from the child insofar as this is considered necessary for a successful surrogacy arrangement. Yet the acceptance of the fact of giving the child away can also be as subverting of the prevalent norms of child bearing and rearing. The surrogates strongly articulated their concerns about the nature of relinquishment and the relation with the commissioning parents and with the child after birth, explored further below.

How Surrogates Understand their relationship with the commissioning parents

At the time of entering the surrogacy arrangement and thereafter over the course of the pregnancy, most surrogates have expectations of building a relationship with the commissioning parents.

SP3 chose the centre where she was being attended to currently over another because in the latter centre she was told by the doctor that she would not be allowed to meet the commissioning parents throughout the entire process.

SD2 also expressed her dissatisfaction with the commissioning mother in her second surrogacy,

This lady only talks about what she should (regarding progress of pregnancy). The earlier lady, she used to talk to me so much. She asked me, 'when the baby is delivered and you give it to me, you will not have any problem? You are not doing this by hurting yourself, right?' I knew she will keep in touch. She used to say, 'Please don't think that I am keeping the baby and breaking away from you.' She used to say all these things on her mind, all the way from [the] UK. This [current] one doesn't do so at all.

SP4, who was in her third month of pregnancy, had not met the commissioning mother yet. Nevertheless, as she undertook the surrogacy, she had certain expectations from the commissioning parents.

Given that I am doing this huge task for them, giving them babies, they should be the ones to feel that. It is not my child. It is just that somehow the money has to be earned. We [commissioning parents] should enquire about the well-being of the one who is giving us a baby.

For SP4, the act of giving up the child is also seen in the context of a possible compensation that she may receive, that is, in being respected by the commissioning parents, and receiving their gratitude, that they will appreciate the task she is performing for them. Her expectations also rise from a previous experience in which she had given away her own child to a couple who were very grateful, and whom she also saw as caring a great deal for the child. She has repeatedly voiced her concern and even asked the doctor to speak to the commissioning mother. Despite the doctor's insistence that the commissioning mother should call up SP4 and ask about her health and how she and the child are, SP4 continues to be shunned by the commissioning parents, meeting only silence. This has led her to articulate her perception of the child as her own.

How do you feel about the child?

That it is mine! Those who don't talk to me, don't ask about how I am . . . then it is mine. Mine and my husband's. If it is their need and there wasn't a child, then they should ask if we are all right, if I need something. If they had, I would have felt good that they are concerned that it's our child. I have given my child (before). I know with such love she used to talk to me, [saying] that by giving [us] this child, you have given us life. Till the time it is inside me it is mine. I keep thinking that it is mine. If I wouldn't, then I could have done something by now [causing a miscarriage]. I would have gone and worked. They don't think like this. I think that I have to give it, but right now it is mine, so I have to be well.

The surrogate had expectations of building a relation with the commissioning parents, who would acknowledge and value her role in the arrangement by giving away the child. However, with the persisting lack of communication and relationship with the commissioning parents, her perception of the child as her own also grew stronger.

SP4's dissatisfaction also stems from the fact that she is unable to contact the commissioning parents herself. The agent is the contact person for both the surrogate and the commissioning parents, neither of whom has the contact number of the other. She also cannot meet the commissioning parents alone, but must be accompanied by the agent.

Agent [AgP] has to [take] the commission! So she has to talk to them. Doctor had said that tell them to ask SP4 how she's doing. Agent said, 'Doctor, you make them speak to me. I will talk to them.' And then she told him [doctor] that the husband [commissioning father] has my number.

SD1 (surrogate) had never spoken to or met the commissioning mother either. Her interaction with the commissioning father was limited to one meeting at the hospital in the presence of the agent, where she was unable to talk to him. Both SP4 and SD1 perceive the agent to be an inhibiting presence, always mediating the communication between the commissioning parents and the surrogate.

SD1 said,

They could say something like 'very good'. That much English we can all understand. She [commissioning mother] could have called from abroad. I would have liked that. Once they have paid me, they will say we have given the money, so there was only this much relation with us.

As a way of negotiating the fact of giving away the child, there is an expectation of continued interaction and relation with the commissioning parents. This expectation extends even after the birth and relinquishing of the child, which is seen as the end of the arrangement in most cases by the commissioning parents. The relationship between the commissioning parents and the surrogate changed significantly after the birth and once the child is given to the couple.

SD2 was placed in a separate room from the commissioning mother and the baby.

They weren't possessive about the baby or I would have felt that I had kept the baby for nine months and suddenly they have taken it and it's theirs. I had told her that you may be taking the child away but I would like to meet her. She said that it is not like once the delivery is over, you will not be able to have any relation with the child. I would like to keep a relationship with her for life. She is a good woman. (SD2)

SD2 states above that she was satisfied after she did her first surrogacy since the commissioning parents kept in touch and called her from the UK and told her about their daughter to whom SD2 had given birth. They also sent SD2 photographs of the girl. The frequency of calls, however, declined from every week to once in two months. The continued contact nevertheless exists from the side of the commissioning parents, who are also keen for SD2 to undertake a second surrogacy for them.

Contact between the two parties is controlled solely by one side, the commissioning parents. SP1 described her last attempt to contact the couple.

We had changed our [phone] number and asked him [commissioning parents' lawyer] to give them [commissioning parents] our new number. He said I have given them your number; if they don't call then I can't do anything. I asked him to give us their number so we could call [them], but he said they had told him not to give us their number.

In this case, the doctor asked SP1 to approach her if she ever wanted to know about the child. SP1, however, refused to do so, holding the commissioning parents responsible for maintaining some communication. Despite her wish to have some contact with them, she was unable to achieve that as an outcome of the arrangement. Similarly, SP3 experienced a significant change in her interaction with the commissioning parents over time after the birth. Stating her concerns, she said,

Who knows if they will stand by their word or not. They fulfilled whatever was written on the paper. Don't know about their word – whether they will fulfil it. They said they will meet. If you have any needs, we will fulfil them. They said so, but now who knows. Now they have not called, though it is three months. Earlier, when the stitches were still not opened, they used to call. From this behaviour I think they won't bother again.

SP2 in retrospect, thinks that it is better to not try and build relations with the commissioning parents, “Your child is your child . . . [but] later there won't be [any contact]. You know this is how it is with bade log [rich people]”.

SP2 accepts the reality of the unequal relation between her and the commissioning parents, and expects it to play out so, with the commissioning parents' capacity to pay and secure the arrangement in their favour.

Given the lack of information about the commissioning parents and in the absence of paperwork directly involving them, the surrogate and her family are further marginalized in the arrangement, unable to do anything. The alienation from the child and the distance between the surrogate and the commissioning parents are conditions that are unilaterally imposed on the surrogates. Additionally, within the framework of a commercial exchange, such concerns are not considered legitimate.

So why do you think people don't talk?

They must be afraid. As soon as the kids grow older, they will say that mummy didn't give birth to us. Because of this reason, they have reduced the number of their phone calls. The calls have lessened as compared to before. They don't call; we call them. I think they don't call up because of this fear only, that if they meet, then they [children] will ask who am I?(SP3)

I went mad after giving the child. I used to be very scared of the dark. I kept crying for 2-3 months that we should have never given the child away. After the delivery both the children had been admitted since it was a premature birth they were under supervision. I heard

she (commissioning mother) sat with them all day but she didn't come to see me even once. I was told the next day to leave. She came to meet me before I left. I asked her why are you sending me away so soon? She said it's better if you leave now. This time we will not repeat our mistakes. We will not sign on a wrong agreement. And we will ask to see the child. We will tell them to call after taking the child. But no one is ready to do that, they are very much concerned that the child should not get to know (SD6)

SD6 recounted that she had expressed regret after giving away the child, and her experience of the separation. Despite the problems that SD6 faced in her arrangement, however, she is considering entering into another arrangement given the financial compulsions that she faces and the responsibility of her sister's marriage that she bears imminently.

This time we will not repeat our mistakes. We will not sign a wrong agreement. And we will ask to see the child. We will tell them to call after taking the child. But no one is ready to do that. They are very much concerned that the child should not get to know.

Both SP3 and SD6 expressed a desire that the arrangement should accommodate an openness that would allow for some contact between the surrogate and the commissioning parents and the child. However, they had misgivings about this ever happening when it became clear that the commissioning parents wished to keep the surrogacy a secret and feared the child might discover the fact of surrogacy in the future.

The relinquishment of the child poses certain challenges for feminist politics and contentions for policy to resolve. The fact that it is a commercial arrangement requires the surrogate to relinquish all rights in exchange for the payment she receives. While the surrogates experience alienation from the child, there are instances where they have expectations of keeping contact and communication with commissioning parents and the child. Often there is also a desire to build a relation with the commissioning parents as a way of negotiating giving up the child. The possibility of multiple kinship relations and a more open arrangement is more desirable from the standpoint of a progressive feminist politics. Yet the extent to which a legal contract can address such concerns in the form of terms of the arrangement is doubtful, especially given the prevalent norm of complete relinquishment and no lasting contact, which is supported by the industry as well as the commissioning parents and reflected also in the existing policy framework.

Conclusion

Throughout the period of the surrogacy arrangement, efforts were made by all the actors involved to ensure the birth of a healthy child and to ensure the relinquishment of the child by the surrogate to the commissioning parents. In the context of the unprecedented nature of this practice and the prevalent notions of motherhood and the mother-child bond, these efforts were directed towards distancing the surrogates from the child, both emotionally and physically, so that they were prepared to give her away without too much difficulty or conflict.

In light of this, the practice has evolved to a point where this concern with separation and relinquishment overrode all other concerns, such as ensuring the health of the surrogate, observing the protocols of informed consent. Instead, processes such as the drawing up and the signing of the contract, counseling and the nature of the technological intervention of IVF were appropriated as tools to serve the purposes of controlling the surrogate's experience of the pregnancy and of ensuring her compliance.

As has been discussed, the contract, which established the legality of the arrangement and which settled the terms for both the 'parties' (the commissioning parents and the surrogate) involved, reaffirms and reinforces the unequal footing on which the surrogates entered the arrangement. The position of surrogates, who were already disadvantaged in terms of access to legal aid or action, in the arrangement was further weakened because of their exclusion from any negotiation, or rather the lack of it, and because of the complete lack of information about what the arrangement and the 'treatment' entailed. The contract was turned into a tool aimed at minimizing any conflict or contestation over the commissioning parents' rights to the child, leaving out a whole array of crucial issues that needed to be negotiated and settled as the terms of the arrangement. It was evident from the fact that none of the surrogates had read the agreement that they had signed, and further that they were considered legitimate signatories only when spousal consent had been acquired. The contract becomes a security for the commissioning parents while the surrogates have none, with no control over, and with no say in, the matter.

Similarly, while counseling services were extremely important for both the commissioning parents and the surrogate, they were not offered in any of the centres. 'Counseling' turns into informal interaction that the surrogates have with actors such as doctors and agents, meetings during which they receive information and explanations from a biased standpoint aimed at ensuring that the surrogates will comply with the instructions given and that they will be ready to give up the child when the time comes, and not aimed at catering to their concerns or to their psychological well-being, and not just their physiological health.

Significant decisions or requirements that are part of the treatment – such as ensuring that the surrogate has no genetic link with the child, preventing her from breastfeeding, and refusing to enable any contact post-delivery with the child – have become so-called standard practices designed to create a subjectivity of the surrogate who then cannot make any claims on the child. How necessary these practices really are and what the impact can be on the surrogate's health and on her life, and on the life of her family, are not matters of concern to the other parties in the arrangement. The current proposed policy framework looks at the arrangement, which bans genetic surrogacy and permits only gestational surrogacy, in this light.

There is a strong deployment of 'biology' here that seeks to draw linear links of kinship in order to establish the surrogate's tie to the child as inferior, and not as the legitimate relationship in deciding parentage. Such ideas of deciding what can qualify as a legitimate kinship bond and attempts at creating definitions of biological link while narrowing the definitions of relatedness reveal how science and commerce can dictate and build kinship definitions.

The surrogates, it can be seen, consciously prepare themselves for giving the child away, challenging the prevalent social meanings of child bearing and rearing that they themselves might share. At the same time, some of them also resist the attempts to dismiss their role or contribution in this kind of reproduction.

Hochschild¹ argues that 'surrogates do the emotional labour of separating themselves from the baby they carry, and from the part of their body that carries that baby.' This 'emotional labour of estrangement' remains invisibilized and unaccounted for, even though it becomes a part of their performing the labour of child bearing in this instance. 'The work that was invisible otherwise in the 'private' now comes out in [a] commercial way[,] yet the attempts to keep it under wraps with workers whom it would be easy to keep under wraps and who would not be your equals.'

Surrogacy challenges the idea that reproductive labour can be performed only in the private, familial sphere, where it is idealized in terms of motherly love and the separation of this motherly love from the market and from commerce. Surrogates gradually do make efforts to enable the separation after the birth of the child. However, many of them also resist the nature of relinquishment that often takes the shape of complete loss of contact with the commissioning parents and the child. This raises certain questions, that while as a commercial arrangement the requirement of payment for the service of a deliverable (which in the case of surrogacy is a baby) gains its legitimacy from the logic of the market. Does it also require the surrogate's complete alienation and separation from the child as well? Does the surrogate have a right to any contact and interaction with the child or with the commissioning parents or is there a possibility of some notion of relatedness with her that can take shape? Greater dilemmas also arise in deciding how surrogates' concerns and their desire for some kind of contact can materialize as part of the practice or how legal provisions can be made to address these issues.

Notes

¹ Hochschild, A. (2009). *The Back Stage of a Global Free Market*. ([//www.havenscenter.org/files/backstage_global.free.market.pdf](http://www.havenscenter.org/files/backstage_global.free.market.pdf))

CHAPTER 5

Remuneration For Surrogates: Transacting Value and Patterns

This chapter examines the remuneration that surrogates are receiving or have received. It also explores the various transactions, both monetary and material, between different actors in the study. Although information in this regard was shared by most surrogates, limited information was available from doctors and agents.

Undoubtedly, the commerce of surrogacy is the central factor that draws all the actors in the industry together—the commissioning parents, who for a price have their child through surrogacy, the surrogate, who by ‘giving’ a child is able to earn money, and the doctors, surrogacy centres, and agents, who facilitate this process for substantial returns.

The chapter examines the commonalities as well as differences with regard to payment practices and also examines the impact of the absence of standards and the inherent power inequities in the matter of payment, negotiation, and remuneration.

In the course of the research, several questions and concerns about payment for surrogacy have emerged. The discussion of payment to surrogates in surrogacy arrangements necessitates an understanding of what the ‘expected output’ is for which the payment is being made for. Within the arrangement it is observed that it is the ‘expected output’ that is central to surrogates’ remuneration. Payment is generally made on the ‘delivery’ of an ‘acceptable product’, that is, a live-born, healthy child/ren and for the relinquishment of any rights over the child/ren. However, payment should be construed as compensation for the surrogate mother’s time and effort during the entire surrogacy period—coinciding with her participation in the process of IVF, her participation in pregnancy and delivery, her experience of the risks of pregnancy and childbirth, and her loss of employment, including her inability to perform household work and her inability to earn wages during and after the surrogacy period, etc.

Surrogates’ access to information about remuneration

Details about remuneration for the surrogacy arrangements were in all instances, according to the surrogates, provided verbally. While nine of the surrogates had some information about the total remuneration that was negotiated, two surrogates, SD4 and SD5 stated that they did not have any details about their remuneration. Both of them were in surrogacy arrangements mediated by an agent through a medical tourism agency.

SD4 remarked, “So when I need 10,000 or 5,000, I take it from her [agent] and spend [it].”

SD5 said,

I don't know anything. The doctor did not speak to me. [The] monetary issue was discussed with my bhabhi [agent]. I think my

husband knows, but I have no idea about the money . . . I asked my husband to tell me about the money. He said you don't worry, everything will be fine.

SP6 stated that she was not receiving any payment for the surrogacy, since the commissioning parents were distantly related to her husband, "It is in my relations and she [the commissioning mother] is known. It feels strange to talk about money. It is like it is going to our family only.

She was certain though that the medical and other incidental expenses would be taken care of.

Table 9: Payment patterns and the amounts paid to surrogates

Surrogate code	Surrogate pregnancy status at interview	Total amount agreed (Rs), includes medical	1st installment	2nd Installment	3rd installment	Balance (Rs) - current/ after delivery
SP1	4 years since her surrogacy	3,00,000	50,000	50,000	NA	2,00,000
SP2	1 month after delivery	2,00,000	20,000	20,000	Not known	1,60,000
SP3	3 months after delivery	2,00,000	10,000	25,000	25,000	1,40,000
SP4	3 months pregnant	1,75,000	10,000	10,000	Not discussed	1,55,000
SP5	2.5 months pregnant (on medication), ET to be done	2,00,000	15,000	10,000	Not discussed	1,75,000
SP6	ET done, pregnancy yet to be confirmed	Did not discuss money; said that she was not doing it for money	NA	NA	NA	NA
SD1	3 months pregnant	3,70,000	10,000	25,000	Did not know	3,35,000
SD2	5 months pregnant (second surrogacy)	3,50,000 (current)	10,000	10,000	10,000 (10,000 every month)	2,30,000
		3,00,000 (previous)	10,000	10,000	–	2,80,000
SD3	3 months pregnant	3,70,000	10,000	25,000	–	3,35,000
SD4	2 months pregnant	Does not know	20,000 (asked for and got it)	NA	NA	NA
SD5	ET done after 2 months; pregnancy to be confirmed	Thinks husband knows but has no idea about the money.	NA	NA	NA	NA
SD6	3 years since delivery	1,10,000	27,500 25% of total amount	–	3,000 monthly (for last 3 months)	74,000

Note: The values have been calculated based on the information provided by the surrogates.

Source: Fieldwork, December 2011-April 2012

Table 9 provides details of remuneration, including installments, based on information shared by the surrogates. Surrogates who were in the beginning of their surrogacy were mostly unable to provide information about the third installment of their payment. The final balance presented

in Table 9, merely reflects the balance amount calculated based on information available to surrogates at the time of the interviews and hence may not be accurate in all cases. The remuneration for surrogates included travel and monthly expenses, which were deducted from the amount agreed upon and the balance given at the end of the surrogacy period, that is, after delivery.

Payment to surrogates was either made directly by the commissioning parents to the surrogates or was made indirectly through agents and consultants. The access of surrogates to commissioning parents and their participation in negotiations for payment were restricted, and took place only through agents or consultants, where the latter were involved. Nine surrogates from both the sites were involved in surrogacy arrangements through the intervention of agents and consultants, and all monetary transactions and negotiations were carried out by the agents. Of the remaining three surrogates, SP6 stated that she was not receiving any payment for the surrogacy (although the doctor who was involved in the arrangement refuted this claim), while SD6 and SD3 were involved in direct money transactions with the respective commissioning couple. SD2, who was in her second surrogacy arrangement, had approached AgD as she was planning to explore surrogacy in Delhi. She said that dealing directly with the commissioning parents, as she had done in the first surrogacy arrangement, was better, particularly in the context of negotiating money. She said,

You get the complete amount. The doctor takes his due and you get yours.

(Do you think there is any advantage of having an agent?)

What [is the] advantage when the agent takes the money?

(To take care [of things], for getting things?)

No. He will get a surrogate and if he pays for the expenses in the first month, he will deduct it later.

Another surrogate, SP3, echoed SD2's concern about the presence of the agent, which usually meant reduced remuneration for the surrogate due to the requirement of paying the agent's commission. Surrogates also had very little information about the amount of payment and/or commission that agents were getting, except for a common perception among several surrogates that agents were cutting into their own remuneration. As SD1 commented,

No, I don't know about that. They [agents] get a lot, and give us very little. You will have such information. They give us after making their cut. (Woh toh kaat-koot ke dengain).

Surrogates articulated their concerns about being disadvantaged monetarily when entering surrogacy arrangements through the intervention of agents. The involvement of agents prevented surrogates from dealing directly with commissioning parents, particularly on payment issues. SD2 had hoped to receive higher payment, but had to settle for less,

(Do you think you should have stuck to 4 lakhs? Did you try?) Yes, I did ask for it, but here there is an agent and he is going to give that much only. . . so it is okay.

However, direct transactions with commissioning couples did not necessarily translate into increased payments for surrogates. SD6 and SP2, who did not go through agents, received Rs

1,10,000 and Rs 2,00,000 respectively. SD6, who had done the surrogacy three years prior to the study, knew very little about the payments, “We didn’t know how much the rate was. They just gave us half of what was usually given. It was when I had started this, then I found out”.

SP2 said:

I said 2 lakhs. (How did you decide on that figure? Was there any negotiation?) I said 2 because we needed that much. They didn’t ask to reduce it.

AgD, on the other hand, pointed to the advantages of surrogates dealing with commissioning parents through agents compared with surrogates dealing with commissioning parents directly, stating the benefits that agents offer commissioning parents and surrogates alike,

Till the pregnancy is positive, the couple doesn’t say anything to them [surrogates]. They are dependent on me. Once it is positive, the couple forgets me and forgets the surrogate also. If they give me 8,000 for the diet, I will give the surrogate 5,000, but I make sure that it is spent on diet and not on something else. However, they might directly give [me] 8,000, which goes into the account and [which] might not be spent on diet. She might get anaemic, there might be bleeding. Then how can I take care [of the surrogate]? So I say, you are directly dealing [with her], so you take care [of her]. After delivery, the surrogate follows me when the money isn’t paid. Those people give surrogates gifts initially and then after delivery they don’t even turn back to ask [about her].

Payment Pattern

Yes, the money is paid on a monthly basis for the diet. Rs 10,000 after the embryo transfer. Rs 10,000 when the pregnancy is positive. And Rs 5,000 after an ultrasound. So 25,000 within one month. Rs 8,000 starts from the beginning and is ongoing. Rs 25,000 in the third month and Rs 25,000 in the sixth month. After being admitted, the surrogate gets Rs 50,000 and the balance after the delivery. However, there has not been a single case where the Rs 50,000 has been paid to the surrogate on her being admitted. The clause regarding the payment of Rs 50,000 to the surrogate on her being admitted is always ignored. At that time, they [commissioning parents] are concerned with their baby and the surrogate’s family is concerned that she is admitted. So no one pays attention to that money. After delivery, they remember that this money was to be paid.

Source: AgD’s interview

Total amount paid to surrogates

The minimum amount paid to a surrogate was Rs 1,10,000 and the maximum was Rs 3,70,000. Five surrogates received payments in the range of Rs 1,00,000 to Rs 2,00,000, while four surrogates received payments between Rs 2,00,000 and Rs 4,00,000. Four of the surrogates whose remuneration was Rs 2,00,000 and below were from Punjab, while four surrogates from Delhi received between Rs 2,00,000 and Rs 4,00,000. Access to information about the amount of remuneration paid, the payment pattern, etc. was generally through interactions with

other surrogates, which were seemingly more common in Delhi than in Punjab. These exchanges among surrogates were important sources of information that influenced the surrogates’ payment expectations as well as determined the basis for negotiations. These interstate differences may also be a result of the nature of the industry in Delhi and Punjab. The former is a global and visible destination for surrogacy, with the presence of medical tourism and with a range of national and international clientele. In Punjab, however, the industry is more nascent and catered primarily to local clientele from neighbouring states and to the overseas Punjabi diaspora. Representatives of the surrogacy centres in both Delhi and Punjab stated that they

did not have differential rates for Indians and non-Indians, or that the difference was minimal. The exception to this was in the case of the 'surrogacy package', which is essentially a payment option chosen largely by foreign nationals, and which was substantially higher. This, however, did not necessarily imply higher remuneration for the surrogates. The surrogacy package is discussed in some detail later in the chapter.

Table 10: Payment for surrogates: As per doctors and agents

Code	Punjab (in INR)	Code	Delhi (in INR)
DP2	4,00,000– 5,00,000	DD1	2,50,000 – 3,00,000
DP3	2,50,000 minimum (could be lower)	AgD	3,00,000– 3,70,000
AgP	(as low as) 1,00,000 – 1,50,000		

Intra and inter-site variations with regard to remuneration for surrogates were evident from the responses of both doctors and agents (Table 10). Remuneration amounts and installments received or those yet to be received by surrogates were arbitrary. Three doctors and one agent quoted the average payments made to surrogates as much higher (Table 10) than what the surrogates in the sample were in reality getting or had got. This was true for more than a third of the surrogates. AgP, however, stated that the payment to the surrogate,

'...depends on the 'patient' [commissioning parents]. If the patient is not rich, they give less. Sometimes they [surrogates] do it in 1,50,000 or 1,00,000, if they are poor.'

The ambiguity in the payments for surrogates was justified on the basis of claims about variation in the willingness of, and the capacity to pay on the part of the commissioning parents or the desperation of poor surrogates that restricted their freedom in negotiating for a higher payment.

Payment through installments

Surrogates explained that payments to surrogates were made in installments. They shared that generally, the first installment was made after the transfer of the embryo (ET). The second installment followed the confirmation of pregnancy and after an ultrasound. The final installment was made after the birth of the child/ren. In addition to these bulk installments, a pre-determined amount was usually paid to the surrogate for her monthly household expenses, including food, medicine, wages of a domestic worker, and other recurring costs. While this was a general pattern, there were wide variations too. SP1 and SP2 (See Table 10), for example, received two installments after embryo transfer and confirmation of pregnancy and the final payment, but no monthly expenses. Five surrogates received monthly expenses along with the above-mentioned installments, whereas SD6's request for

Remuneration Pattern

(SD2's remuneration for becoming a surrogate was Rs 3,50,000).

They said that on the day of the [embryo] transfer, we will give you Rs 10,000. If the report is positive, we will give you Rs 10,000 more. After the ultrasound, they gave me Rs 10,000 more. So, in total, they gave me Rs 30,000 in the first month. Then they asked how much money they should give me every month. I said you give me Rs 7,000, which will cover all my expenses. So they began paying me Rs 7,000. Thereafter, they called from the UK and said that they were going to pay me another Rs 3,000 every month and that I should keep a maid with that amount as they were worried about a miscarriage owing to me doing all the household chores. Then the rest of the amount they paid after nine months and after I delivered the child. Once the delivery was over, they called the lawyer and gave me the final payment for which I signed, stating that I had received the full and final payment.

Source: SD2's interview

monthly expenses was denied by the commissioning parents, who relented only in the last three months at the behest of the doctor. SD4 preferred receiving a lump sum whenever she required money rather than monthly payments as she was nervous about overspending.

From the information that was made available with regard to payments to surrogates, it was evident that the payment prior to the birth of the child(ren) was a small fraction of the total amount of the remuneration. This proportion of the payment ranged from about 20 per cent to 45 per cent. The information in this regard, particularly in the case of surrogates who were in the early stages of pregnancy, was limited or unclear. This pointed to the arbitrary payment patterns decided by the commissioning parents and to the lack of standard payment schedules and to the absence of rules and regulations to ensure the enforcement of these schedules.

Two surrogates, SP2 and SD4, however, stated that they preferred taking a 'small' amount as and when this was required, so as to ensure that there was no overspending on their part. SP2 said,

It is our choice how we want to take the money. We take it as we feel the need for it. Like 20,000 twice. We don't get it monthly. That will just reduce the money. There is no benefit in that. We will take the rest after the child is born.

Non-monetary 'payments'

In addition to making pre-negotiated payments in cash to the surrogate, some commissioning parents made additional payments and/or gave gifts, to the surrogate and her family. SD2 spoke about the commissioning parents in her first surrogacy arrangement (she is currently in her second) who gave her Rs 1,00,000 more than the agreed remuneration. SP3's commissioning parents gave her Rs 20,000 over the agreed amount, clothes for her entire family, and organized a farewell party for her. SP1's commissioning parents got a mobile phone for her husband, although, according to SP1, they drew back from their promise of taking her son abroad with them and arranging for his employment.

Surrogacy packages

One of the options that was being made available by the agent to commissioning parents was that of a surrogacy 'package', which includes a pre-negotiated lump sum to be paid by them. This package, according to the AgD was mentioned in the contract between the commissioning parents and the agent. It was inclusive of all payments – payment to the surrogate, the hospital and the doctor's charges, the agent's commission, and the payment to donors (when required). The 'package', which was determined well before the arrangement is implemented, does not specify the number of cycles nor the number of donors, and includes multiple cycles if necessary towards a successful outcome, that is, the birth of the child(ren).

According to AgD,

So in [the case of] this package, I tell them [commissioning couples] to do the pickup and give semen samples. Mostly foreigners do this and they don't stay here. So they do it in advance. Or if they are not successful, then we use a donor. Then it is taken, the embryo is fertilized, and the transfers are done. Till it is successful, we keep

getting it done. At times it can lead to a loss. Suppose there is a Rs 20,00,000 package, it might cost Rs 22,00,000 or so; Rs 2,00,000–2, 50,000 is spent on semen and on procuring eggs. They give us Rs 5,00,000 s down payment and Rs 15,00,000 after success. So at times I spend from my own pocket . . .

If there is a package of Rs 15,00,000 –20,00,000 , it is decided that I will take so much from the couple. Then I will give 3.5 or 4 lakhs to the surrogate. The couple has nothing to do with that. Suppose they agree to Rs 20,00,000 , then the surrogate may be given Rs 4,00,000. She will sign for Rs 4,00,000.

DD1 explains,

Why does the commissioning couple need agencies? They don't live in India. They need some responsible person who can look after the surrogate for nine months. Agents have only come [sic] for foreigners because they don't live in India. So they [foreigners] pay 7, 8, 9 lakhs, and tell the agents to take care of the surrogate. Surrogacy normally is [for] Rs 2, 50,000 – 3,00,000 , but with an agent it is [for] Rs 12,00,000 – Rs 13,00,000. It is not for the surrogacy. It is for the nine months and for the responsibility given [to the agent].

Surrogacy packages, as described by doctors and agents, were popular among commissioning parents of foreign origin, who preferred agents to coordinate and monitor the arrangement in their absence to its 'successful' end.

Valuation of the surrogate's services

The payment seeks to remunerate the surrogate for the 'positive outcome', that is, the birth of the child(ren), and their relinquishment thereafter. The payment thus followed a set pattern overlapping closely with the perceived industry targets of embryo transfer, positive report, confirmation through ultrasound, birth, and surrender. All primarily sought to enhance the possibilities of a 'healthy' child(ren) or in preventing the surrogate from placing the prospective child(ren) at risk.

According to SP3,

They said that I should not do any heavy work and that I should take care of myself. The chances of miscarriage in their case [twins] are more. I have to pay more attention than in a normal delivery, and work less. So I hired a domestic worker [kaamwaali]. They [couple] used to give her pay also.

The value of the surrogate's services was thus linked directly to the child(ren)'s health. Additional payments were promised to surrogates to recompense them for these 'prized' outcomes.

Payments were also higher for social characteristics that were perceived as adding value, such as the 'higher caste' of surrogates. AgP said that Rs 50,000 to Rs 1,00,000 extra is paid in case the surrogate is from a 'high' caste as requested by the commissioning parents.

Such an instrumentalist view of the surrogate's role in the arrangement was often at the cost of her health, and persisted despite the known limitation of ARTs, that is, their low success rates. SD6, who was attempting to enter into a surrogacy arrangement, described an offer that she had turned down,

Then there was another couple. They had even come to Ranchi. But I made it clear that I will take 25 per cent of the money at the time when the egg is inserted. They did not agree to that. They said they will pay only once the egg is implanted successfully. But how can that be? If they [hospital or doctor] have to do it two or three times till it happens successfully, I will not be paid for all those times? I said no. I don't want to sit around and just be paid for food. I can sit at home and eat. Why to go through this?

This account highlights SD6's understanding that multiple cycles may be required for a successful pregnancy as well as her ability to negotiate successfully. While surrogates were not always unaware of the larger conditions and consequences, their capacity to negotiate was also determined by their desperation and circumstances. Although twin or multiple pregnancies and births are not uncommon in the practice of ARTs, given that surrogacy contracts do not explicitly state the possibility of these occurrences nor mention the heightened risks involved, these (multiple) pregnancies were also perceived as valid areas for negotiation for higher/extra payment by surrogates. SD2 said that she had been told that in the case of twins she would get more money. In another instance, too, the surrogate's attempt to negotiate extra payment for twins was denied by the agent, who argued that it was the 'same case'.

Currently, the Draft ART Bill - 2010 as well as norms in practice regarding remuneration unilaterally set down by the industry, are largely favourable to surrogacy centres, doctors, and commissioning parents rather than to surrogates. Remuneration continues to be largely based on the surrogates' skills and abilities to negotiate, . However, these rules, too, are flouted by the same industry, thereby emphasizing the need for comprehensive guidelines and payment protocols for the surrogates' remuneration. Accessible systems for surrogates for redressal in case of problems/issues vis-à-vis payments also need to be put in place.

While medical procedures for the surrogacy pregnancy were provided free of cost, post pregnancy care for surrogates was not covered by commissioning parents in all cases. Any payment towards this was based on an understanding between the surrogacy centres and the commissioning parents, and was completely dependent on the decisions of the commissioning parents; current practice does not mandate coverage of medical and any other costs following the birth of the child. Any negotiations by the surrogates were rare or near impossible beyond the conventional surrogacy period.

Surrogates did not receive any coverage after the birth of the child(ren). The need for continued care and nutrition, and the requirement for support for domestic help even after the child(ren)'s birth, were completely disregarded. According to the AgD,

People [commissioning parents] give diet only for nine months. When you deliver, it is not like it is over. She [surrogate] has to return to the normal state, like she was when I first took [her for surrogacy]. I take medicines from the couple, whatever is needed after delivery also. For the next 2-2 ½ months . . .

Of the five surrogates who had given birth to child(ren) through surrogacy, three of them described their experiences of the follow-up medical treatment and costs. SP1 had a very negative experience and was forced to go to another hospital at her own cost,

No, they didn't even give any medicines. We had to buy from our own money. I went to the hospital once; they didn't give any medicine. They said once they [commissioning parents] say, then we will give it. I said but I am in pain, after the delivery.

SD2 did receive medical care following the delivery, for which she did not have to pay. SP3 said that the commissioning parents paid the costs of follow-up treatment at the hospital. Nevertheless, SP3 also forcefully expressed her thoughts in this regard,

Every woman should talk about her share clearly. You must take care of me till this time, till the time I do not get well. Shouldn't one take care [of the surrogate]? Like there are stitches; it is also through operation. Whenever I asked the doctor about the delivery, he said that all the surrogates who come, their deliveries have been done through operation only. For three months, these women suffer a lot. And for three months they should be taken care of. They [commissioning couple] should be there. They should pay for the expense of a housemaid. And if we hire someone for massage, their expense should also be taken care of.

This highlights the need for the provision of continued care to surrogates following the birth of the child(ren). Currently, post-pregnancy care was either absent or arbitrary, and generally no payment was extended to cover this period. Wherever follow-up care was available, it is limited to medical treatment related to the delivery in the hospital, for example, removal of sutures or treatment for excessive bleeding.

Payments to Other Actors

Agents

Information about payments to agents was available only from agents themselves and from surrogates. Very limited information in this regard was available from doctors and from surrogacy centres. One of the agents, AgD, said that he used to take a percentage of the payment earlier, but had shifted to a flat amount as payment, so as not to be affected by lower payment rates negotiated between surrogates and commissioning parents. He currently takes a commission of about Rs 1,00,000 from commissioning parents, and between Rs 50,000 and Rs 75,000 from surrogates,

From surrogates, I don't take payment like that. So say the diet is of 8,000, then I give her 5,000. That is how [it is done]. So they don't feel it.

In contrast to the security that the agent has against a drop in his commission, the same agent's insistence to see how well the surrogate would 'perform' in her first surrogacy with him led the surrogate to settle for a lower wage.

AgP said that her commission was usually about 35 per cent from the commissioning parents,

If they seem like they are doing fine [financially], then I charge 35 per cent. But I don't charge the surrogate. Like M... [referring to a commissioning parent] said she doesn't have that much money, so I said it's okay; I have kept my [cut] very little in this [case]. I say you do it for the surrogate, I just pray that your wish is fulfilled

Agents received cuts either from commissioning parents or from surrogates generally, but not always from both. Agents also said that they deducted an amount from the monthly payments to surrogates; at other times, their payment was a specified amount or percentage of the surrogate's remuneration.

Payments to doctors and staff of surrogacy centres

Payments to the surrogacy centres, doctors, and staff were made by commissioning parents as well as agents, but for different reasons. Surrogates had a very sketchy idea of these payments and were able to comment based on their experience of payment arrangements in which they had participated.

The doctors were not involved in any other transactions in the surrogacy arrangement. According to AgD,

There are no payments between the doctor and the agent. Neither pays the other. The doctors do not have any role to play. They take surrogates from us to develop their business. And I supply [the surrogates]. So, no give and take there. But there is some with the staff.

AgD described the rationale and the mode of payment, which was informal,

[Payment for] the people who sit outside, at the reception. If you need to get your work done quickly, you have to give them [money]. I have so many cases. I need to get work done, want appointments. They recommend and do things in our favour. With the doctor, I have a personal touch, but outside, despite a long queue, our work gets done. The medicine, credits, and all, I can pay, as I want. Between 10,000 to 25,000 is paid per case. No, only one [person] is paid from the staff; for the rest, there are parties. All are involved in that, including the doctor. Like say something is ordered from the restaurant when the surrogate delivers, or [when the] ET is successful, when the report is positive. There is one box of sweets; the rest is food from a restaurant. And wine for the male staff.

The above description throws light on how networks in the surrogacy industry were forged and sustained. These linkages extended way beyond the surrogate, and were built and sustained through formal and informal, monetary and non-monetary incentives and transactions, and through the creation of patronage, akin to the way in which other businesses were operated and maintained.

Surrogates as agents

Surrogates were also paid a commission for ‘identifying’ and ‘introducing’ other egg donors and surrogates to agents. AgP said that she gave a commission of about Rs 1,100–1,200 in the case of egg donors who received Rs 11,000–12,000 for donation. AgD paid between Rs 25,000 to Rs 40,000 to surrogates for ‘introducing’ other surrogates to him. Three surrogates stated that they had received commissions/payments for identifying and introducing donors and surrogates to agents.

According to SD2,

If it [the practice of surrogacy] spreads, then the competition will increase. When I stitched pants, in the beginning, very few people did it, and I got 25 [rupees] for a pant. And after some time, when everyone learnt to stitch, I got 11 [rupees] for the same pant. So it's the same thing. If there is more publicity, then the rate will be lower.

This presents a plausible picture of the surrogacy industry, which, like other industries, may well be subsumed by the competitive market, flagging the need for deliberation on its implications for surrogates. This issue is raised by Bailey (2011),¹ who discusses the fear that the outsourced surrogacy industry, like the garment and electronics industries, will follow the race-to-the-bottom pattern, as more and more women enter this work, supply will increase, and remuneration will fall. The surrogacy industry functions by the rules of the market and is structured by the consequences of market competition and free trade. Like in other industries, in the same policy climate, this reinforces the need for greater state responsibility for the evolution and implementation of safeguards for the protection of surrogates’ rights and health.

Surrogates had no access to payment records, receipts, or contracts, particularly with respect to monetary transactions, nor was there any system in place that provided protection to surrogates in situations that could potentially deprive them of the payment/money that was due to them. This was a matter of particular concern given that they were located at the edge of power hierarchies and power dynamics at play in surrogacy arrangements. No formal records are maintained, it seems, with regard to the payments (installment, bulk or monthly) transacted between surrogates, commissioning parents, and agents. One of the surrogates, SD2, said that the final payment that was due to her was not paid by the agent for some months and that after the delivery she had to return home, her home being in another state, not in the state where she had been residing during the period of surrogacy. She eventually received the amount from the agent after a long delay. Such incidents may not be rare and could be particularly challenging in the case of overseas commissioning parents.

AgD also described a situation in which the commissioning parents alleged that the child born was not theirs. This, according to him, was done knowingly,

Yes, knowingly, for the money. They wanted the baby but they made this allegation against the surrogate. They just wanted the surrogate to say, ‘I don’t want the money, just take your baby.’ So they paid 50,000 less.

Thus, transparent and fair contracts, access to all related records and contracts for surrogates, and systems for redress vis-à-vis payment are extremely critical matters.

It is evident that in the industry, the surrogate, although the central actor, receives extremely low 'non-negotiable' remuneration, one that is based on her vulnerability and inequitable location vis-à-vis other actors. Some have argued that the payment offered should be adequate and should be made in keeping with global remuneration levels, given that in a country like India, surrogates are invariably poor and are the source of cheap labour in the unorganized sector, characteristic of a globalizing Third World economy.

As Qadeer (2009)² states, "*There is no way to put a value on the product of the latter (a baby), except arbitrarily. Therefore, its value has to be the same as anywhere else in the world even if the Third World provides cheap human labour and technological services such as ART*". Qadeer compares the Indian situation with the US, where a surrogate receives higher remuneration and is also better provided for in terms of medical expenses, health insurance (including for her family), expenses for maternity care and clothing, and access to legal services. However, therein lies the crux of the matter – India's attraction as a global market for reproductive tourism is founded on an unregulated industry and on underpaid surrogates.

What should be the modality of calculating remuneration for surrogates? Should there be a minimum payment for surrogates? Answering these questions requires a strong understanding of the context from which surrogates are coming at the same time a robust mechanism of participation for them. It requires the inclusion of factors such as the surrogate's loss of wages for herself and for her husband, the relocation costs (in some situations) for her and her family, and the impact on her health in the short and longer terms. Hence, clarifying the ambiguities that characterize the payment arrangements for surrogates, including the laying down of guidelines for the calculation of these expenses, is an urgent and necessary matter. The current provisions in the draft legislation with regard to payment to the surrogate raise serious concerns as they reflect a skewed priority of the law when it comes to setting a value to this work, undermining the surrogate's position and her participation in the arrangement.

According to the current provisions, payment to the surrogate is to be made in five installments instead of three (Draft ART Bill - 2008), with the majority, that is, 75 per cent, to be paid as the fifth and final installment, following the delivery of the child. This is in complete contrast to the provisions or recommendations made in the previous Draft ART (Regulation) Bill and Rules - 2008, wherein the majority of the payment, that is, 75 per cent, was to be paid as the first installment, and is reflective of the skewed priority accorded to commissioning parents and agents at the expense of surrogates.

Standard protocols and transparent systems for transactions between the different actors in the surrogacy arrangement are, therefore, most urgent. They must necessarily take into account the surrogates' levels of literacy, their understanding of surrogacy and the demands this places on them, and their socio-economic status.

Remuneration from surrogacy may temporarily alleviate the difficult life and health situations experienced by surrogates, and may be a limited solution to the debilitating and systemic problems of poverty. However, the surrogacy industry like all others does not create an economy that provides an alternative solution to the poverty itself and exists within the same lop-sided norms of free market. The majority of surrogates and their husbands were in poor life and work situations, and surrogacy was an option that they felt could allow them or their family an escape route out of their immediate problems. The remuneration from surrogacy

was expected to ease the purchase of a house, to support children's education, to facilitate debt repayment, to permit mortgage settlement for the family house, to support independent living from a domineering mother-in-law or from a violent partner, etc.

Three of the surrogates planned to repeat surrogacy. SD6 was desperately looking to become a surrogate as she wanted money to get her younger sister married. SP3 was considering doing surrogacy again so that she could earn some money for herself, thus enabling her to move out of her husband's home and escape from a violent relationship. Her expectation was that surrogacy would provide her the financial support that she was not hopeful of receiving from any of her family members. SD2 had become a surrogate for the second time, having used most of her remuneration from the first surrogacy to pay off family debts. According to her,

Surrogacy is a means of securing our children's future. With the income we had before this [from stitching clothes], that would not have been possible . . . I have to look after everyone in the family. The rest of the money I can think of keeping aside for my children's needs, perhaps to spend on their education. In the future, expenses on education are also going to be high. All I would want is for them to get an education and to be able to stand on their own feet and earn for themselves. I would not want them to go through troubles like we do.

Given the surrogates' socio-economic backgrounds, it could be argued that the option of surrogacy offers these women and their families some monetary benefit. Nevertheless, the roots of the problem lie much deeper. While monetary gains make surrogacy an appealing option, or may be a survival strategy, or a way of earning an income, it does not diminish the structural injustices and realities that are often the reasons that compel poor or otherwise powerless/marginalized women to opt for surrogacy. However, as the practice stands today, there are several concerns that need to be raised and addressed urgently regarding the surrogates' place in the arrangement, their ability to negotiate the terms of the arrangement and to control the ways in which they are remunerated as well as the actual control over the earnings.

Clear guidelines regarding remuneration to surrogates need to be urgently drawn up that compensates for the surrogate mother's time and effort during the entire surrogacy period as well as for post-pregnancy follow-up and care, not restricted to medical treatment alone. The duration for support needs deliberation as does the provision of longer-term cover for surrogates for any health care needs that may arise in the future.

Notes

- ¹ Bailey, A. (2011). Reconceiving Surrogacy: Toward a Reproductive Justice Account of Indian Surrogacy. *Hypatia*, Vol. 26, No. 4: 715-741.
- ² Qadeer, I. (2009). Social and Ethical Basis of Legislation on Surrogacy: Need for Debate. *Indian Journal of Medical Ethics*, 28-31.

CHAPTER 6

Stigma: Trajectory of Negotiations and Rationalizations

This chapter analyzes how surrogates face stigma in the course of their work. In order to understand the nature and significance of the stigma attached to being a surrogate, the chapter explores the various avenues through which surrogates face stigma; how the negative reactions and social censure structures the practice of surrogacy, and how this, in turn, affects the surrogates' positions in the arrangement, and the consequences for the surrogates' lives and relationships. The chapter also examines how the surrogates' own perceptions of surrogacy has evolved.

Problem of Perception

The practice of commercial surrogacy is surrounded by an air of secrecy and often various actors such as the agents, surrogates and commissioning parents are hidden from the public eye. In this section, we examine the perception of surrogacy that evokes fear and anxiety in a way that compels surrogates to invisibilize themselves in a bid to escape the stigma attached to it.

How lack of information leads to comparisons with other stigmatized activities and contributes to stigmatization

Surrogates were apprehensive about how others perceive surrogacy and how it could affect them and their families. They feared that others may equate surrogacy to baby-selling.

If you tell others, people won't let you live. They will say things like they gave away their child; they hurl abuses at you. (SP1)

They will say she is doing it for money, selling a baby for money. Things like that may be said. They might draw the wrong conclusion. (SP3)

According to the other surrogates, the misconception that becoming a surrogate requires one to have sexual relations, combined with the assumption that a child is given in exchange for money, are the sources of the stigma. The act of bearing children outside marriage and as part of a commercial transaction goes against the dominant perception of reproduction as an activity to be performed within the private, familial space, motivated by love and care, and thus is seen as undesirable and 'immoral'.

The use of IVF technology in conceiving and implanting the embryo for a surrogate pregnancy is not widely known or understood by many people. The assumption that conception will be achieved through sexual relations leads people to compare surrogacy with sex work.

The elders do not understand such things in the first place. Like how it happens. And they misunderstand. So it's better to do your thing instead of explaining it to them. (SD2)

In this respect, the discovery of SP3's surrogacy led to an argument between her husband and his brother, who compared her surrogacy to sex work.

My brother-in-law even told my husband to take money from him and send me to him. My brother-in-law has said to him quite a few times that "you are living off your woman's earning".

Similarly, SD1 said,

In our village, they will say that we sold our child. That we earn [money] from selling (babies). People say such things. It's not good here either. People say things here as well that 'tum dhanda karte ho' (you do sex work).

SP2 and SP4 point to how in the village (*pind*) in Punjab where they reside, discovery of their being surrogates would result in their being insulted and dishonoured, and how it could even result in a possible conflict within the community.

My mother said don't do it, it doesn't seem appropriate for you. She's very scared of my brothers. Her in-laws are from the pind (village). Do you know how insulting it is there? (SP4)

If my brother comes to know, he will kill me. He loves me too much. My mother also does not know this. They will think that we have sold the baby, that just to earn money we have got into a bad business. Villagers think like that. (SP2)

SP4 also suggested to her mother that she should donate oocytes. Her mother expressed shock and dismissed the idea, stating that this was highly inappropriate given her old age and the fact that she does not stay with her husband, "How the surrogate's husband confers validation on the pregnancy."

For SD4, who is separated from her husband, the dilemma is the visibility of pregnancy outside marriage, which forced her to stay away from her family and community, "There's no man. I can't keep explaining all this to everyone, right?"

The power of such ideas of reproduction as defined by, and accepted only within, marriage is also reflected in the account of an agent, AgD, of rejecting initially a surrogate who was a widow, fearing that her family would make allegations of sexual assault against him. In this case, AgD had the woman sign a statement that she would make no such allegations. However, it was the surrogate's insistence and her own well-considered decision to enter into surrogacy that was consistent with the agent's interest, and this was what prevailed over the more dominant considerations of 'morality'.

Similarly, when SP3 convinced another woman, who was single, to become a surrogate, the agent involved, refused, saying,

How will they do it? People will ask where the baby has come from, since the husband is not there.

As discussed above, agents and doctors seek the surrogate's entry into the arrangement in a smooth and trouble-free manner, specifically the process of carrying, delivering, and relinquishing the child. To ensure this, they demand that the surrogate be married and that her husband be aware of her becoming a surrogate, so that no conflict arises later on account of objections from her family. Given that women's fertility is seen to be linked to their family and to marriage, the attempts to seek consent and gather information often place the surrogate in an inferior position vis-à-vis her husband and other members of the family, emphasizing her lack of control over her own body and choices. As AgP explains,

Tomorrow someone may say that god knows what work I make them do. So I don't take such cases. I do tell them that you speak to your husband and if he wants to speak to me, then I will. Or your mother-in-law, or someone bada. They should speak to someone, but they shouldn't do it hiding it completely (chori chupe). Sometimes there are cases where the husband-wife say that we have talked between ourselves and have agreed to do this, but they won't be telling anyone else. That is fine. No one should say anything tomorrow/ later, so you speak to someone now [in the initial stage]. We tell them that.

It was evident from the surrogates' accounts that surrogate pregnancy invited or evoked societal disapproval because it was seen as defying the norms of sexual behaviour and reproduction as constructed and followed within hetero-patriarchal institutions. Limiting women's sexual and reproductive capacities within marriage and family, the exchange of money in this context led to the labelling of surrogacy as baby-selling and sex work, both of which were also stigmatized on the basis of similar notions. Further, these ideas manifested as notions about morality and were often regulated and reinforced by the family. Despite this, however, women were choosing to push the boundaries of what was 'acceptable' and were negotiating in various ways to enter the market in an unprecedented way.

Negotiating by Invisibilizing

As discussed above, surrogates feared stigma, prejudice and negative perceptions about surrogacy, which they encountered frequently. Consequently, they attempted to invisibilize this work, often hiding the fact of being a surrogate from their families, from their neighbours, and from other community members.

Who do you tell, who do you not tell

The desire to avoid any kind of conflict and the fear of facing prejudice led surrogates to hide the pregnancy and to not talk about it to anyone. In the case of SP1, the only people who knew were her husband and her two older children. In the case of SD2, the husband and the niece knew. In the case of SD1, SD4, SD5, SD6, SP2, and SP6, only the husband was aware. SP3 had decided to not inform anyone of the surrogacy except her husband; however, the agent informed her sister-in-law, leading to a conflict between SP3 and the agent. A few months into the pregnancy, she also confided in a woman in her neighbourhood about her surrogacy. SD3 and SP4 appeared to be most open about their surrogacy, SP4 having shared this fact with her mother, sisters, estranged husband, daughter, and landlord; and SD3 with her husband, people

in her neighbourhood, and co-workers. SP4 stated that she was not afraid of anyone; as a single mother, she could not afford to be afraid; and she talked openly to everyone. Similarly, SD3 said that she generally talked to people quite openly; in her village, people understood the compulsions faced by others, so they did not pronounce any judgments or create any conflict.

While the surrogates chose not to disclose their identity as surrogates, the pregnancy nevertheless had to be explained to the people with whom they interacted on a daily basis. This often led them to create explanations for the pregnancy as well as the giving away of the child, or to make themselves physically unavailable to hide the pregnancy. Yet it was apparent that the surrogates negotiated their circumstances in different ways, assessing risks in various ways. SP4 revealed that being outside the socially accepted place of a married woman and a mother, of a wife living with her husband, she had to adopt a more assertive approach and be prepared to confront prejudice, stigma, and other difficulties as she did even otherwise in her life.

Shifting residences

SD2, who was currently in her second surrogacy arrangement, had shifted residence during both pregnancies. In her previous surrogacy, she lived in her hometown, Indore, but shifted to a separate space with her husband in the seventh month. In her present arrangement, she had moved temporarily for the duration of the pregnancy to a rented room in Delhi. Explaining their absence from home for many months, SD2 and her husband informed the family that the husband had found work for some months outside the city. SD4 and SD5 stayed in a hostel run by a medical tourism agency in Delhi. SD5 has informed her family that she had gone out of the city for work, while SD4 had informed her natal and her husband's families that she was staying with the other family.

The stigma that surrogates faced over the course of the pregnancy consequently structured the practice of surrogacy in a way that had a direct bearing on their position in the arrangement. Agents become responsible for arranging the residence, which was often in a location conducive to the supervision of surrogates. The shift to a new place, then, places surrogates under the direct control and supervision of agents, especially increasing the surrogates' dependence on agents in case of a shift to a different city or state.

SD2 chose Delhi over Indore as the site for her present arrangement because of considerations of anonymity and the desire to hide the pregnancy from her family, even though she would be paid less in Delhi than Indore. However, given the choice of receiving a larger payment and the fear of facing stigma, it is the latter that prevailed, even though it was to her disadvantage.

'Making it up, making it sell'

SP2, SP3 and SP4 had informed members of their husbands' families and their natal families that the children were their 'own' 'their husbands' and that they would be giving them away to relatives in the other side of the family. SD1 and SD6 had informed people in their respective neighbourhoods that the children were their own; after the pregnancy they said that the children were stillborn.

In all instances, it was to avoid people questioning them about the pregnancy, the fear of word spreading that they were surrogates, and the expectation of suffering disapproval, prejudice, and conflict that led the surrogates to create these explanations. In some situations, surrogates were not physically present around their families and in their neighbourhoods. In others, they simply did not inform them about the pregnancy. Others who stayed in their own homes gave the impression that they were carrying their own children to be given away to family members, an explanation that seemed plausible to everyone.

SD2 had decided to speak to other women in Indore and convince them to become surrogates and refer them to her agent. However, even in this context, she had decided that she would not inform them of having done surrogacy twice herself, and would only state that she had heard about it during her stay in Delhi.

SD1, who ran a nursing bureau, and who was in contact with many hospitals and doctors in Delhi, had kept the fact that she was a surrogate from another surrogacy agent. She had also hidden the fact that she ran a bureau from her own agent and from the medical staff at the place where she was being attended to as a surrogate. Her concern was that her other work should not suffer.

Furthermore, added precautions, such as wearing a sari when stepping out, arranging for a pick-up in a car when attending an appointment at the hospital, and staying indoors more often as the time of delivery approaches, were taken so as not to draw any attention to the pregnancy.

The invisibilizing stigma of infertility

The surrogates were not only negotiating their own circumstances while undertaking surrogacy, but were also experiencing and bearing the burden of the commissioning parents having to negotiate the stigma faced by them regarding their infertility.

They had taken a separate room. One was my room and there was another room taken. Someone had come to meet them and they had asked my husband not to come outside. Then I also got to know that they had not told anyone. They asked my husband if he had told anyone. He said that he hadn't. She was made to meet in such a way as though she had had the delivery. This means that it is still not that open. Everyone does it also, then hides it also. I also have some fear. That's why I haven't told anyone. I wonder what others will think about it – about what I have done. (SP3)

The fear of undesirable consequences and the awareness of the stigma attached to surrogacy were further intensified in this case, as SP3 encountered the attempt by the commissioning parents also to invisibilize the arrangement and SP3's role.

Her [commissioning mother's] parents had come to meet us. They were told to find out what kind of people we were. She had lied to everyone and told people in her neighbourhood that she was pregnant. As the pregnancy progressed, along with mine, I saw her belly also increasing. And then, at the time of delivery, the file was

made in her name, not mine. The doctor who came to deliver the child was not the one who had done the IVF. So when she [the doctor] came and asked for my file, she asked why someone else's name was written on it. She asked for a new file to be made in my name. So I found out in this way. Maybe she [commissioning mother] did it for her in-laws or for her children, so they don't get to know when they grow up. (SD6)

The stigma of infertility led the commissioning parents to create an elaborate pretense of pregnancy in the same way that that surrogate often sought to invisibilize her own pregnancy. SD6 revealed the complicity of the medical establishment and of the doctors involved in the arrangement in ensuring that surrogacy was wholly and entirely geared towards the convenience of the commissioning parents. Maintaining confidentiality to protect the commissioning parents could often turn into yet another service offered by the clinic, often at the expense of having to erase all evidence or indication of the surrogate's involvement in the arrangement. The lack of any records of being a surrogate, and this privileging of other interests reinforces the inferior status assigned to these women by the other actors within the hospital.

How invisibilization affects surrogates

Responses in this study

The concern about maintaining anonymity and the fear of judgment also influenced the interaction between the researcher and the surrogate during the interview, where the researcher, like others, was also perceived as one likely to formulate opinions and possibly pronounce judgment. At a hospital in Chandigarh, during the interview, SP6 emphatically stated that she was not taking money for the surrogacy arrangement. It was her attending doctor who informed us afterwards that she had come for an appointment as part of a commercial arrangement. This was yet another example of how social interaction becomes an avenue for encountering stigmatized perceptions and how surrogates respond to the same. Having to enter an arrangement that was likely to invite stigma, prejudice and social disapproval, and the desire to avoid any such negative consequences, led the surrogate to portray commercial surrogacy as altruistic surrogacy. In such a situation, the attempt to evade scrutiny led to complete invisibility and to the denial of the practice, making it even harder to access surrogates and increasing the surrogates' vulnerability. Such a practice further makes remote the possibility to maintain any checks on the practice.

Lack of acknowledgment

SP3 regretted that her surrogacy would remain unacknowledged by her family members,

No one knows that I have made such a big sacrifice. It is a sacrifice for one year. Someone will know only if I tell them. Only then will someone say to him [her son] that she has done so much for you, what have you done for her? It is something to think about. What is the point if no one knows?

SP3, whose entry into surrogacy was strongly motivated by the desire to ensure a better future for her children, also expressed her desire for recognition and that her act would be valued by

her children one day as a significant contribution made by her, although admitting the unlikelihood of such an eventuality.

Routine of invisibility: implications for psychological health

SD2 highlighted that the entire process of keeping a surrogacy under wraps itself becomes part of the surrogates' routine, such that the persistent anxiety, worry, and concern were an integral part of their experience of fulfilling this role. Does the labour of becoming a surrogate and of bearing a child also include the labour of invisibilizing it?

Here you don't sleep peacefully. You have to think so much. What if people find out there? What will they think of you? You are always tense because of that. He's [husband is] also worried constantly about this.

These psychological health consequences for surrogates are completely unaccounted for; they are neither acknowledged nor addressed in providing health care to the women during or after the pregnancy. Nor are they considered as a substantial risk and inconvenience that need to be acknowledged and compensated through care, support or wages. There was no support system to help surrogates cope with their dilemmas and concerns regarding surrogacy. While counseling could play an important part in this context, at present it was hardly made available as part of the practice.

In contrast to the visibly flourishing industry, here we see that even though the most integral part of the arrangement is to ensure the successful birth of the child, the labour that makes it possible is meticulously invisibilized, denied the 'dignity' and adequate valuation. The labour of bearing children remains invisible and unaccounted for when performed in the private sphere within the confines of the institutions of family and marriage. On crossing over to the market, despite the price that is put on it, it is still deprived of the dignity and equal worth accorded to an economically and socially productive activity mainly due to its transgression of the same norms.

Surrogates also suffer the consequences in their personal lives and relationships. SD2 remarks that although she lives with her husband, they do not discuss anything related to the surrogacy or the child. Despite the agreement to enter the arrangement, the awareness of the nature of the work has affected her relations with her husband. Faced with a similar silence in the hospital setting (as explored in the previous sections), she asks who is she expected to talk to.

SP3's surrogacy led to a grave conflict between her husband and her brother-in-law, resulting in scuffles. The atmosphere, as she described it, was one of complete hostility and abusive behaviour towards her from some other family members, despite her husband and her sister-in-law encouraging her initially to do a surrogacy in order to repay a family debt and to stabilize the family income. Similarly, SP4 had to repeatedly bear abuse from her estranged and alcoholic husband. He would turn up at her house and create a scene, screaming and castigating her for having sold herself and for selling her child.

SD2 and SP3 also reflected on the changing nature of their relationship with their husbands. SP3, during the course of the pregnancy, discovered that her husband was sexually involved with another woman, a cause of great distress for her. For SD2, the fact of having to stay away from the rest of her husband's family combined with the fact that she was earning for the

family, and that too from work that was perceived as problematic and shameful, led to occasional fights between her and her husband.

Impact on evolving the practice and surrogate's position

In most cases, the separation from the family, and having told hardly anyone about the surrogacy, reinforced the isolation of surrogates, often weakening their ability to ask for additional information or to negotiate the terms of the contract.

In some instances, such as in the case of SD1, SD3, and SD2, all located in Delhi, they had some contact with other surrogates in their locality, and reported that through their interactions had gathered information regarding various aspects of the arrangement or other actors. However, surrogates were generally discouraged from interacting with each other. Given their disadvantaged class position with which they enter the arrangement and the medical establishments that they generally found alienating, such practices have consequences on the nature of the industry where the surrogates remain invisibilized impeding their possible collectivization or organization.

Despite the burden resulting from the stigma that the surrogates bear, SD2 points out that it was the present invisibility of surrogates, and the difficulty in accessing them, that had resulted in the relatively higher remuneration that surrogates were able to receive compared to other avenues of work:

(If everyone knew about it and there was nothing to hide in it, do you think even then there is something problematic in this work?)

No, why would one think that then? If many were doing it then there would not be such problems in it. But then, if it spreads, then the competition will increase. When I stitched pants, in the beginning, very few people did it and I got 25 [rupees] for a pant and after some time when everyone learnt to stitch, I got 11 [rupees] for the same pant. So it's the same thing. If there is more publicity, then the rate will be less.

SD2, as a result of having to uproot herself from her home to hide her surrogacy from the family, was unable to find stitching work for herself and her husband for the time of the pregnancy in Delhi, a new and unfamiliar place. SD2's children had to be home schooled since they could not be enrolled in the schools in Delhi.

The cost of work wages or earnings lost and the rent of the room determine what they were actually able to earn from the surrogacy arrangement. Having to negotiate stigma can be financially taxing and disadvantaging, which is not necessarily considered when deciding the fees.

Everyday negotiations, everyday rationalizations: Why surrogates took on the challenge of facing the stigma

Material reasons

The negative perceptions of commercial surrogacy encountered by surrogates compelled them to offer various rationalizations. They were constantly negotiating between their reasons and

motivations for undertaking surrogacy, and for regarding it as an appealing option, on the one hand, and the resultant stigma, on the other hand. Emphasizing the severity and urgency of their compulsions, and at the same time differentiating surrogacy from other kinds 'dirty' or 'wrong' work, they sought to refute the stigmatized status of surrogacy. In some instances, surrogates also questioned the stigma and pointed to a class prejudice in which they saw it rooted.

We can't do much about our situation. There's not much income in our work. So whatever I am able to do for my children, I do. Whatever I am doing, it is for them. Not for myself or for my family, only for my children. After all, every parent wishes to do something good for his/her children. It is not like I am doing this because I would like to. Why would I do it if everything was fine? My home . . . I cannot even go there.

In today's world, money has the highest value. You can't step out if you don't have it in your pocket. People will pay attention only to those who have money. I have seen a lot in all my years, I have suffered a lot. Then I said no, that's it. When I heard about this, it seemed okay to me, so I said I will do it. My children will not suffer the way I have. No one is your own in today's world. I'm telling you from my experience. (SD2)

Weighed against such realities, SD2 sought to give legitimacy to her 'choice'. In the face of suffering a life marked by insecurity, this 'choice' becomes imperative for her in order to achieve a respectable and equal status in society, even if it comes at the cost of separation from her family and of having to face societal disapproval.

SP4, prioritizing her children's needs, entered into the arrangement despite her mother cautioning her against her brothers' reactions,

I am not concerned about anyone, only my children. Not even my brother[s]. Neither my brothers nor my mother is going to give me anything to eat. I have to take the injections on my own. I have to do this for my sake, for the sake of my children. (SP4)

"At least it's not sex work"

In encountering and dealing with stigma, surrogates cited the compelling reasons that motivated them to undertake surrogacy. In addition, they sought to rationalize their 'choice' and the want of social acceptance in different ways. For instance, surrogates and agents compared surrogacy with sex work, which was considered stigmatizing, to construct surrogacy as 'not an immoral activity'.

Actually, there is nothing that is wrong about it. I just keep thinking about people, that you never know how one looks at you. To steal is a wrong thing, to do a wrong work (galat kaam, meaning sex work) is also wrong. I am doing neither. The rest is all okay. These two are considered wrong in our society. (SD2)

"Science has progressed so much, so we are educated and understand. It is not wrong; it will not be done in a wrong way." SP6 similarly argues that since there were no sexual relations between her and the donor or the commissioning father, surrogacy was acceptable.

Similarly, SP3 described engaging in sexual relations as ‘wrong’, and understands surrogacy on the basis of this difference,

I don't think there is anything wrong about it, because whatever happens is in a medicalized way. If we have any disease we go to a doctor. The doctor treats us. In whatever manner and wherever . . . everything is open before the doctor. So this also has been done in front of the doctor.

Interestingly, SD3, who worked as a peer educator with sex workers, also referred to sex work as “dirty work” and had also arranged for some sex workers to go in for surrogacy arrangements. In the face of the stigma encountered by surrogates, there was a tendency among them to stigmatize their own selves for engaging in this work.

There is some anxiety/fear in people's minds about this. It happened to me as well and I thought that I would refuse to give the child.
(SP3)

Altruistic reasons: Glorification

Often surrogates also highlighted the altruism of the act of giving a child to someone, a sacrifice that they made to give this “gift” to someone. The role of the child in creating a family, and the surrogate’s role in bringing joy and satisfaction to a hitherto childless couple, were deployed to compensate for, or justify, any deviations from social norms made by the surrogates.

There is no do number ka kaam in this, and this is for the good of someone else as well. (AgP)

Earlier, my neighbour was not aware that I was a surrogate, so she started asking me what I would do with two more kids..... She said, “Whatever others say, let them say. You are doing good for someone. You should think only that you are helping someone.” She gave me confidence that it's okay. (SP3)

By suffering, maybe we will get someone's good wishes. If we give someone a child, they will definitely bless us – they have got a child from us. People go to temples and mosques and everywhere for a child. If we give a child, there is nothing greater than that. It's a very big sacrifice. You have to have strength for it also. A woman needs strength to do this. (SD5)

In facing the stigma, despite the economic vulnerability that motivated the women to become surrogates, the focus was on the altruistic dimension to make it acceptable not only to themselves but also to others.

“You cannot know”: A unique ‘choice’

SD1 points out that despite the various rationalizations offered by other surrogates, in the end the act was a straightforward financial or commercial transaction,

It's all a matter of money. What else? Everyone is not going in for this work. You are also a woman. Will you give your life over someone else? Will you bear a child and give it away? Is this your interest? Tell me, This is not out of fondness or any pleasure. For me, this is the rationale. I don't know about the rest. Because of this

money, we can do away with our misery. That's all there is to it. This is happening only because of money. There is nothing else that I can see in it. What others think of it, I don't know . . . Everyone is simply consuming their misery with this greed for money. It's nothing else. Now this thing has come. Everyone is getting something out of it. "So I'll put this in my work. Oh, I have never seen so much money before." Those who have money have nothing to fear, no troubles. And those who don't have, get ten rupees and say I have got a lot. This is the matter. (SD1)

SD1 critically points to the fact that those who are privileged will never have to face this choice. On the other hand, the implications of deciding to enter into surrogacy could be crucial to the lives of surrogates in terms of the money earned and the impact it had on their lives, and on the lives of their families. The money earned from surrogacy cannot be matched easily by the earnings from any other available avenue of income generation. She points to critical questions of who, and from what vantage point, prescribes what work is desirable and what choices are dignified, and in turn highlighting the conditions of life and work that women of a particular class inhabit in all spheres of life and the need to question what structures them so.

SP2, SP3, SP4, and SD2 have explained to other women what surrogacy was and arranged for them to be surrogates. Given the perceptions about surrogacy and the anxiety it evokes, SD2 and SP3 said that it was easier to convince the women who are likely to opt for it, given their circumstances.

SP2, however, does not consider this work, equating it with having her own children, something that she also does not consider work. According to SD2,

What you earn from your own hard work is a different thing altogether. You're working in the midst of other people and earning. That is very satisfactory. You sleep satisfied. You can just say that there is no happiness or suffering in this work [surrogacy]. Only that whoever has a need, will get that fulfilled. That's it. Have you seen that movie Gadar, the one with Sunny Deol? He says in the movie, "Life is very difficult. But you have to live." In whatever the conditions are that a person faces, if you step back, then how will you live? Whatever it is, you must face it and live.

This also shows that SD2 defines work as something that requires effort, performed socially and publicly. There is an idea of what counts or can be seen as 'work' that draws from the construction of legitimate productive activities that does not include care work, largely performed by women. Surrogacy is not seen as a form of labour within the framework of particular moral and social norms and traditionally unacknowledged labour of child bearing and rearing, and hence is not granted the dignity or respect given to other forms of labour that can be performed socially and publicly.

According to SP3,

All my problems have been resolved through surrogacy. I couldn't have got as much money as there is in this [surrogacy]. If I do stitching work, then how much do I get? Sixty rupees. Someone gives fifty rupees, someone sixty rupees. That gets spent immediately at home. This money has come as a single sum, so some has been saved

while some hasn't been. I say that it's all right. If it works, if women are doing it, then it's fine. But communication needs to be open, like I did. I am confessing that in my case, I was quite afraid and I did not communicate. Women should communicate. They should talk openly, the way I have talked about money, one should talk openly.

If women are opting for this as a 'viable choice' given their circumstances, for SP3, it is a choice as respectable as any other. She points out how self-stigmatization and fear can inhibit women from communicating their concerns and interests to the other parties in the surrogacy arrangement, and prove to be detrimental to their ability to bargain and negotiate. In light of this, strengthening their position and ability to negotiate, and asking for greater openness and exhibiting more confidence in settling the terms of the contract, were desirable actions according to her.

Conclusion

Surrogates are constantly negotiating ideas and perceptions about the nature of their work, reacting and responding, and defining what kind of use of the body is acceptable and for what reason. In each instance, surrogates have to gauge their work against existing perceptions about work and the body. When faced with the imposition of any notions of 'morality', they problematize the source of this 'morality' as based on class privileges and also emphasize their own needs and their own 'choice'. They thus effectively argue that there can be no single or absolute prescription about what kind of use of the body qualifies as 'work', which can be redefined on the basis of the existing social meanings.

Further, they face stigma because of their deviance from traditional patriarchal roles and institutions wherein reproduction is seen to be carried out in private, familial space. This stigma is heightened because of a deflected stigma attached to other occupations such as sex work. It is pertinent to ask why surrogacy is viewed and valued differently from other stigmatized work. Is there a hierarchy based on the degree of transgression? And if so, to what extent can it be made to seem acceptable? And if there is indeed such a hierarchy, is it also because of a different configuration of an industry that is simultaneously producing these meanings and references?

Within the surrogacy arrangement, the experience of facing stigma results in the curtailing of possibilities of greater participation for the surrogates. Their ability to negotiate the terms of their arrangement with other actors is severely compromised. Furthermore, any possibility of surrogates communicating with each other is effectively and deliberately eliminated. Being compelled to make surrogacy invisible in their homes, hospitals, and neighbourhoods, and being forced to maintain a distance from, and being unable to interact uninhibitedly with, commissioning parents, doctors, agents, family members, and even with each other, leads them to experience this work as a decidedly unique and isolating phenomenon. The surrogates seek to rationalize their choice as socially acceptable, deploying various cultural meanings and references to buttress their claim. The stigmatized nature of the work also very concretely disadvantages them and makes the arrangement in the current form socially undesirable. Yet the norms that are transgressed, such as the restriction of reproduction within patriarchal institutions and the assignment of gender roles, specifically those of women, are also not socially desirable. The burden of social disapproval, strained personal relations, and other difficulties arising from engaging in surrogacy means that this is a highly restricted and 'risky' option, chosen only by those who are disadvantaged and marginalized.

CHAPTER 7

Emerging Issues

Women's work and reproductive labour

Perception of work

Commercial surrogacy has brought child bearing into the domain of the market in an unprecedented manner. The prevalent norms of family and gender roles construct reproduction within the private domain of the family, as a sacred and superior space, external to the market. Commercial surrogacy poses a challenge to these ideological constructs of the family, to the perceived separation of the family from the market, and indeed to the very basis of kinship. In this scenario, women's reproductive labour is being performed in a particular configuration. The focus needs to be brought upon how the nature of this labour changes when it transgresses these norms and enters the marketplace; to scrutinize the norms as well as the rationale governing this labour once it is commercialized; and at the same time to examine how the prevalent social norms and meanings are alternately negotiated and deployed. It is important to understand that this subversion is located within an industry that is operating in a political economy context of the increasingly liberalizing economic policies of the Indian state, of an established and flourishing privatized health sector, and of the availability of women's cheap labour.

Commercializing the labour of child bearing has given rise to various explanations for the practice and to the deployment of existing social meanings assigned to reproduction. Surrogacy in its more visible articulations is accompanied and justified by a vocabulary of altruism. Conformity to certain norms is also sought in other ways.

Reproduction is regulated by certain norms and existing social hierarchies such as those of class, religion, caste which often restrict entry into and mediate institutions like marriage and family. In the case of commercial surrogacy, it can be seen that women's reproductive labour may be similarly regulated and the market can also accommodate these norms. This can be observed from practices such as having criteria for women who can become surrogates, which include being married, having had children, compulsory spousal consent as well as preferences for her social identity markers such as those of caste/religion/class.

Furthermore, right from the initial stages of the arrangement when women are considering surrogacy, there is an articulation of the nobility of the act of giving the greatest gift, that of a child, and the generosity of allowing a hitherto childless couple to experience parenthood. This articulation is used repeatedly for different purposes. In one way, it imparts an informal character to the arrangement, thereby adversely affecting the possible negotiations and

weakening the bargaining power of the surrogates in a commercial arrangement. The vocabulary of altruism also becomes a significant device when surrogates encounter stigma attached to this 'work'. It is employed by various actors involved in the practice and surrogates themselves as a process of self-rationalization in the face of the perceived *deviance*. The labour of bearing children remains invisible and unaccounted for when performed in the private sphere within the institutions of family and marriage. On crossing over to the market, despite the price that is put on it, it is still deprived of the dignity and equal worth of being an economically and socially productive activity mainly due to its transgression of the same norms.

Surrogates' own perception and understanding of surrogacy is also evolving as it interacts with existing definitions of work. While surrogates acknowledged the labour of bearing a child and of making extra efforts to take care during pregnancy, they also exhibited a degree of ambivalence when it came to looking at surrogacy as work compared to other kinds of work such as those that they were doing earlier. Some of the surrogates often equated surrogacy to child birth as in their own lives, and said that like they did not consider giving birth to their own children as work, they did not see surrogacy as work either. On the other hand, some surrogates also said that the satisfaction and respect one gets from working 'hard', from earning a living 'openly', and from being among people, as is found in other kinds of work (such as tailoring and cooking) was lacking in surrogacy, because most often they were forced to hide their identities as surrogates. Yet, from some accounts it was evident that they saw surrogacy, like other options of work, was structured by the logic of market. For instance, one surrogate compared the changing trends in garment work, where increasingly more women were employed in this homebased work driving the wage rate lower, and anticipated a similar trend in surrogacy as well.

Women's reproductive labour is performed within the institutional settings of the family and marriage within which it is granted legitimacy and recognition. Nevertheless, it occupies an invisible and unacknowledged place in our society, being excluded from the formal economy and not considered as a productive social activity. Instead, it is couched in terms of familial bonding and caring. These notions persist in the perception of surrogacy as a 'non-legitimate' option of work for women. The transgression of the prescribed norms through which reproduction is constructed, regulated otherwise, lead to the depiction of surrogacy as undignified and stigmatized work. The form of labour in a surrogacy arrangement, such as that of 'distancing' oneself from the child, also referred to as the 'emotional labour of estrangement', (Hochschild 2009¹) and the invisibilizing of the pregnancy in response to the existing stigma, also remains unacknowledged. Debates on the commodification and use of women's bodies must take into account these constructions as well.

A surrogate remarked, 'What use of the body is acceptable and where one draws the line of morality are articulations that very often come from those who are privileged and who will never have to enter into these kinds of work.' This raises questions about the ideal use of the body. Where should the line be drawn? What are the principles upholding these distinctions?

Commercial surrogacy is the most recent addition to the spectrum of avenues opening up in women's sexual and reproductive labour. Chayanika Shah locates this in the changing nature of labour post the liberalizing economic policies that have led to an upsurge in informal labour.

While decreasing public support and investment in centralized industries, 'the unorganized sector has increased greatly leading to more temporary, that operate with minimalistic controls and labour regulations, increasing urbanization but reducing urban organized sector jobs, a growth in the unorganized sector, an increased service sector leading to more temporary, contractual jobs for unskilled labour and a simultaneous reduction of traditional skilled jobs... Women have always been part of the unorganized informal sector both in the urban and the rural settings...(and) have been pushed into the newly emerging sweat shops and export zones or in the growing service sector. The new decentralized organization of the industry has structured itself on smaller units that survive due to availability of women as cheap labour in the face of this growing globalization of capital and the shrinking local avenues for jobs and resources, women from hitherto and newly marginalized communities and regions find themselves more impoverished, powerless and vulnerable. For these women, over a period of time, while access to traditional jobs and occupations have decreased, new markets have opened for both their sexual and reproductive labour' (Shah 2009)². The preference for women in such conditions of work also stems from their perception to be 'docile' workers.

Hierarchy of Valuation of Work

There is a hierarchy of valuation of female reproductive labour that can be observed through the practice of commercial surrogacy. Agents and surrogates, in their accounts, used definitions of morality and distinguished surrogacy from sex work, constructing the latter as inferior and immoral and as having less value (even monetary value) attached to it. This raises critical questions about what kinds of work are valued and how they are valued. Surrogacy as a work 'option' appeals to women from a certain class, since no other resources and avenues of support are available to them through which they can earn a similar or comparable amount of money. Within the practice, the remuneration paid to surrogates is most often decided by the other actors, such as commissioning parents, agents, and doctors, with the surrogates' ability to negotiate being compromised by the limited information made available to them and their possible discomfort with the existing stigmatized perception of surrogacy. The amount is decided based on various factors. It may be increased based on certain social identity markers possessed by surrogates, or in the case of multiple gestation, or even, more arbitrarily, depending on the place where the surrogate entered into the 'work' and the 'going rate' prevailing in that place. The amount offered for surrogacy, however, may be greater than that available or paid for other kinds of women's sexual and reproductive labour, such as sex work and bar dancing. This raises the question whether there is a hierarchy within these 'deviant' options depending on the kinds of norms transgressed, the nature and organization of the industry, and the role of the accompanying ideological constructs in establishing the same.

In the case of surrogacy, there are other factors that also influence this valuation. Most of the remuneration amount decided is paid to the surrogate after the birth of the child. This payment is understood to have successfully culminated the arrangement.

This nature of a payment structure depends on two beliefs: first, the surrogate's labour in this arrangement is only worth the payment in the form of the child borne and does not account for the gestational and emotional labour undertaken during the period of the pregnancy; two, there is a lingering suspicion that the surrogate will not take care of the child or that she may create a problem at the time of relinquishing the child, and thus holding the payment until that

time is supposed to work as a security for both the commissioning parents and the agent. The value in this case is attached to the birth and relinquishment of a healthy child.

There are other factors that operate in determining this particular valuation of labour. Following the logic of the market and the organization of production in other industries, the proportion of payment to surrogates is significantly small compared with the payments for other clinical or agency services, as can be seen through the overall cost of surrogacy packages of which the payment to surrogates form a small portion. Additionally, the amount paid to surrogates is much lower in India than in other developed countries, often making the practice in India more popular due to its low costs. This is again driven by the macroeconomic forces that result in cheap availability of women's labour. In other words, it is strictly a commercial deal where payment is for 'services' rendered on the basis of an arrangement previously arrived at by the contracting parties and in which there is no scope for becoming sentimental about the emotional repercussions of such 'work' for the surrogate.

A matter of choice

Debates on commercial surrogacy have often centred the question of women's autonomy in opting for surrogacy. It has often been presented as a 'win-win' situation. Such a view depicts surrogacy as a matter of free 'choice' on the part of individual women and is a matter of women's right over their own bodies, while completely lacking a critique of the practice as conducted in its present form. At the other end of the spectrum, surrogates have been perceived as victimized Third World women who lack agency and who, lacking any agency, are coerced into the arrangement.

Both the perspectives are problematic in that they completely obscure the processes and organization of the industry as well as the context of women's participation in it, and they also reflect an abstract notion of individual choice. It is essential to understand that no choice is unencumbered. We need to examine the conditions in which surrogates make the choice to enter into the surrogacy arrangement, the ways in which they exercise their agency, and the ways in which such possibilities can be increased.

The motivations of women to enter into commercial surrogacy arrangements stem from the emergent conditions of survival or deprivation. Their choices and engagement in this and other options of work are also steeped in their perception of their roles and responsibilities towards their children and families. Contrary to the more popular discourse of altruism of giving the gift of motherhood to an infertile woman, the idea of a good and responsible mother for their children and responsibility towards their families is what seems to be gearing women into not just considering but also, often, convincing their husbands into agreeing for them to enter such arrangements.

Some surrogates have also chosen surrogacy over other available work options, for instance, domestic work or other kinds of work that are too arduous and have long working hours, or have stated a preference for remaining at home and earning money. Their choices are thus a reflection also of the constraints of the larger context of work availability or unavailability and of the factors that influence the employability of women from a particular class and that hence structure their lives.

Additionally we need to seek to understand how often women are actually able to successfully negotiate with the families to have some control over the earnings and in what ways their relationships change as a consequence.

The access that surrogates have to their earnings from surrogacy similarly reflects the control they are able to exercise over income in the household. Surrogates negotiate their access variously, in some cases expressing a desire to create savings in their own names or entering into surrogacy arrangements repeatedly to be able to do so. In some cases, access to income is reduced because of the overall loss of wages when the husband gives up his own work during the course of the pregnancy. This could be due to the husband's own decision given the new source of income made available by the wife's surrogacy 'work', or as a consequence of the unavailability of work in the case of migration for the period of the surrogacy, or even as the result of the demands of agents to ensure that care is provided to the surrogate during the pregnancy.

It is of utmost importance to foreground the unequal footing on which women engage in this 'work', and the extent of their participation and ability to control the terms of the arrangements and the outcome. We cannot undermine the choice of individual women in entering these arrangements and negotiating their everyday compulsions and even opening up new spaces of negotiation within families. On the other hand, these choices have to be understood as embedded in coercion of limited choices, the arrangement of household responsibilities, providing and caring for children in a situation of complete lack of support and resources. For instance, the experiences of the women questions the idea of what 'risk' is acceptable, where given their 'risky' life situations they are willing to use their body as a resource in this manner, anticipating certain effects on health, however, also concerned about the degree of these effects, so that it should not in any way incapacitate them in life and that they can adequately care for their children. This 'balancing' of risks is a considered decision that is hers and taken individually and is similar to that in many other options of work where there maybe consequences for health due to poor conditions of work that exist currently. More urgent is the need to question the present scenario, where individual choices have to be made to counter the 'risk' of such life situations, where the onus of getting oneself out of an impoverished situation falls on the 'individual', normalizing the idea of seeking such solutions to structural problems and coercions.

Medical practice

The commercial surrogacy arrangement is located in health care settings characterized largely by private profit-oriented centres and hospitals offering services for infertility, including surrogacy. In this scenario, the commissioning parents have the power to set the terms of the surrogacy arrangement; their position as 'paying customers' for the services accessed is accepted as legitimate and thus privileged. This creates a perception of the surrogate as merely an appendage to the commissioning parents.

This is further amplified by the class differences that characterize the arrangements, with surrogates being able to enter the spaces of these facilities by virtue of being surrogates, spaces that are otherwise inaccessible to and unaffordable for them. The health care extended to them is conditional on their role as surrogates and on the health of the child(ren) to be born through

surrogacy. In such setups, the administration and providers are left completely unsupervised and unaccountable for situations when decisions are taken at the expense of the health of the surrogate.

The inferior status of surrogates in the surrogacy arrangement is evident from the process of information transaction, which is largely under the control of commissioning parents, hospitals, and agents. Access to, and flow of, information and participation in the decision-making process are predicated on the hierarchies of knowledge, expertise and class that structure the surrogacy arrangement.

The contract and the process of 'counseling' are tools designed to serve the interests of the commissioning parents, the hospitals and the surrogacy industry. In current practice, the contract does not embody the interests and conditions of the arrangements and are not set by all 'parties' equally. It is merely an affidavit signed by the surrogate agreeing to hand over the child after birth and to relinquish all rights over the child. Nor are all the 'parties' obligated equally through this contract., resulting in an extremely biased contractual agreement. 'Counseling', too, is practised as an informal interaction between surrogates and doctors/agents. It is aimed at building a particular perspective among surrogates that is designed to 'convince' them initially of the benevolence of becoming surrogates, and thereafter of the need to relinquish the child.

The practice is also seen to reflect compliance with, and the strengthening of, the prevailing social hierarchies by catering to the demand for specific oocytes, to the demand for specific kinds of women as surrogates based on caste, religion, or class identity, and to the demand for practices of selecting embryos on the basis of sex or against disability.

The medical practice is motivated most by the need to keep up the 'success rate' and to ensure the satisfaction of the commissioning parents, wherein the rights of the surrogates do not feature as a concern. The study revealed that several decisions taken in the course of the treatment" such as those of opting for IVF in all cases, transferring multiple embryos, performing foetal reduction, deciding on the time of delivery and preference for caesarean sections, denying surrogates to breast feed, are motivated by the concern for ensuring conception and relinquishment on the terms of the commissioning parents. The fact that these decisions translate often into unnecessary invasive procedures, can result in lasting effects on the body has no bearing. Of equal significance is the fact that while such decisions are supported by the commissioning parents' intent as well as payments for the "treatment", surrogates may find themselves left to their own selves and resources when it comes to facing and dealing with health consequences post-pregnancy.

Privileging the financial interests over considerations of surrogates' health, while evading any scrutiny by grounding all decisions in being "medically indicated", poses a great challenge to ethics of medical practice, where "treatment" for one party (infertile couples) can come at the expense of health and participation of the surrogate, who lacks the privileged status of the client. The process lacks any transparency and the use of technology, and the rationale for it, is seen to take into account the wishes of the commissioning parents. Such skewed priorities and decisions in provisioning healthcare are not surprising when the channel is that of profit-run, private enterprises that are more concerned with the satisfaction of their 'consumers' and stand completely unaccountable.

The state is just as implicated in this scenario with its gross failure to regulate this sector and instead, abetting this situation by its failure in constituting a robust public health system. Infertility is not covered under the public health system, and such services are provided mostly in the private sector, with arbitrary and questionable practices and completely bypassing supervision as described above. The other side is that women who are entering these arrangements as surrogates are attended to at private hospitals, spaces which by themselves they cannot afford to enter and ordinarily depend on the public health services that have been proven to be inadequate and insufficient. The level of medical care that they receive during their surrogate pregnancies stands in stark contrast to the services available or accessed by them at the time of their own pregnancies. In fact, often it was seen that some of their illnesses or medical conditions such as TB or anemia were detected at the time of being selected as a potential surrogate during medical screening. Are these women entitled to decent health care only when they stand to be of interest to another class of consumers? Who is responsible for their health when the paying customer is no longer available? Given the complete absence of a legal framework, the need for regulation, the need for addressing the absence of standards, ethical protocols, and practices, and the need for adopting systems for redressal and accountability in the private healthcare sector are serious and urgent concerns. Equally important is the question of state responsibility in providing access to good health care for all citizens equally.

Ideology: For legitimacy and profit

The provision of ARTs and the evolving practice which includes multiple actors is seen to be accompanied heavily by ideology and rhetoric that focuses on motherhood, parenting and bonds of kinship and family. Often in the process, definitions and meanings are variously deployed and created, to give validity and normalize seeking these services. There is a huge emphasis on the joys of motherhood/ parenthood and the possibility to 'escape' infertility that work to reinforce the existing ideas of compulsory motherhood and parenthood. The growth of the industry has been seen to be parallel to the increasing trend of a pathologizing of infertility and the industry's advertising face has often been pitched in a way to normalize seeking surrogacy.

Within the variety of "treatments", commercial surrogacy however, poses certain challenges. The transgression made possible by commercial surrogacy of the otherwise linear connections between 'biological' parenthood and 'natural' motherhood has led to a generation and deployment of ideas and vocabulary by various actors. New definitions of 'biology' are being crafted by the industry to establish what characterizes a biological link and parenthood, with alternative definitions being chosen depending on the case at hand. Various actors such as doctors and agents emphasize to the surrogates that gestating the child does not imply a biological connection. Often privilege is accorded to the genetic tie over the gestational bond in the context of surrogacy in a bid to dismiss or undermine or deny the surrogate's link with the child.

This approach is validated as 'scientific' in the name of ensuring the smooth management of the arrangement, the avoidance of contestation, and the containment of any challenge that could possibly be posed by technology or industry to the hegemony of 'nature' and 'biology' in dictating parenthood and in determining the basis of the family. Yet these rationalizations

are not consistent or logical. In cases where there may be no 'biological' link with the commissioning parents, it is their procreative intent and desire for offspring that is portrayed as the legitimate ground for associating the parentage of the child with the couple.

Doctors and agents emphasize that gestating the child does not imply a biological connection, thereby undervaluing gestational surrogacy, irrespective of whether or not the gametes belong to the commissioning parents. This claim is also reinforced through reference to the prevalent ideas of reproduction and marriage, for instance, emphasizing that the child is not conceived by the surrogate from her husband, and that therefore she cannot extend any right over the child.

More importantly, it brings to the forefront the question of whether the norms of market exchange can be negotiated against the present dismissal of the surrogate's role and of her relatedness to the child. The contract is often posed as a legal centerpiece that clinches the arrangement between two transacting parties with the final outcome seen as the complete relinquishment of the child. Can the contract then accommodate a multiplicity of kinship entailed by surrogacy?

Regulation: Policy and law

Responses to commercial surrogacy as a matter of law have included the prohibition, regulation, or legalization of non-commercial surrogacy; state-supported or state-arranged non-commercial surrogacy; and restricted access to people with certain identities (for instance, excluding people with queer identities). Approaching the regulation of the industry as a desired policy framework from a feminist perspective requires much debate and close attention to several points of conflict.

Arguments supporting the denial of any form of legalization of commercial surrogacy, including regulation, often identify the fact of gestating a child and of giving birth in exchange for money as problematic. As we have discussed in the above section, such a debate on the commodification of the body does not take into account the reproductive labour performed by the women both within and outside the market and its critique of the practice is coloured more by the preference of non-market forms of the existing institutions. Such a perspective can often misrepresent the exploitation within such non-market forms of domination and does not adequately build a critique of the prevailing economic system, including that of the family.

However, the rejection of the prohibition of commercial surrogacy as a response does not imply an uncritical acceptance of the practice in its current form. Nor does it imply choosing its legalization only because of an anticipation of its invisible, underground growth outside the purview of the law, even though this is a probable and undesirable consequence.

Similarly, the preference of non-commercial/altruistic surrogacy over commercial surrogacy raises concerns since it obscures the gravity or precariousness of the conditions in which women may enter into such arrangements, being pressured by relationships of power and the lack of autonomy to make certain choices regarding reproduction and childbearing.

The current framework for the regulation of the ART and surrogacy industry in India is the *Draft ART Bill - 2010*, formulated by the Indian Council of Medical Research (ICMR) and the

Ministry of Health and Family Welfare (MoHFW). A substantial part of the legislation comprises provisions for the regulation of surrogacy arrangements.

Regulation, it is argued, far from being an interference, provides a framework that enables the market to operate. Regulation is often sought by industry actors to safeguard and promote their interests; it is conceived as a tool to ensure the pliability and compliance of the surrogates, in this instance. For example, regulation so that surrogates are legally bound not to make decisions independently about abortion, or to part with their babies.

Although any regulatory framework is limited, its efficiency and efficacy are determined by the motivation and objective of the regulation that is sought to be carried out within its ambit, as well as by the motivation and objective of those who it seeks to benefit. A well-founded regulation that is implemented effectively may be able to allow access to key benefits for the surrogates, such as access to enhanced medical processes, access to the contents of surrogacy contracts, and access to accountability mechanisms on the part of the various actors involved.

However, it is clear that in its current form, the proposed legislation is not in the interest of the surrogates. It compromises the safeguards designed to protect the health and rights of surrogates and of the children born from surrogacy arrangements. The implications for the rights of surrogates and of the children born cannot be ignored.

The Draft ART Bill - 2010, is designed to protect the interests of the surrogacy industry, which seeks to minimize legal conflicts in its operation and management. It is decidedly in favour of commissioning parents, hospitals, and other actors. The rights of surrogates, their participation in the surrogacy process, and their ability to negotiate the terms and conditions of the surrogacy contract are curtailed in a manner similar to that seen in the case of workers engaged in other forms of market-based or market-oriented labour. The Draft ART Bill - 2010 at present constructs surrogacy as an isolated problem and proceeds to resolve conflicts engendered by the practice, a perspective that is in favour of the industry. The surrogacy industry, in effect, seeks to open up the market by removing any legal impediments in its smooth functioning.

The draft legislation displays certain inconsistencies that raise serious questions about the state's priorities. For instance, the cap on five live children by the surrogate in her lifetime stands in contrast to the state's own aggressive population control policy based on the two-child norm, which also targets mostly the same section of women. Similarly, the state's own breastfeeding campaigns for safeguarding maternal health and for reducing child and maternal mortality stand against the current prescriptive practice of denying surrogates the right to breastfeed. There are also inconsistencies in the provisions regarding access to these ART services, along with the provisions regarding adoption. Also the entire process of adoption is much more legally complicated and time consuming, with greater qualifications for those who can legally adopt a child. What are the principles being upheld by the state? This question demands serious answers and clarifications given the inconsistent policies being adopted by the Indian state.

The implementation of the policy is a matter of grave concern even as we formulate a comprehensive legal framework. How accessible will these legal provisions be for surrogates? Will adequate legal aid be available to surrogates? Will surrogates have the ability, capacity,

and opportunity to make use of these provisions in safeguarding their interests? Or is the judicial arm too remote and too inaccessible for surrogates (that is, a section of the population belonging to a certain class, caste, or gender), thereby becoming irrelevant to their lives? In this respect, policy making is only one site of feminist response.

Further, it is imperative to recognize that the unequal relations and structures driving the commercial surrogacy industry are also similar to those faced by women in other occupations as well as to those that are available to them in the current climate of liberalization, which is increasingly creating informal, insecure, and unstable options of work. As Fraser³ points out, a pertinent concern should be whether the protections ensured in one arena are consistently guaranteed in another. Being a surrogate is only one among the multiple identities, including engaging in multiple work options, of a woman. Her autonomy over her body and her decisions regarding her health, working conditions, and participation in society are structured by the constraints she faces in the different activities and spheres of her life. A feminist response to commercial surrogacy, then, effectively demands careful deliberation of, and consistent action in, these activities and spheres as well.

Notes

- ¹ Hochschild, A. (2009). The Back Stage of a Global Free Market. Retrieved 2011,15-September from <http://www.havenscenter.org/files/backstage.global.free.market.pdf>.
- ² Shah, C. (2009). Surrogate Motherhood and Women's Sexual and Reproductive Rights. *My body, My Life, My Rights: Addressing Violations of Women's Sexual and Reproductive Rights*.
- ³ Fraser, N. (2011). Between Marketisation and Social Protection: Ambivalences of Feminism in the Context of Capitalist Crisis. Lecture 3: Humanitas Visiting Professor on Women's Rights 2011 (<http://www.crash.cam.ac.uk/events/1536/>).

Glossary

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

Assisted Reproductive Technologies (ARTs): 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 outside the body, and the gametes or embryos are transferred into the uterus.

Embryo: The fertilized ovum that has begun cellular division and continued development up to the blastocyst stage till the end of eight weeks.

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

Foetal Reduction: Foetal reduction is an invasive/interventional process by which a higher order multiple pregnancy is reduced to a single or twin pregnancy in order to improve the perinatal outcome.

Gametes: Is a mature sex cell: the ovum of the female or the spermatozoon of the male.

Genetic/Traditional Surrogacy: It is an arrangement in which a woman agrees to carry and give birth to a child for another person or couple, where the surrogate is the genetic mother of the child (her ovum is fertilized by donor or commissioning father's sperm)

Gestational Surrogacy: It is an arrangement in which a woman agrees to carry and give birth to a child for another person or couple, where the surrogate's ovum is not used and a fertilized embryo is transferred into her uterus. This is done through IVF technique.

IVF-ET (In Vitro Fertilization - Embryo Transfer): In Vitro Fertilization-Embryo Transfer is the fertilization of an ovum outside the body and the transfer of the fertilized embryo to the uterus of a woman.

Insomnia: Prolonged and usually abnormal inability to obtain adequate sleep.

Intra Cytoplasmic Sperm Injection (ICSI): Injection by a micro-needle of a single sperm into an egg; followed by transfer of the egg to an incubator where fertilization takes place and then introduction of the fertilized egg into a female's uterus. Used most commonly in cases of male infertility or where the oocytes cannot be easily penetrated by sperm.

Intra Uterine Insemination (IUI): Placement of washed sperm into the uterus.

Miscarriage: A miscarriage is the loss of a foetus from natural causes before the twentieth week of pregnancy.

Multiple Pregnancies/Multiple gestation: The condition of having more than one foetus in the uterus.

Oocyte: The female sex cell (ovum) produced by the ovary, which when fertilized, produces an embryo.

Oocyte Retrieval (Egg Retrieval): Process of removal of the egg by the technique of aspiration from the ovaries.

Ovarian Cyst: A benign or malignant growth on an ovary.

Ovarian Hyper Stimulation Syndrome: OHSS is an illness caused by the drugs and hormones given to stimulate the ovaries. Excessive stimulation may cause ovarian cysts and moisture in the chest cavity or the stomach and may result in serious, even fatal, consequences. In mild cases, ovarian enlargement, abdominal distension and weight gain may occur. In severe cases women may also suffer renal impairment, liver dysfunction, thromboembolism.

Pre-implantation Genetic Diagnosis (PGD): Pre-implantation Genetic Diagnosis is a technique in which an embryo formed through in vitro fertilization is tested for specific genetic disorders or other characteristics, prior to implantation.

Preterm Birth: (Also known as premature birth): The birth of a baby before the standard period of pregnancy is completed. In most cases of human pregnancy, prematurity is considered to occur when the baby is born sooner than 37 weeks after the beginning of the last menstrual period (LMP).

Sperm: The male reproductive cell that fertilizes a woman's egg. The sperm head carries genetic material (chromosomes), the mid-piece produces energy for movement, and the long, thin tail propels the sperm.

Still Birth: A still birth is the loss of a foetus from natural causes after the 20th week of pregnancy.

ANNEXURE I

Form M2: Information on Surrogate

Draft Assisted Reproductive Technologies (Regulation) Bill and Rules - 2010

History:

12. Obstetric history
 - a. Number of deliveries
 - b. Number of abortions
 - c. Other points of note
13. Menstrual history
14. History of use of contraceptives
15. Medical history
16. Family history
17. Has she acted as surrogate earlier: Yes No
If so, how many times did it lead to a successful pregnancy?
18. History of blood transfusion
19. History of substance abuse

Investigations(1):

20. Blood group and Rh status
21. Complete blood picture
 - a. Hb
 - b. Total RBC count
 - c. Total WBC count
 - d. Differential WBC count
 - e. Platelet count
 - f. Peripheral smear
22. Random blood sugar
23. Blood urea/Serum creatinine
24. SGPT
25. Routine urine examination
26. HBsAg status
27. Hepatitis C status
28. HIV status
29. Hemoglobin A2 (for Thalassemia) status
30. HIV PCR (1):
 - a. Surrogate
 - b. Spouse
31. Any other specific test(2)

ANNEXURE II

Procedures¹

This annexure gives a brief overview of some of the medical procedures that are a part of ARTs.

In Vitro Fertilization

IVF consists of several laboratory and medical procedures. Though the finer details might vary from clinic to clinic, women undergoing IVF need to go through the following phases of “treatment”.

PHASE 1: Selection of “patients”

Most clinics and hospitals have their own criteria with regard to selection of “patients”. The criteria is laid down generally with respect to age and marital status; usually married women under 40 years of age are recommended for “treatment”.

PHASE 2: Ovarian Hyper Stimulation (OHS)

The ovaries need to be stimulated to generate more number of eggs and to facilitate this, the woman undergoing IVF is required to take hormones like Clomiphene Citrate daily from the second or third day of menstruation. Around the 9th day the woman is given hormone injection of hMG (Human Menopausal Gonadotrophin)² usually marketed as Pergonal or Humegon. This hormone helps the follicles to mature. Regular blood and urine tests are taken to check the hormone levels, and to determine the time of ovulation. A daily vaginal ultrasound scan is performed to measure the size of the follicles. When the largest follicle reaches 18 mm in diameter, hCG (Human Chorionic Gonadotrophin)³, usually marketed as Pregnyl or Profasi is administered. This is a hormone that induces ovulation. The entire hormone treatment lasts for about 17 days.

PHASE 3: Egg Retrieval

Within 24-38 hours the egg cells, which have developed, are sucked out of the follicles. This procedure is called egg-cell puncture. One of the techniques through which this is performed is Trans Vaginal Ultrasound Directed Oocyte Recovery (TUDOR). In this, the eggs are harvested through the vagina instead of via laparoscopy, which is a surgical procedure. This procedure is done under local anaesthesia and lasts about 40 minutes⁴. During this phase, sperm from the husband or donor is obtained.

PHASE 4: Treating the gametes

In this phase the sperm and egg cells are treated. The egg cells are kept for a few hours at 37 degree Celsius to incubate/develop. The semen if provided by the partner is prepared for fertilization by removing inactive cells and seminal fluid. Or a donor sperm is used. Sperm selection and manipulation take place in this phase.

PHASE 5: Fertilization

Within a few hours of the above-mentioned process of egg cell puncture, the egg is put together with sperm in a petri dish in a culture medium, for fertilization to take place.

PHASE 6: Embryo Transplantation

Once the fertilized egg cell splits from a single cell into a two to four to eight-cell stage, it is ready to be transferred into the woman's uterus, where normal gestation follows. This replacement/transfer happens about three days after fertilization. There is a very short period when egg cells can be fertilized, therefore to improve the chance of a successful pregnancy, more eggs are retrieved, fertilized and usually multiple embryos are replaced. As more than one embryo is transferred there are chances of multiple pregnancies. In such cases the woman might have to undergo foetal reduction.

Intra Cytoplasmic Sperm Injection (ICSI)

Intra Cytoplasmic Sperm Injection (ICSI) is an IVF procedure in which a single sperm is injected directly into the cytoplasm of the egg. This technique is used in cases of severe male infertility, including very low sperm count; immotile sperm; and sperm which cannot penetrate the chemical barrier which protects the egg. It is also used in cases where women are unable to conceive due to closed tubes. Sperm can be extracted directly from testis where ejaculation is not possible.

- The ovum is acquired as in IVF. For this the woman undergoes OHS and then the eggs are retrieved.
- Once the eggs are retrieved, the sperm is acquired through :
 - Microscopic epididymal sperm aspiration (MESA): procedure in which spermatozoa are obtained from the epididymis, by either aspiration or surgical excision.
 - Testicular sperm aspiration (TESA): procedure in which spermatozoa are obtained directly from the testicle, by either aspiration or surgical excision of testicular tissue.
- The sperm is then selected and manipulated before injecting.
- The sperm is injected into the oocyte under a microscope using micromanipulation devices.
- After this procedure, the oocyte is placed into cell culture and checked on in the following days for fertilization.
- After fertilization the embryo is transferred into the uterus for gestation.

Intra Uterine Insemination (IUI)

Intra Uterine Insemination (IUI) is the simplest form of assisted reproduction. It entails sperm being deposited in a woman's vagina close to the cervix. This procedure includes artificial insemination using either the semen of the male partner, typically referred to as artificial insemination husband's sperm (AIH), or artificial insemination by donor sperm (AID). During one menstrual cycle women are inseminated 3-4 times.

- The first step in IUI is hyper stimulating the ovaries through drug treatment to encourage multiple eggs to mature.
- At the appropriate time when ovulation has been induced, prepared sperms are injected into the uterus twice, at 24 and 48 hours after the injection of hCG.
- After insemination is done, hormone (hCG) injections continue till after 12th week of gestation or till the test for pregnancy comes out to be negative pregnancy test.

Notes

- ¹ Edited and referenced from 'ARTs and Women: Assistance in Reproduction or Subjugation?' Sama. (2006). pp. 117-119.
- ² Gonadotrophin is any of the several hormones synthesized and released in the pituitary gland that acts on testes or ovaries to promote production of sex hormones and sperm or ova (Oxford concise medical dictionary, 1998)
- ³ HCG is a hormone similar to the pituitary gonadotrophin. It is given by injection to treat delayed puberty, undescended testes, premenstrual tension and sterility due to lack of ovulation. (Oxford concise medical dictionary, 1998)
- ⁴ Gupta, J.A. (2000). *New Reproductive Technologies, Women's Health and Autonomy, Freedom or Dependency?* Sage Publications. India, 2000

ANNEXURE III

Side effects and complications of the drugs and procedures¹

Reporting of adverse side-effects of ART has been conducted in very casual terms and no systematic attempt has been made to document the short- and long-term side effects of these technologies. This is because these side-effects are often considered to be insignificant when weighed against the urge to have one's own child.

However, this negligent attitude towards health risks for women is not specific to the arena of ARTs. Between the 1940s to the 1970s, diethylstilberol (DES) was administered to pregnant women in order to prevent spontaneous abortions. But this was done without adequate information regarding the potential side effects of this drug. Disastrous consequences were reported. Daughters of women who took DES suffer cancer of the vagina and cervix at a rate higher than that of daughters of women who did not take DES. Other side effects include increased rates of infertility, spontaneous abortions and ectopic pregnancies. Moreover, even after such a long time span, women who took DES suffer from 40 per cent to 50 per cent higher rates of breast cancer even today².

The Dalkon Shield case is another example of this neglect. The Dalkon Shield was an intrauterine contraceptive device, extensively marketed in the United States in the 1970s. It was inserted in numerous women worldwide, again without being researched thoroughly for potential side effects. Complications, compiled after administration, were numerous. These included severe haemorrhaging, miscarriages, ectopic pregnancies, infertility, mutilated reproductive organs, and even death in some cases³.

There is not much literature available on the health risks associated with ARTs. The short-term and specifically long-term side effects of the drugs used and the complications associated with the procedures have also not been studied in depth. A WHO Summary Report⁴ 1990 defines IVF as experimental and takes the position that no new technology should become an accepted medical practice until it has undergone a thorough and scientific evaluation which has not been the case with ARTs. The U.S. Office of Technology Assessment (OTA)⁵ issued the report "Infertility: Medical and Social Choice" listing ovarian hyper stimulation, ectopic pregnancy, miscarriage and pre-term birth as some of the common complications resulting during IVF treatment. The medical procedures used in infertility programmes for oocyte retrieval, foetal reduction and embryo implantation are also associated with a wide variety of complications. In addition to the procedures, the drugs used for treatment also have major side effects. The clinics often overlook or underplay the associated health risks while providing information to the women undergoing these treatments.

An informal review of medical literature suggests that many physical side effects of ARTs are directly related to the drugs used to stimulate the ovaries to produce more eggs. In the following

section, we made an attempt to highlight some of the side effects and complications of the drugs and procedures. However, this annexure is merely a summary of some of the essential health risks posed by ARTs. It is not a comprehensive account of the medical implications of these technologies.

One of the most commonly used drugs in fertility treatment is Lupron. It is often used to “shut down” a woman’s ovaries for egg retrieval and has been associated with a range of problems like depression, rashes, chest pain, hot flashes, itching, amnesia, nausea, hypertension, thyroid abnormalities, difficulty in breathing, fainting, weakness, asthma, dimness of vision, bone aches, loss of memory, insomnia and so on. It has United States Food and Drug Administration approval only for the pre-operative management of patients with fibroids and anaemia, and for treatment of endometriosis. Data supporting its use for egg retrieval have not been submitted to any regulatory body. Overuse of Lupron may result in osteoporosis. In the U.S., Linda Abend started a National Lupron Victims Network after her sister was hospitalized with seizures along with debilitating bone and muscle pain while taking Lupron in 1991⁶.

Some drugs like Clomid and Pergonal, are used not only in relation with IVF but also to stimulate multiple egg production. This can result in multiple pregnancies which are high risk. One well-known instance in the U.S. was of the Frustaci septuplets. Four of these babies died within four months and the surviving three were left with lifelong disabilities including cerebral palsy and severe developmental disabilities. Although they were not born of IVF, their birth illustrates the problems that result when women are placed on fertility drugs⁷.

Some of the major health risks associated with these drugs are as follows:

Ovarian Hyper Stimulation Syndrome (OHSS)

The most important risk during the phase of artificial stimulation of the ovaries is OHSS. OHSS is caused by the drugs and hormones given to stimulate the ovaries. Excessive stimulation may cause ovarian cysts and moisture in the chest cavity or the stomach and may result in serious, even fatal, consequences⁸. In mild cases, ovarian enlargement, abdominal distension and weight gain may occur. In severe cases women may also suffer renal impairment, liver dysfunction, thromboembolism. OHSS can result in death⁹.

Ovarian twisting

An over-stimulated ovary can twist on itself, cutting off its own blood supply. Surgery is required to untwist or even remove the ovary.

Increased risk of cancers

The question of whether women exposed to fertility drugs face an increased risk of cancers has attracted a lot of attention with many small studies suggesting that women on IVF have a higher risk of cancers of the breast, ovary and uterus compared with the numbers expected among women of the same age in the general population. Some studies assert that ovulation induction may be a risk factor for certain types of hormone-dependent cancers. Researchers have associated excessive estrogen secretion with ovarian and breast carcinoma, and gonadotrophin secretion with ovarian cancer¹⁰. Studies indicate that hormones play a major

role in the development of several human cancers. The ability of hormones to stimulate cell division in certain organs, such as the breast, endometrium, and the ovary, may lead to the accumulation of random genetic errors that ultimately produce cancer. Hence, techniques such as IVF that rely on massive doses of hormones may be quite dangerous¹¹.

The drug Tamoxifen used extensively in the treatment of breast cancer carries a slightly increased risk of endometrial cancer. As it has similar properties to the fertility drug Clomiphene, there is a concern that women who use Clomiphene for long periods might have an increased risk of endometrial cancer. Also many women who seek fertility treatment do not ovulate regularly on their own and face an increased risk of endometrial cancer owing to the imbalance between estrogen and progesterone levels¹².

The following table summarizes some of the drugs which were used for ovarian stimulation / egg extraction and their long-term effects:

S.No	Drug	Side Effects
1.	Fertomid	Ovarian enlargement, hot flushes, abdominal discomfort, birth defects, ovarian hyperstimulation syndrome, multiple pregnancy and ectopic pregnancy, hair thinning, visual blurring, breast discomfort, depression, ocular toxicity. <i>Ref: Monthly Index of Medical Specialities , MIMS, Vol 26 Number 2, Feb 2006</i>
2.	Profasi	Oedema, headache, mood changes, tiredness, sensitivity reactions, sexual precocity, ovarian ascities, pleural effusion, ovarian cyst rupture, multiple births, arterial thromboembolism, depression, restlessness. <i>Ref: Hormones, Trophic Hormones & Related Drugs, MIMS, Volume 26 Number 3, March, 2006</i>
3.	Pubergen	Oedema, headache, mood changes, tiredness, sensitivity reactions, sexual precocity, ovarian hyperstimulation or enlargement, ovarian cyst rupture, multiple births, arterial thromboembolism, depression, restlessness. <i>Ref: Hormones, Hyper & Hypo- glycaemics, MIMS, Volume 26 Number 3, March, 2006</i>
4.	Metformin	Nausea, vomiting, gas, bloating, diarrhoea and loss of appetite, lactic acidosis, general malaise, fatigue and occasional aches, gastrointestinal disturbance, vitamin b12 mal absorption, anemia, liver or kidney problems, hair loss, lactic acidosis, bile abnormalities. http://www.medicinenet.com/metformin/article.htm
5.	Cetrotide	Serum Injection site reactions, ovarian hyperstimulation syndrome, headache, nausea, elevated enzymes (e.g., alkaline phosphates) <i>Ref: Hormones, Hyper & Hypo- glycaemics, MIMS, Volume 26 Number 3, March, 2006</i>
6.	Clomiphene	Citrate Include hot flushes, blurring of vision, abdominal discomfort, ovarian enlargement, nausea, vomiting, breast soreness, depression and allergic dermatitis. <i>Ref: Hormones, Trophic hormones & related drugs, MIMS, Volume 26 Number 3, March, 2006</i>
7.	Gonal - F	Sensitivity reactions, multiple pregnancy, thrombo-embolism, Acne, injection site irritation, fatigue, breast tenderness, ovarian enlargement or cysts, G-I upset, headache, distention, gynacomastia. <i>Ref: Hormones, Trophic hormones & related drugs, MIMS, Volume 26 Number 3, March, 2006</i>
8.	Gonotrop F	OHSS with pulmonary and vascular complications, ovarian enlargement or cysts or rupture, abdominal pain), local reactions, multiple pregnancies. <i>Ref: Hormones, Trophic hormones & related drugs, MIMS, Volume 26 Number 3, March, 2006</i>
9.	Pergonal- 75	Sensitivity reactions, ovarian enlargement or cysts or rupture, multiple pregnancies, abdominal pain, G-I upset, hemopritoneum. <i>Ref: Hormones, Trophic hormones & related drugs, MIMS, Volume 26 Number 3, March, 2006</i>
10.	Pregnyl	Headache, tiredness, changes in mood, irritation in area of use, abnormal enlargement of breasts in men (gynaecomastia), over stimulation of the ovaries causing production of many ova in the woman, excessive fluid retention in the body tissues, resulting in swelling (oedema), pregnancy with two or more foetuses. <i>Ref: Hormones, Trophic hormones & related drugs, MIMS, Volume 26 Number 3, March, 2006</i>

11.	Puregon	Over stimulation of the ovaries causing production of many ova in the woman, blood clots in the blood vessels (thrombosis) that may detach and travel in the circulation to another area of the body (thromboembolism), pregnancy with two or more foetuses, pain, soreness or bruising at the injection site. http://www.appco.com.au/appguide/drug
12.	Human Menopausal Gonadotrophin (HMG)	Weariness, mood changes, hot flushes, nausea and headaches, increased pelvic pressure/pain, high risk of miscarriage, ovarian enlargement, abdominal pain. www.bchealthguide.org/kbase/topic/detail/drug/

Risks with the procedures

Apart from the drug-related side effects and risks, there are also risks or surgical complications in relation to the various procedures that are a part of IVF. Procedures normally used for egg retrieval are laparoscopy and ultrasound-guided oocyte retrieval or Transvaginal Ultrasound Aspiration. Although there are few data about the hazards associated with these two procedures, the general risks from laparoscopy include bleeding from the ovary or from adjacent pelvic structure and abdominal wall, and pelvic infection is also common. Laparoscopy is conducted under anaesthesia and the associated risks are allergic rashes, temporary paralysis, vomiting and even, in more extreme cases, death. Patients who have had previous surgery (and this applies to many requiring ARTs) may have bowel adhesions. This increases the risk of injury to the bowel.

Another risk is that the carbon dioxide gas that is placed into the abdomen during laparoscopy may not all be expelled at the end of the operation; again this is more common in patients with adhesions. This may provide some discomfort under the ribs or in the shoulder.

Transvaginal Ultrasound Aspiration might cause undetected bleeding. Symptoms should be noted within six hours and nursing observation must be carried out for this period of time.

Another procedure used for egg retrieval, Transvaginal Ultrasound Directed Oocyte Recovery (TUDOR), can result in pain, bleeding, or damage to internal organs, swelling in the pelvic area and infections in the vagina and bladder.

Ectopic pregnancies

Up to eight per cent of pregnancies achieved by IVF may be ectopic, with the consequent dangers of haemorrhage and even death. Emergency laparotomy may be necessary, with its attendant risks. However, most “patients” are closely monitored with ultrasounds and ectopic pregnancies are identified before they can cause complications. Fewer ectopic pregnancies are seen in GIFT/ZIFT. Occasionally women can have multiple ectopic pregnancy in two different sites which may prove dangerous¹³. Studies also show that five to seven per cent of all IVF pregnancies implant outside the uterus¹⁴.

Multiple gestation pregnancies

Multiple gestation pregnancies have been found to occur in up to 25 per cent of ART pregnancies while they occur in only two per cent in the general population¹⁵. Multiple-birth pregnancies increase the danger of miscarriages, caesarean sections, early labour, and placental dysfunction. High order multiple gestation pregnancies are associated with an increased risk of pregnancy

loss, premature delivery, abnormalities in the infant, pregnancy-induced hypertension, haemorrhage, and other significant maternal complications.

Spontaneous Abortions

The rate of spontaneous abortion increases with increasing age of the mother and in multiple pregnancies, especially with three or four foetuses. 20 – 35 per cent of such pregnancies result in spontaneous abortions.

Risks of foetal reduction

Multiple gestation pregnancies are a complication of infertility drugs and treatments. The continued use of fertility drugs and the implantation of more than one embryo to improve success rates can pose a risk to the mother and foetus. Multiple gestation pregnancy is one such complication. Foetal reduction is used to selectively terminate foetuses in multiple gestation pregnancies. A saline solution is injected into the uterus to abort some foetuses. This can cause uterine bleeding, infection, premature labour and loss of all foetuses¹⁶. One hazardous technique is used to correct a problem which is the result of the use of another faulty technique.

Risks of multiple pregnancies

Obstetrically, carrying two babies places greater pressures on the pregnant woman. There is an increased risk of miscarriage, obstetric complications, premature deliveries and birth complications. Maternal morbidity is seven times higher in multiple pregnancies than in singletons¹⁷.

Risks on Children

However, the adverse side-effects of ART are not limited to women but also affect children born through these procedures. Most important risk to the baby results from multiple pregnancy. The Rate of premature delivery increases from 7 per cent with a single gestation to 41 per cent with twins and to 93 per cent with triplets. Thus many IVF programs have now reduced the number of embryos transferred. The risk of congenital and chromosomal anomalies seems similar in IVF and naturally conceived children. This risk is not increased after transfer of thawed embryos but is influenced by female age and multiple pregnancies.

Concerns have been raised about the safety of ICSI in two areas: genetics and child development. Men with abnormal sperm production have an increased rate of sex chromosome anomalies, presumably increasing the potential for transmission of sex chromosome anomalies to the offspring. Another concern is child development. Though no difference has been noted between IVF and general population up to the age of 13 years however a small study from Australia suggests that the Bayley score at one year is statistically significantly lower after ICSI conceived compared with IVF conceived and naturally conceived children.

Notes

¹ Edited and referenced from 'ARTs and Women: Assistance in Reproduction or Subjugation?' Sama. 2006. pp. 120-127.

- ² Inmaculada de Melo-Martin, Ethics and Uncertainty: In Vitro Fertilization and Risks to Women's Health, Risk: Health, Safety & Environment 201 [Summer 1998].
- ³ *ibid.*
- ⁴ WHO Summary Report, "Consultation on the Place of In Vitro Fertilization In Infertility Care, WHO Regional Office for Europe, Copenhagen, June 18-22, 1990.
- ⁵ Inmaculada de Melo-Martin: In Vitro Fertilization and Women's Health, Risk: Health, Safety & Environment 201 [Summer 1998].
- ⁶ <http://popdev.hampshire.edu/projects/dt/dt33.php>.
- ⁷ Janice Raymond The production of fertility and infertility: East and West, North and South, in *Women as Wombs*, Harper Collins 1993
- ⁸ Jyotsna Agnihotri Gupta, *New Reproductive Technologies, Women's Health and Autonomy: Freedom or Dependency?*, Sage Publications, India, 2000
- ⁹ Inmaculada de Melo-Martin: In Vitro Fertilization and Women's Health, Risk: Health, Safety & Environment 201 [Summer 1998]
- ¹⁰ See, e.g., John Jarrel et al., *Adverse Health Effects of Drugs Used for Ovulation Induction, New Reproductive Technologies and the Health Care System. The Case for Evidence-Based Medicine*, Royal Commission on New Reproductive Technologies (1993); cited in de Melo-Martin: In Vitro Fertilization and Women's Health, Risk: Health, Safety & Environment 201 [Summer 1998]
- ¹¹ Inmaculada de Melo-Martin: In Vitro Fertilization and Women's Health, Risk: Health, Safety & Environment 201 [Summer 1998]
- ¹² www.victoriafertility.com
- ¹³ A case of simultaneous tubal-splenic pregnancy after assisted reproductive technology. *Fertility and Sterility*, 2005 Apr; 83(4):1042
- ¹⁴ Medical Research Institute, Society of Assisted Reproductive Technology, The American Fertility Society, *In Vitro Fertilization/ Embryo Transfer in the United States: 1988 Results from the National IVF-ET Registry*, Fertility and Sterility 1990
- ¹⁵ World Health Organization (WHO), *Recommendations on the Management of Services for in Vitro Fertilization from the WHO 1990*, cited in Inmaculada de Melo-Martin: In Vitro Fertilization and Women's Health, Risk: Health, Safety & Environment 201 [Summer 1998]
- ¹⁶ Janice Raymonds, *The production of fertility and infertility: East and West, North and South*, in *Women as Wombs*, Harper Collins 1993
- ¹⁷ Wimalasundera RC, Trew G, Fisk NM., Reducing the incidence of twins and triplets in *Best Pract Res Clin Obstet Gynaecol*. 2003 Apr; 17 2):309-29.

ANNEXURE IV

Commercial Surrogacy: Main Provisions

Draft Assisted Reproductive Technologies (Regulation) Bill and Rules - 2010

1. Both the couple or individual seeking surrogacy through the use of assisted reproductive technology, and the surrogate mother, shall enter into a surrogacy agreement which shall be legally enforceable.
2. All expenses, including those related to insurance if available, of the surrogate related to a pregnancy achieved in furtherance of assisted reproductive technology shall, during the period of pregnancy and after delivery as per medical advice, and till the child is ready to be delivered as per medical advice, to the biological parent or parents, shall be borne by the couple or individual seeking surrogacy.
3. Notwithstanding anything contained in sub-section (2) of this section and subject to the surrogacy agreement, the surrogate mother may also receive monetary compensation from the couple or individual, as the case may be, for agreeing to act as such surrogate.
4. A surrogate mother shall relinquish all parental rights over the child.
5. No woman less than twenty one years of age and over thirty five years of age shall be eligible to act as a surrogate mother under this Act. Provided that no woman shall act as a surrogate for more than five successful live births in her life, including her own children.
6. Any woman seeking or agreeing to act as a surrogate mother shall be medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the child, and must declare in writing that she has not received a blood transfusion or a blood product in the last six months.
7. Individuals or couples may obtain the service of a surrogate through an ART bank, which may advertise to seek surrogacy provided that no such advertisement shall contain any details relating to the caste, ethnic identity or descent of any of the parties involved in such surrogacy. No assisted reproductive technology clinic shall advertise to seek surrogacy for its clients.
8. A surrogate mother shall, in respect of all medical treatments or procedures in relation to the concerned child, register at the hospital or such medical facility in her own name, clearly declare herself to be a surrogate mother, and provide the name or names and addresses of the person or persons, as the case may be, for whom she is acting as a surrogate, along with a copy of the certificate mentioned in clause 17 below.
9. If the first embryo transfer has failed in a surrogate mother, she may, if she wishes, decide to accept on mutually agreed financial terms, at most two more successful embryo transfers

- for the same couple that had engaged her services in the first instance. No surrogate mother shall undergo embryo transfer more than three times for the same couple.
10. The birth certificate issued in respect of a baby born through surrogacy shall bear the name(s) of individual/individuals who commissioned the surrogacy, as parents.
 11. The person or persons who have availed of the services of a surrogate mother shall be legally bound to accept the custody of the child/children irrespective of any abnormality that the child/children may have, and the refusal to do so shall constitute an offence under this Act.
 12. Subject to the provisions of this Act, all information about the surrogate shall be kept confidential and information about the surrogacy shall not be disclosed to anyone other than the central database of the Department of Health Research, except by an order of a court of competent jurisdiction.
 13. A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy.
 14. No assisted reproductive technology clinic shall provide information on or about surrogate mothers or potential surrogate mothers to any person.
 15. Any assisted reproductive technology clinic acting in contravention of sub-section 14 of this section shall be deemed to have committed an offence under this Act.
 16. In the event that the woman intending to be a surrogate is married, the consent of her spouse shall be required before she may act as such a surrogate.
 17. A surrogate mother shall be given a certificate by the person or persons who have availed of her services, stating unambiguously that she has acted as a surrogate for them.
 18. A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple/individual. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.
 19. A foreigner or foreign couple not resident in India, or a non-resident Indian individual or couple, seeking surrogacy in India shall appoint a local guardian who will be legally responsible for taking care of the surrogate during and after the pregnancy as per clause 34.2, till the child/children are delivered to the foreigner or foreign couple or the local guardian. Further, the party seeking the surrogacy must ensure and establish to the assisted reproductive technology clinic through proper documentation (a letter from either the embassy of the Country in India or from the foreign ministry of the Country, clearly and unambiguously stating that
 - (a) the country permits surrogacy, and
 - (b) the child born through surrogacy in India, will be permitted entry in the Country as a biological child of the commissioning couple/individual) that the party would be able to take the child/children born through surrogacy, including where the embryo was a consequence of donation of an oocyte or sperm, outside of India to the country of the party's origin or residence as the case may be. If the foreign party seeking surrogacy fails to take delivery of the child born to the surrogate mother commissioned by the foreign party, the local guardian shall be legally obliged to take delivery of the child and be free to hand the child over to an adoption agency, if the commissioned party or their legal representative fails to claim the child within

one months of the birth of the child. During the transition period, the local guardian shall be responsible for the well-being of the child. In case of adoption or the legal guardian having to bring up the child, the child will be given Indian citizenship.

20. A couple or an individual shall not have the service of more than one surrogate at any given time.
21. A couple shall not have simultaneous transfer of embryos in the woman and in a surrogate.
22. Only Indian citizens shall have a right to act as a surrogate, and no ART bank/ART clinics shall receive or send an Indian for surrogacy abroad.
23. Any woman agreeing to act as a surrogate shall be duty-bound not to engage in any act that would harm the foetus during pregnancy and the child after birth, until the time the child is handed over to the designated person(s).
24. The commissioning parent(s) shall ensure that the surrogate mother and the child she deliver are appropriately insured until the time the child is handed over to the commissioning parent(s) or any other person as per the agreement and till the surrogate mother is free of all health complications arising out of surrogacy.