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Labor pains: An exploration of the complex roles of identity, the body, and policy in surrogacy discourses in India

Jennifer Aimee Sandoval

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**LABOR PAINS:
AN EXPLORATION OF THE COMPLEX ROLES OF
IDENTITY, THE BODY, AND POLICY IN SURROGACY
DISCOURSES IN INDIA**

BY

JENNIFER AIMEE SANDOVAL

B.A., Organizational Communication, Pepperdine University, 2002
M.D.R., Dispute Resolution, Pepperdine University
School of Law, 2003

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

**Doctor of Philosophy
Communication**

The University of New Mexico
Albuquerque, New Mexico

July, 2010

DEDICATION

For every mother who has sacrificed to improve the lives of her children...
especially mine.

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I did not always know this would be my path, but there are many amazing people in my life who have shone their light, paved the road, and sometimes carried me to make this accomplishment possible. I am blessed to have wonderful friends, family, and mentors who saw me through. This list is surely incomplete. There have been so many souls I have encountered in this life that have contributed to this day in powerful ways. However, there are a few unique individuals who have given much of themselves to allow me to complete this project and it is here that I attempt to do justice to what they have done for me.

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Chantelle, who knows me best, let me cry, complain, and threaten to give up without an ounce of judgment. She has been an integral part of my journey, showing me what it means to have a heart too big for this world. She is the truest friend I have ever known and a gift to my life. Rex has made me tougher by reminding me what I'm made of. He was here for all of the meltdowns, the freak-outs, as well as the victories. From doing laundry, to cooking dinner, to just giving me a much needed hug; he was a true partner-in-crime, fan club, and coach through it all. The final months were a test of endurance and fortitude, and he remained steady, running to the finish line by my side.

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ABSTRACT

This study applied communication theory about the body, identity, and policy to analysis of the process of surrogacy in India. Using qualitative inquiry and critical discourse analysis, the study aims to increase understanding of how the process of transnational surrogacy emerges and the impact it has on participants. Interviews were conducted in Ahmedabad, Anand, and Mumbai with doctors, health officials, surrogates, and activities. The interview data was used to answer four research questions that worked to identify how the process of surrogacy is communicated and enacted, how surrogates bodies are positioned, how surrogates construct their identities, and how policy constructs the rights of the individuals involved.

The findings indicate that surrogacy is seen as a medical intervention, a commercial enterprise, and an altruistic exchange. Additionally, Balsamo's (1996) four post-modern body categories are used to understand the positioning of the surrogate's corporeal experience. Their responses revealed ways in which their bodies are laboring, marked, repressed, and disappearing in the surrogacy process. The surrogates' identities intersect around their roles as mothers, as earners, and as gift givers. Finally, the policy

positions the commissioning parents and the healthcare providers in positions of power, while subjugating the surrogates in a way that limits their autonomy and agency.

This study was important to expanding the use of communication theory in contemporary sites where the body is a vital source of knowledge. It also contributes to future studies that look at the cultural and individual implications of policy on lived realities. Finally, the study confirmed previous research that centers around intersectionality of identities in complex ways as they are embodied by individuals.

TABLE OF CONTENTS

LIST OF FIGURES	xvi
LIST OF TABLES	xvii
CHAPTER 1: INTRODUCTION.....	1
What is Surrogacy?	5
Surrogacy in India	6
Surrogacy in the United States	7
Transnational Surrogacy	9
India	10
Historical Positioning of India	10
Cultural Positioning of India	12
Competing Discourses of Surrogacy	13
Significance of Study	14
Visiting India	16
CHAPTER 2: LITERATURE REVIEW	20
Surrogacy	20
Policy	22
The Body.....	27
The Body and Philosophy	27
Defining the Body	31
The Post-colonial Body	35
Writing the Body	37
Agency	40

Identity	46
Paradoxes of Identity Construction	48
Research Questions.....	49
CHAPTER 3: METHOD	51
Overview of Methodology.....	51
Interpretive Paradigm	52
Critical Paradigm	53
Feminist Framework	54
International Fieldwork	58
Research Design.....	60
Field Visit	61
Planning Stages	61
In the Field	62
Ahmedabad	64
<i>Mr. Kiran Chabra</i>	65
<i>Gender Resource Center (GRC)</i>	66
<i>Pulse Women’s Hospital</i>	68
Anand	69
<i>Akanksha Infertility Clinic</i>	70
<i>Jagrut Mahila Sangathan</i>	71
Gandhinagar	71
Delhi	71
<i>Jagori</i>	72
Jaipur	73
Mumbai	75

<i>Malpani Infertility Clinic</i>	76
<i>Dr. Nandita Palshetkar</i>	76
<i>Surrogacy India</i>	77
<i>Trivector Scientific International/Cryos Bank</i>	78
Role of the Researcher	78
Data Collection	80
The Participants	81
Surrogates	81
Healthcare Providers	82
Government Officials	83
Women’s Organizations	83
Data Gathered	84
Qualitative Inquiry and Discourse	85
Analysis of the Data	86
Summary.....	90
Structure of Following Chapters.....	90
CHAPTER 4: SURROGACY IN INDIA	92
Medical Intervention.....	93
Akanksha Clinic	93
Pulse Women’s Hospital	97
Mumbai Clinics	100
Commercial Enterprise	107
Surrogacy India	108
Surrogacy Leading to Medical Tourism	110
Ashaben Dalal, Founder of Jagrut Mahila Sangathan	116

Altruistic Exchange.....	117
Surrogacy as a Process.....	119
CHAPTER 5: BEING A SURROGATE	122
The Surrogate Body	122
Akanksha Surrogates	124
Community Support	126
Embodied Experience	128
Dividuation of the Surrogate’s Body	134
The Surrogate Identities	135
<i>Amma</i> (Mother).....	136
Worker and Earner	139
Giver	143
Intersections of Identities	144
The Surrogates’ Location.....	144
CHAPTER 6: POLICY	147
Precedent Setting Cases	147
The German Twins	147
Baby Manji	150
International Surrogacy Law.....	152
The Law in India.....	153
Indian Council of Medical Research (ICMR)	154
The Assisted Reproductive Technology (Regulation) Bill, 2008	156
The Stakeholders.....	157
Lawmakers	157

Healthcare Providers	159
Surrogates	163
Commissioning Parents	167
The Baby	171
The Future of the Bill.....	171
The Positioning of Rights in Policy	174
CHAPTER 7: CONCLUSIONS & IMPLICATIONS	176
Findings	177
Surrogacy as a Process	177
Being a Surrogate	179
Policy	183
Theoretical Contributions	184
Strengths and Limitations	188
Future Research	190
Reflections	191
APPENDICES	193
Appendix A: Interview Guides	193
Appendix B: Form J Agreement for Surrogacy	198
Appendix C: Form M (2) Information on Surrogate	201
REFERENCES	205

LIST OF FIGURES

Figure 1.1 Map of India with location of field visits	18
Figure 3.1 Photo of city traffic in Ahmedabad (source: author).....	64
Figure 3.2 Photo of a shepherd along a street in Ahmedabad.....	65
Figure 3.3 Photo of Sabarmati Ashram in Ahmedabad	65
Figure 3.4 Photo of Mr. Kiran Chabra	66
Figure 3.5 Photo of the Gender Resource Center in Ahmedabad.....	68
Figure 3.6 Photo of Ms Jigna ben	68
Figure 3.7 Photo of sign in entry of Pulse Women’s Hospital	69
Figure 3.8 Photo of recovery room at Akanksha Clinic	70
Figure 3.9 Photo of ladies’ sangeet at wedding ceremony in Jaipur	73
Figure 3.10 Photo of cleansing ritual at wedding ceremony	75
Figure 3.11 Photo of IVF Comic Book from Malpani Infertility Clinic	76
Figure 3.12 Photo of waiting room at Dr. Palshetkar’s clinic	77
Figure 3.13 Photo of interview at Surrogacy India.....	78
Figure 4.1 Photo of outside of Akanksha Clinic.....	94
Figure 4.2 Photo of exam room at Akanksha Clinic.....	96
Figure 4.3 Photo of research team at Malpani Infertility Clinic	101
Figure 4.4 Photo of interview with Dr. Malpani.....	103
Figure 4.5 Photo of Mr. Dilip Patil of Trivector Scientific International	106
Figure 4.6 Photo of interview at Surrogacy India.....	110
Figure 4.7 Chart outlining the surrogacy process in India.....	113
Figure 4.8 Photo of Ashaben Dalal of Jagrut Mahila Sangathan.....	117

Figure 6.1 Nicolas and Leonard Balaz in the news	149
Figure 6.2 Photo of Dr. Nayna Patel in a Zee News interview.....	150
Figure 6.3 Photo of ICMR guidelines presentation	155
Figure 6.4 Photo of Dr. Patel and Dr. Dholakia, Gujarat Ministry of Health.....	158
Figure 6.5 Photo of Dr. Desai at Civil Hospital in Ahmedabad	166

LIST OF TABLES

Table 3.1 Travel and appointment schedule for fieldwork in India.....	63
Table 6.1 International Surrogacy Law Summary	153
Table 6.2 Outline of the Assisted Reproductive Technology Bill.....	156

Chapter 1: Introduction

“When there are no alternatives to have a family you’ve gotta believe in something...out of desperation I Googled surrogacy.”

Millie, an Australian woman, was visiting the leading surrogacy clinic in India, Akanksha Clinic, to have a baby. I was fortunate to meet her at the clinic during my visit to Anand, Gujarat in 2009. Millie and her husband had been trying to have a baby for years without success. They invested thousands of dollars in in-vitro fertilization (IVF) for over three years before they began to look for alternative solutions. Out of desperation, Millie began to look for surrogacy options on the Internet. Millie and her husband knew that they would not avail of surrogacy services in the state of Victoria, Australia, as surrogacy was not allowed by law. On her search, Millie found an article in *Marie Claire* magazine about Akanksha Clinic and its founder, Dr. Nayna Patel, who had successfully done several surrogacies for international patients such as Millie. Convinced by Dr. Patel’s credibility, Millie and her husband decided to visit the small town of Anand in the state of Gujarat in India.

Hundreds of couples have sought the help of Dr. Patel when looking for reproductive options. Millie and her husband are one of those couples. Millie was actually beginning her second surrogacy cycle when I met her at Akanksha Clinic. She had traveled without her husband to have her eggs extracted and meet their new surrogate. The following is her story as told to me on a warm December evening in the crowded and famous clinic.

Once Millie made contact with Akanksha Clinic, she and her husband began e-mailing about her need to have a child and determining a time for Millie and her husband

to travel to the clinic. Unsure about how everything would pan out and whether or not the clinic would be authentic, Millie and her husband planned a vacation to India and decided to visit the Taj Mahal. They traveled almost 6,000 miles from Victoria to Anand and were unprepared for the culture shock they were about to experience.

Akanksha Clinic is located in a narrow alley among the streets of Anand that are scattered with cows and the occasional sheepherder crossing railroad tracks. It is not the first place you expect to go to seek highly technical medical treatment. Their initial fears were calmed when they met a number of other foreign couples who had also traveled to Anand for treatment. They bonded with two other couples who were on the same surrogacy schedule and stayed in contact during the entire cycle.

The first time they met their surrogate, Gauri, they were unsure of what to do or how to act. Over the next few visits with her, they built a relationship of trust and comfort level. They even met Gauri's husband and children. During the coming nine months, Millie's friends would visit Gauri at Akanksha Clinic and update Millie and her husband of her progress. Dr. Patel would also inform them of her progress via email.

When it was finally time to return to India to pick up their baby, they missed the birth by less than 24 hours. Arriving at the clinic they found Gauri's entire family was with her in the recovery room. They met her mother, grandmother, mother-in-law, and many other friends and family. When it was time to take baby Alex back to Australia, they had a small goodbye party for Gauri and even paid her extra money. Gauri asked for photos of the baby with his new family members, so Millie put together an album for her. Gauri then gave Alex a gold ring to remember her by. The experience was very emotional for all involved.

Alex was six months old when I met Millie. Millie had already visited Gauri and brought her photographs of Alex, who was in Australia. Millie said that they planned to bring Alex to India if they were able to have a second baby with the new surrogate. They hoped Gauri would meet him at that time. Millie's experience was extremely positive and she and her husband had shared their knowledge with other Australian couples seeking surrogacy.

Here in the United States, in October of 2007, Oprah Winfrey highlighted the Akanksha Clinic and Dr. Patel on her talk show (www.oprah.com). She asked her viewers, "How far would you go to have a baby of your own?" She spoke with couples who were choosing surrogacy after other methods had failed. One couple had traveled to India to seek out the services of Dr. Patel and her surrogates. Oprah sent correspondent Lisa Ling to the clinic to show the viewers happy surrogates living together during their pregnancy. The Oprah Winfrey show boasts a viewership of an estimated 42 million people in 145 countries, (Associated Press, November 20, 2009) making this program one of the largest introductions to international fertility tourism on American media.

Millie's story of how she became a mother is an emotional tale similar to the ones on Oprah, but it also reveals the complex processes in reproductive health that have resulted from globalization, technological advances, and the availability of medical information online. The 21st century has brought together rapidly changing societies with increased technology and resulted in globalization. Certainly the political, financial, and industrial landscapes have been pushing new boundaries and crossing the borders of nation, culture and geography with increased ease. These shifting lines have impacted many areas of people's daily lives, from the food that is available to eat, to information

resources. However, while these shifts have largely focused on business and government, the arenas of family and health often have been ignored in the larger public discourses. While more time will be required to understand all the implications of these changes, there are important issues arising in contemporary society that can be examined in order to more thoughtfully engage the future.

Recent advances in medical science have provided new opportunities for the creation of a family for people who previously may have not been able to conceive or have genetic offspring of their own. Through processes like intra-uterine insemination (IUI) and in-vitro fertilization (IVF), couples and individuals have been able to work around fertility challenges and have a family they have always dreamed of. Like many new technologies, these reproductive advances are not without cost and complication. It requires significant resources, time, and energy to create a child with new assisted reproductive technologies. For many, the reward is greater than the cost, but the complexity of these choices deserves attention.

While reproductive medicine has made it more possible for many to conceive a child, there are still circumstances that prevent many women from being able to successfully carry a baby to term. One solution to this barrier is surrogacy. Surrogacy can be found throughout history where a family member or servant may have stepped in for a woman who could not become pregnant. Today, the technology allows for more clinical approaches to this process and also makes it possible to maintain a genetic link to the child in question. However, this by no means makes the process simple or easy. This study is intended to examine some of the complications and paradoxes of this

process found in the way participants communicate about surrogacy and the formation of family.

What is Surrogacy?

With the complex medical procedures and issues related to surrogacy, it is useful to define several of the terms that are common in this area. A surrogate mother is a woman who carries to term and gives birth to a baby on behalf of others (Brinsden, 2003; Chang, 2004; Kandel, 1994-1995; Larkey, 2003; Spar, 2006). The individual or couple who hires a surrogate are referred to as the commissioning or intended parent(s). These parents may or may not have contributed genetic material depending on the type of infertility that is affecting them.

Important to note is that there is more than one type of surrogacy. Generally four categories are recognized including gestational, traditional, altruistic, and commercial. The American Surrogacy Center (2009) defines traditional surrogacy as one where the surrogate is artificially inseminated with the intended father's sperm, and the intended mother adopts the child once it is born. Gestational surrogacy occurs when the surrogate has no genetic relation to the child, and a complete embryo is implanted through in-vitro fertilization (Larkey, 2003). Altruistic surrogacy can be either traditional or gestational, where the surrogate receives no compensation for carrying and giving birth for intended parents. This is most common among family members or very close friends. Finally, commercial surrogacy involves a legal agreement where a surrogate will receive financial compensation for her service. Most laws require that a commercial surrogacy be gestational only. This study focuses on commercial gestational surrogacy in an international context. The emerging international surrogacy market that I explore is

India. India is becoming increasingly prominent in the medical tourism world with surrogacy rising in popularity.

Surrogacy in India

Commercial surrogacy agreements have been recognized in India since 2002, and in only a few years, dozens of fertility clinics offering surrogacy services have surfaced all over the country. *The Times of India* (September, 2008) reports that at least 15% of Indians of reproductive age are infertile. This percent is much higher than in the United States, which was estimated by the Center for Disease Control and Prevention to be between 3% and 7% in 2005. While more Americans choose India as a site for fertility treatments and options because of the low cost, many Indians still are unable to afford the services available in their own country.

Even with a growing local demand for alternatives for starting a family, a large amount of business seems to be coming from outside of India. The Malpani Infertility Clinic in Mumbai (www.drimalpani.com/surrogacy) focuses their attention on foreign clients. They even offer information about where to stay, information about flights and the city, as well as suggestions to travel to the Taj Mahal or get an ayurvedic massage while on the trip to the clinic. Their website describes the convenience and cost saving as major benefits for coming to India.

With increasing business in this area of medical tourism, some organizations like the Indian Surrogacy Law Centre are calling for greater regulation of the surrogacy industry in India (www.indiansurrogacylaw.com). Currently, the Indian Council on Medical Research (ICMR), a division of the Indian Ministry of Health and Family Welfare, has published a document titled, *National Guidelines for Accreditation,*

Supervision & Regulation of ART Clinics in India. Chapter three of the guidelines describes conditions for surrogacy in assisted reproductive technology clinics. These requirements include that all expenses of the surrogate related to the pregnancy be covered by the intended parents, including compensation for her services that is negotiated between the surrogate and the parents. The surrogate cannot have a genetic link to the child, so she cannot donate her own eggs in the process. Additionally, third-party donors and the surrogate must relinquish all parental rights in writing.

The Supreme Court of India upheld the legality of surrogacy agreements in the controversial case of Baby Manji in 2008. In this case, a Japanese couple hired a surrogate in Anand to carry an embryo created from the husband's sperm and an anonymous egg donor. However, by the time the baby was born, the couple had divorced and only the intended father wanted to raise the child. There were no provisions under Indian or Japanese law to determine the parentage or citizenship of the baby in this case (Points, 2008). This case has raised many questions regarding how surrogacy complicates issues of identity, nationality, and parentage.

Surrogacy in the United States

The history of surrogacy in the U.S. also is centered on a "Baby M." In 1985, a New Jersey court was faced with an unprecedented case. Mary Beth Whitehead signed an agreement to be artificially inseminated and carry a baby for William and Elizabeth Stern. Once the baby was born, Mrs. Whitehead refused to surrender the child to the Sterns, beginning a two-year legal battle over parental rights and the enforcement of a surrogacy agreement. With no precedent in place, the court used a "best interest of the child" analysis and awarded custody to the Sterns. A year later, the New Jersey Supreme

Court invalidated surrogacy agreements saying they were against public policy (Bezanson, 1990). Almost 25 years later, there is still confusion and inconsistency when it comes to the legality of surrogacy in the U.S. Many states do not recognize the legality of surrogacy agreements allowing surrogates to maintain “parental” rights if they so choose. This has led more and more couples to look for options beyond their local fertility specialist.

In 2002, the U.S. Center for Disease Control report on reproductive health estimated that over 12% of women of childbearing age in the United States had sought some form of fertility services. The market for genetic material in the form of eggs and sperm has entered this realm through large international "banks" and fertility is now outsourced to surrogates and clinics in various international locations. The services are marketed to couples who have experienced some kind of challenge, whether physical, legal or financial, in the fertility system of the United States. The process of creating a "family" has shifted from the private sphere of the home to what Markens (2007) has called the online reproductive supermarket.

The tangled American history of reproductive politics is a good example of the tension that lies between structural constraint and individual choice. Debates and positions have been influenced by the intersections of cultural constructions of woman, mother, state, and nation with all of the raced and gendered ascriptions attached. The process and business of transnational gestational surrogacy (popular media has termed it "wombs for rent") as a reproductive alternative has become big business overseas. The discourses as well as the material processes contribute to new definitions of motherhood, cultural identity, and agency.

Transnational Surrogacy

With transnational surrogacy becoming a more widely known reproductive alternative, there are ongoing debates both in academia and the media regarding the extent to which women are empowered in the current structure of surrogacy. Critics question whether or not surrogates outside of the U.S. can willingly, as free agents, enter into the role of surrogate, given that they could be experiencing financial constraints. They call the business of surrogacy in developing countries “baby farms” (*USA Today*, December, 2007). Others might argue that it is a unique economic opportunity for women in a location where there are few, if any, alternatives that could provide similar compensation. In a country where a majority of the population is believed to live on \$2 U.S. dollars a day, the surrogates may make \$5,000-8,000 USD for one surrogacy. This would take her years to earn doing anything else (Nurluquman, Xin, & Lee, 2009).

There is no official estimate of the number of surrogate births occurring in India, but the Delhi IVF and Fertility Research Centre reported delivering over 100 surrogate children in 2006. Medical Director Anoop Gupta told *The Times of India* that he receives six to 10 emails a day asking about surrogacy services from foreigners. “The reasons are the same,” he said. “Superior medical treatment available at cheaper rates in India, with no legal hassles involved” (*The Times of India*, September, 2008).

Additionally, surrogacy agreements are not legal or recognized in many states in the U.S, complicating issues of "parenthood" when the baby is born. A baby can essentially have three “mothers” when taking into consideration the intended mother, an egg donor, and a gestational surrogate all participating in the birth. Most laws are not prepared to define motherhood in a way that addresses the complexity of these

agreements. Many of these concerns and complications are eliminated when employing a surrogate in India. Indian regulation requires surrogates to have already given birth to at least one of their own children with no complications. Additionally, no surrogate can have any genetic connection to the intended child. Doctors argue that this ensures the surrogate has much less connection to the baby (Indian Council for Medical Research, 2008). One surrogate in a recent news story, confirmed this theory by explaining that when the baby was born, it was white and did not feel like hers at all (Gentleman, 2008). Unlike the U.S. where surrogates often have the right to claim parentage, in India surrogates have no legal rights to the baby, and the law recognizes surrogacy agreements geared in favor of the commissioning parents.

While going to a country like India may decrease some of these challenges for the intended parents, it also gives rise to new concerns. Since surrogates are sometimes positioned in the process in a way that gives them little power in the process, they are vulnerable to this kind of exploitation. Their postcolonial bodies are employed for the service of Western couples who have the time and resources to outsource a pregnancy. Some areas and clinics, however, do cater to Indian couples. The historical position of India as a colonial subject only strengthens some of the objections to this arrangement.

India

Historical Positioning of India

Before we understand the cultural, political, and gendered implication of outsourcing surrogacy to India, it is important to understand the historical landscape of the country. In this global system, India as a geographical site is unique in its colonial legacy as well as present challenges given that history. It is the largest democratic nation

in the world, but young as an independent nation. It has had historical connections to the West due to its long history of British colonization, which has resulted in English being widely spoken by urban Indians. Despite a long history of colonial and imperial rule, India is positioning itself in a unique way in contemporary business as a site for outsourcing a variety of work. Like any developing economy, India is filled with contradictions and paradoxes. India continues to lead the world in technological innovations and computer science. While Bangalore city is referred to as the “Silicon Valley of India” for its technology industry, much of the population of India lives in rural locations with limited access to anything like a computer or the Internet.

Though a significant portion of the population resides in more rural areas there is considerable interaction between the rural and the urban context in India. In a cosmopolitan city like Ahmedabad, (with 6 million people) one can still see livestock in the streets and vendors bringing their wares to markets on the side of the road. You can easily reach the countryside but you might take a modern landscaped highway built by a private corporation. You can walk out of a high-rise office building and at the same time purchase a coconut to drink from a roadside stand. The coconut vendor is probably chatting on a cell phone during your transaction. India has incorporated wireless technology into the daily lives of its citizens on an enormous scale, while the infrastructure for landline phones may not yet have found its way, and probably never will, to a remote village. In fact, in many cities you cannot call a taxi without a cell phone number since you will need to text the cab with your address.

India is a politically democratic country that embraces similar notions of modernity as the West. However, traditional values and religion heavily influence

societal norms and subsequent human actions. In a country where most people have a cell phone, there are still infrastructure challenges in smaller cities. While the levels of education are increasing, traditional ways of life are valued. The institution of family is very important to the Indian people and they work hard at preserving community ties.

India is known for its call centers and businesses that are outsourced from the U.S. and the U.K. In July of 2004, *The Times of India* reported the physician-to-population ratio in India to be 50-69 per 100,000. However, they noted that the distribution is heavily skewed toward urban areas. The 2008 World Fact Book published by the U.S. Central Intelligence Agency reports that an estimated 74% of the population lives in rural areas. This leaves a larger market for medical tourism targeting foreigners who would come to a metropolitan area of India. One of the biggest impediments to development for India is its ever-increasing population. The country has over 1.3 billion people with an acute gap between rich and poor. It is believed that the distance between wealth in India and wealth in England is much closer than the distance between its own poor and the wealthy (Kundu, 2004).

Cultural Positioning of India

Not only are the national and economic structures an important contextual factor in the story of surrogacy, but the cultural challenges that Indian women experience with regard to pregnancy and fertility is a critical component of understanding the larger picture of international surrogacy. While surrogates are receiving compensation for carrying a baby for someone removed from the Indian culture, local women are struggling with their own choices of motherhood.

In her ethnographic work in India, Hegde (2006) uncovers the difficult choices Indian women face when they are mothers of baby girls. Pregnant women often look to abortion or infanticide as options to avoid having female children since a girl-child is viewed as a liability for the family. However, the position of women as mothers is changing, and today there are increasing expectations and greater social controls in place that mark the position of women as mothers (Markens, 2007).

The cultural space of femaleness is increasingly complicated by what Mohanty (1988) defines as “contemporary imperialism” or the positions of “ideological superiority” (p. 196) that leads certain groups or nations to attempt political “conversion” for the good of humanity. The United States insistence on imposing democratic government structures in the Middle East without consideration of historical and socio-cultural beliefs that may fundamentally clash with those ideals (Vernet, 2003) is an example of how the West tends to impose their standards of development on the non-West. This framework is a useful reference when examining the dominance of Western medicine in India. The position of women in India can sometimes limit their choices in many areas of their lives. The neo-colonialism that constructs their identities as mothers in the family home is important in the context of surrogacy. The way women understand their identities and choose to use their bodies for work are influenced by these existing structures. Structural domination is no longer purely legal inequality or physical violence, but rather discursive suppression of difference in attempt to control hearts and minds (Mohanty, 1998).

Competing Discourses of Surrogacy

Very different perspectives emerge from the conversations centering on surrogacy. Kroløkke, Foss, and Sandoval (2010) looked at several surrogacy agency websites for international surrogacy programs and found surrogates positioned primarily in three ways: victim/agent, carrier/goddess, and special woman/commercial provider. Surrogacy is framed as both a gift by the surrogate to the intended parents as well as a "product" designed by the intended parents through careful selection of donors, companies, and carriers. "Motherhood as a discursive concept is always under scrutiny. There probably is no cultural construction approached with as much concern and criticism, commentary and critique as the position of mother" (Kroløkke, Foss & Sandoval, 2010, p. 111). The picture of the responsibilities of a mother change according to cultural context. The definition of a "good" mother is contested in modern media and challenged by women as their other roles in society continue to shift. Reproductive technologies continue to change and develop and so the scrutiny can only be expected to increase, placing women and their bodies at the heart of yet another social controversy regarding the body and choice.

Significance of Study

Information about surrogacy remains limited outside of the areas of medical and legal specialties that focus on new reproductive technologies. While the physical aspects are important, the human experiences, as they are communicated by individuals can shed a meaningful light on the process. This study explores the relationships among various stakeholders in the business of transnational surrogacy in India as well as how identity, agency, and policy are communicated to position each participant in specific ways.

The current state of globalization creates processes by which economic and cultural power lines shift rapidly (Shome & Hegde, 2002). However, the subject of gender and specifically globalization's effects on women's lives is absent in much of the discourse regarding these blurring boundaries (Hegde, 2006). Questions of choice and the construction of changing identity positions require acknowledgement that individual lived experiences are different based on their many identity locations in relation to the global marketplace. Business has been redefined with changes in technology that allow for increased trade across national borders more than ever before. In order to stay competitive as an industry it is important to identify any global audience or customer and determine how to meet their needs differently than in a solely local context. This is no different for the surrogacy industry. The largest economic benefit is coming from outside of India, and many clinics and peripheral businesses in the work of surrogacy have found a way to market and serve the needs of these foreign clients.

This area of research is relatively new in communication scholarship as it is found at the intersection of gender, globalization, reproductive health, and culture. The discursive construction of the role of women's bodies in reproduction as well as the definition of family is always in flux and always culturally bound. Additionally, as the larger conversation changes with new technologies and globalization, the role of communication about these events is paramount. It is a new issue located in an old source—the female body. Discussions of women's rights and social positioning have traditionally centered on a woman's body—and specifically where reproduction is concerned. New reproductive technologies have changed the landscape in regards to what the body is capable of, but much of the controversy around choice remains

unchanged. For a long time the body has been a touchstone of feminist scholarship and the agency afforded to some over that body is contested (Longhurst, 2005). Surrogacy complicates the issue of agency and with the growing industry of fertility tourism the number and nature of the players involved continue to expand. The voices of women who work as surrogates have not been given the same space as other aspects of the industry as of yet, and the opportunity to collaborate with scholars from different areas of research and geographical locations as well as observe the surrogacy process first hand is invaluable to investigating new information regarding women's global positions.

The stories that emerge from visits to clinics, health officials, and community organizations are timely as this global enterprise continues to grow. In many ways, more questions arise than are answered, but it is important to begin this investigation at the early stages of surrogacy's popularity to ask important questions and follow the trajectory of the business for years to come.

Visiting India

In order to collect these stories and to observe firsthand how surrogacy is emerging in India, I traveled there in November and December of 2009. With an ambitious 22 days in the field, I spent time in Ahmedabad, Anand, Mumbai, New Delhi, and Jaipur (See Table 3.1). The city of Anand was an important location for my research because of Akanksha Clinic, headed by Dr. Nayna Patel. Her clinic is considered to be a pioneer in surrogacy in India. Ahmedabad, only one hour away from Anand, also has a reputation as a popular location for fertility tourism. The closest airport to Anand is in Ahmedabad, which becomes the first point of entry for many incoming international medical tourists. Mumbai and New Delhi are major metropolitan areas of India and

offered a useful comparison as well as increased the contextual understanding of the country. Finally, a visit to Jaipur allowed for cultural immersion and participation in a Hindu wedding ceremony that provided vital experiential knowledge.

As my understanding and knowledge of the process grew, so did my curiosity about the complexities of surrogacy arrangements. It was extremely important to me to gain firsthand experience and engage in direct communication with people who are involved in the work. As I began to work through the many questions I had, I connected with several other researchers also interested in the areas of reproduction, globalization, and fertility tourism. This group of scholars belongs to different areas of expertise and interests related to surrogacy and reproductive rights. Through our intellectual engagement, we began to produce some preliminary work and constructed a program of research.

This research team is comprised of an international group of scholars. The members of the team include, Dr. Saumya Pant, a communication and women's studies scholar and Dr. Karen Foss, a professor of communication, of the University of New Mexico as well as Dr. Charlotte Kroløkke, and Dr. Karen Hvidtfeldt Madsen, both cultural studies professors from the University of Southern Denmark. Additionally, Dr. Pant is from India and has conducted much of her own research there in the last few years. The unique international and disciplinary perspectives have produced a useful dialogue among the members of the team. Dr. Foss, Dr. Kroløkke, and Dr. Hvidtfeldt Madsen were able to join in a small portion of the visit to India to investigate their own specific research questions.

Dr. Foss collected data that contributed to answering research questions about choice, self-determination, and agency as it is rhetorically constructed in surrogacy documents. Dr. Pant's focus was on how gender is positioned in the new global market of outsourcing fertility to India from the rest of the world. Dr. Kroløkke's interest centers on the implications of new reproductive technologies and surrogacy for consumer culture and Dr. Hvidtfeldt Madsen investigated how surrogacy alters the cultural category of "family." Each researcher brought their own lens to the inquiries posed in the research and provided valuable sounding boards for the various theories and perspectives that were found in India. My research visit to India overlapped with theirs and we shared several opportunities to meet participants in Anand, Ahmedabad, and Mumbai. Dr. Saumya Pant was with me for most of the interviews, translating and interpreting the exchange of communication from Hindi to English.

The travel, though relatively short, was critical to this study's purpose of increasing understanding of the surrogacy process and the experiences of participants in India. As the country has emerged as a leading player in international surrogacy, the location provided a rich site for investigation. As the study will show, India is currently grappling with the legislation and regulation of Assisted Reproductive Technology (ART) and its popularity in medical tourism.



Figure 1.1. Map of India with locations of field visits (source: <http://www.indianembassy.gov.qa/>)

The field visit led to many additional questions about how surrogacy has emerged as a practice in India. The face-to-face interviews and visits to clinics provided insight into a small piece of this global industry. Additionally, it allowed me to gain a better understanding of the context in which surrogacy is growing.

In the following chapter, I will explore the nature of (a) the practice of surrogacy itself, (b) the body as a site of discourse, (c) the concept of agency, (d) identity and (e) how policy communicates the position of participants in the process of surrogacy. These areas of literature provide the context and background necessary to investigate the modern contradictions, paradoxes, and challenges of surrogacy across culture and country.

Chapter 2: Literature Review

The research questions posed in this study engage several areas of communication scholarship applied in the context of surrogacy including (a) the practice of surrogacy itself, (b) how policy communicates power, (c) the body as a site of discourse, (d) the construct of agency, and (e) an understanding of identity. There are large bodies of literature that allow for foundational understandings of these important constructs. In this chapter I discuss the critical theories and concepts that contribute to the construction of the current study about the practice of surrogacy in India¹.

Surrogacy

Surrogacy is an increasingly popular solution to infertility in the United States and other Western nations. While infertility is not life threatening, it can be considered a very serious situation for some people. Some doctors point to the fact that many women are waiting longer to try to have a child in order to pursue extended educations and careers, as contributing to modern fertility challenges (Yoon, 1990). As the number of people who cannot have a baby on their own has increased, the number of adoptable babies has not. Yoon (1990) argues that with more access to abortion and the social acceptability of raising a child as a single mother there are fewer infants available for adoption.

Estimates place the time to adopt in the United States between three and seven years (Yoon, 1990). With the challenges of the domestic adoption process, some have sought international adoption, but others still do not want to give up on having a baby of their own.

¹ While I refer to India as a nation frequently in this study, I recognize it is a large and complex country and culture that cannot be essentialized as one place. A majority of the fieldwork took place in the state of Gujarat and more detail about this location is provided in the method chapter.

Surrogacy itself does not necessarily require new reproductive technologies as seen from stories as old as the Christian Bible. In Genesis, Abraham's wife Sarah cannot bear him children and so he impregnates his servant Hagar who gives birth to a son (16: 1-4). This was often acceptable because of the social stigma women historically have suffered from not being able to conceive (Spar, 2006). Additionally, surrogacy may have existed in historical texts in Indian literature, but its current practice is based on the Western understanding of surrogacy.

Over centuries, more information about the causes of fertility led to a search for a cure. One of the largest breakthroughs did not come until 1978 with the process of in-vitro fertilization (IVF). While IVF is increasingly common and mostly accepted today, the first "test tube baby" created a lot of controversy. The Browns of Bristol, England were an ordinary couple who had been trying to conceive for over 10 years but could not because Mrs. Brown had blocked fallopian tubes. Two doctors, Patrick Steptoe and Robert Edwards, decided they would advance the technology of their day by not only removing Mrs. Brown's eggs but fertilizing them in a sustainable environment and then reintroducing the embryo into her uterus after hormone therapy prepared her body to accept it (Spar, 2006). This was quite a feat in their day, and they had already failed at 80 previous in-vitro attempts. After years of research and experiments, Steptoe and Edwards were successful, and Louise Brown was born in July of 1978, igniting a firestorm of debate and concern in the Western world.

In the early years, IVF rates of success were low, and the cost was high. Many criticized the process as going against nature and consequently, the technology was not introduced to American medical schools until the early 1980s (Spar, 2006). As the

demand for the latest fertility treatment grew, doctors saw the opportunity and subsequently the number of IVF procedures being performed jumped by almost 40% in the mid 1990s (Spar, 2006, p. 28). In 1986 in the United States, the cost for one IVF cycle was approximately \$6,000 and in 2003 it rose to \$12,000 (Spar, 2006). Even with this advancement and a dramatic increase in the success rates of IVF, some women were unable to get pregnant, and the option of another woman being implanted with an embryo turned the dream into reality. When IVF is used, it is called gestational surrogacy. Surrogacy does not, at least medically, require IVF but also can be accomplished through intra uterine insemination (IUI), where sperm is inserted in the uterus to fertilize the eggs of a surrogate (traditional surrogacy).

Policy

The medical advances and increased fertility options created through IVF and other interventions have brought a number of challenges in the law, regulation, and definition of rights for participants, particularly in the Western world. Reproductive policy has been a hot button topic in the United States for decades, and the introduction of IVF and surrogacy complicated an already contentious debate (Lane, 1994; Sinding, 2000; Townsend, 2007; Wynn, Erdman & Foster, 2007). A majority of the controversy lies in the commercial surrogacy realm where money is exchanged for the service. The U.S. surrogacy policy varies by state and ranges from complete regulation and recognition of commercial surrogacy contracts, to payment for surrogacy as illegal. This range exists on an international scale as well.

The policies and laws communicate the legal rights of participants in a surrogacy agreement, but the definition of parentage has been particularly volatile and difficult to

clarify (Munyon, 2003). I will explain the differences and some of the perspectives in the debates by looking at California, New Jersey, and Illinois in the U.S. and comparing Australia, Germany and India internationally.

California generally recognizes surrogacy contracts and has had several precedent-setting cases in recent decades. In 1993, the case of *Johnson v. Calvert* went before the California Supreme Court, where gestational surrogacy contracts were found legal and enforceable (Pinkerton, 2001). The Johnson case defined parenthood not only through a genetic link, but also by intent regarding the birth of the child. It stated that one who intended to "bring about the birth of a child that she intended to raise as her own is the natural mother under California law" (Pinkerton, 2001). This ruling was extended in *Re Marriage of Buzzanca and The Artificially Inseminated Surrogate*. This case defined the mother of a child as the one who is intended to parent in the surrogacy contract itself. Prior to Buzzanca, a woman would have to adopt the child born to a surrogate using insemination. If the surrogate should change her mind, she could legally keep the baby when it was born (Pinkerton, 2001).

Buzzanca also has been used to argue for sole parentage in the case of a single man hiring a surrogate or a male gay couple. In order to clearly define the parentage, the California Office of Vital Records requires a court judgment that names the intended parents as the legal parents. If no court judgment is presented, the surrogate's name will go on the birth certificate (Pinkerton, 2001). The two cases explained here generally make California a favorable state for surrogacy agreements.

In contrast, the New Jersey Supreme Court has found that commercial surrogacy agreements are illegal and unenforceable. In 1988, the New Jersey Supreme Court was

faced with the first surrogacy case in the U.S with *In the Matter of Baby M* (Levin, 1996). In this landmark case, the surrogate was artificially inseminated by the intended father's sperm. By providing her own egg, the surrogate was also the genetic mother. However, no additional policy has addressed the issue of gestational surrogacy. In terms of the illegality, when people enter into a surrogacy contract in New Jersey, there is no legal consequence. However, the contract is not enforceable by the courts. Ultimately, New Jersey found that surrogates face coercion (financial or otherwise) in the decision to relinquish rights to the child, and therefore, any agreement to do so is invalid (Levin, 1996).

While many states remain silent on the issue of surrogacy all together, the Illinois legislature passed the *Gestational Surrogacy Act in 2004*. This act requires that anyone hiring a surrogate has a medical need for it and has undergone a mental health evaluation. It also requires that either the egg or the sperm be donated by one of the commissioning parents. The surrogate herself must be at least 21 years old and have already given birth to one child of her own. The surrogate must also have her own legal counsel and a health insurance policy (Gitlin, 2005). This act is rather specific in the requirements of the participants, but they have not specifically addressed agreements involving lesbian or gay commissioning couples.

Overall, these three geographically disparate states represent the landscape of regulation regarding surrogacy agreements in the U.S. It is a complex system to navigate and thus far requires legal counsel at several of the states, increasing the cost to use the surrogacy process domestically. Due to the cost and ambiguity in the outcome, many

couples seek a surrogate overseas. However, law and regulation of surrogacy varies just as greatly on an international scale.

Similar to the U.S., Australia's reproductive technology legislation varies from state to state. However, one common factor between all states in Australia is that none of the states recognize commercial surrogacy agreements. This makes Australia unpopular for international surrogacy. Most of the states simply make the agreements unenforceable, meaning parties cannot seek legal recourse if there is disagreement or problems with the contract. However, Tasmania considers commercial surrogacy illegal, and the consequences of its practice result in a fine and/or jail. Queensland prohibits altruistic surrogacy in addition to commercial agreements (South Australia Council on Reproductive Technologies, SACRT, 2007). All states are required to follow the 2004 *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* published by the National Health and Medical Research Council (NHMRC) unless they have state legislation that overrides the guidelines. The Guidelines recommend the development of legislation to address many of the issues that arise in the process of surrogacy.

Even more restrictive is German law regarding surrogacy and egg donation. There is actually very little with regard to lengthy court opinions or reports on why the policy is such. In 1990, the German Embryonenschutzgesetz law prohibited insemination or embryo placement in a woman engaged in a surrogacy agreement. Violation of this law is punishable by a fine or jail (Keppler & Bokelmann, 2000). This stringent law encourages couples to seek surrogacy treatment in other countries leading to challenges in citizenship and documentation.

Finally, India has opened its doors to international patients due to the enforceability of surrogacy agreements. The agreements are recognized because of the Indian Council of Medical Research guidelines, published in 2005, and the *Assisted Reproductive Technology (Regulation) Bill* of 2008. However, the bill has not yet been enacted into law in India. The bill is explicit in many areas about requirements for ethical and legal commercial gestational surrogacy, but there remain gaps and contradictions that create problems for each participant in the process.

The policies and regulations tend to focus on the agreements or contracts that result during a surrogacy process. Ultimately, the policy is talking about something happening within a woman's body. The site of the female body requires a specific inquiry in order to understand the implications of the practice of surrogacy. With the advances of reproductive technology, women's bodies are subject to increased monitoring, regulation, and discipline in the pursuit of pregnancy. The embodied experience has not yet found its place in dominant discourses, yet it can provide important material knowledge. Price and Shildrick (1999) explicate the direction of research that privileges the embodied,

For some, the materiality of the body, and particularly in its female form, comes to the fore only to be once more bracketed out of consideration, but what is different between this and dominant malestream approaches is that rather than a thoroughgoing disregard for things corporeal, feminism starts at least from a position of acknowledgement. More positively, other feminist writers have developed theory that is explicitly embodied and insistent on the centrality of the material body; while yet others, influenced by poststructuralism and

postmodernism in particular, have put into question the givenness and security of the so called natural body, positing instead a textual corporeality that is fluid in its investments and meanings. (p.1)

The centrality of the body in female experiences is particularly salient in regard to motherhood and reproduction. This study attempts to contribute to that growing collection of investigation into the corporeal lived experiences of women. The following section explores feminist literature related to the body as a site of discourse.

The Body

Every individual is housed in a body. Yet it is incredibly challenging to define the body without becoming essentialist or completely relativistic. For feminism, the body is an excellent site for examining difference and contradiction (Birke, 1999). As Riley (1988) explains, “the body is notoriously difficult ground when it comes to theory” (p. 220). The body houses subjectivities and experiences written onto the body. The body is about biology, but it is more importantly about the meanings and values attached to that biology. It is a permeable boundary between the lived and the observed. “The body is at once, material, discursive and psychical” (Longhurst, 2005, p.91).

Surrogacy constitutes an issue that is housed in the female body. The corporeal, emotional, and spiritual experiences of the women involved become a part of their bodily existence. The body is an important site of understanding. It is also the location of a practice that is emerging in complex ways. In order to understand the implications of this experience, a more complete recognition of the value of the body in communication theory is necessary.

The Body and Philosophy

From early philosophy to current issues of globalization, the body is at the center of discourse surrounding gender equality. Feminism, as it is understood today, has shifted primary goals and ideologies through several eras or "waves" of thought. The early focus of these movements was largely limited to white Western feminist work; a criticism that is often part of contemporary discussions of what feminism is and does. For the purposes of understanding the site of the female body in a global sense, it is critical to turn to international feminists and feminists of color for insight into contemporary problems related to womanhood and the body.

Throughout the decades of various feminist movements (in particular the U.S.'s Second Wave feminism), the location of being female, and struggle for equality, has centered around the body. While many rights were being sought at the time, frequently issues like reproductive control took center stage. The body has taken on different meanings and ideological significance with each developing era and continues to be a popular construct for investigation in today's academy. Gatens (1992) attributes the importance the body enjoys in scholarship today to Foucault. Foucault (1975/1979, 1976, 1984/1990) focused on ways in which people are disciplined to conform to their culture by examining power structures as well as practices of society that create socially disciplined bodies. His understanding of connections between individual bodies and regulatory institutions is the basis for many feminist thinkers today. The body cannot be above or below history (Riley, 1988, p. 222), but rather must be bound to it in any contemporary investigation.

The body is important to feminist epistemologies that include lived experience as a site of knowledge. That experience is found in and on the body. It is a site of cultural

and social inscription. The body has been defined differently based on philosophical beliefs regarding corporeality and social value of the body one inhabits. The body exists in tension with its environment (Gatens, 1992, p. 228). The body is subject to distinct realities that position an individual in their social world (Riley, 1988). The politics of these definitions have raised many questions about the position of the body. Is the body good? Can it be owned? Who can own it? Who can and/or should regulate the body? What do body differences mean? Is the individual body really an undivided person or an infinite number of parts for various uses? Throughout history attempts to answer these questions, when made, have not always been kind to those who find themselves outside of the dominant power structures.

Spelman (1982) has argued that the way in which women have been described by philosophers is "nasty, brutish and short" (p. 32). She starts with Plato and the emergence of somatophobia (Spelman, 1982; Gatens, 1992). Plato taught that the body was the ultimate betrayal of the mind. The goal was transcendence beyond earthly and bodily desires that detract from ultimate intellectual potential. The body was weak, where the mind was strong. Beyond the inherent weakness of the body was the belief that women were contained in even less controllable bodies, making them unstable, unpredictable, and in need of regulation. Merchant (1980) argues that these beliefs continued well into the 15th through 17th centuries as disturbing constructions of women are revealed in the literature of the time. They were depicted as child-like or worse, witches, or as having sexual relationships with the devil.

Symbolically associated with unruly nature was the dark side of woman.

Although the Renaissance Platonic lover had embodied her with true beauty and

the good, and the Virgin Mary had been worshipped as mother of the Savior, women were also seen as closer to nature than men, subordinate in the social hierarchy to the mend of their class, and imbued with a far greater sexual passion. The upheavals of the Reformation and the witch trials of the sixteenth century heightened these perceptions. Like wild chaotic nature, women needed to be subdued and kept in their place. (Merchant, 1980, p. 132)

Women were continually characterized as being even less capable of transcending the body, and their bodies left much to be desired when attempting to reach human potential.

Not much changed in the Enlightenment era, except that rather than superstition or conjecture, science was used to "prove" the natural deficiencies of women. Science was interested in defining nature as chaotic, unruly and random in order to justify man's quest to control it. The scientific method developed in pursuit of undeniable truths contributed to the process of categorizing all things sub-human, where woman was placed in the hierarchy next to animals (Warren, 2000).

During this surge in scientific exploration, early experimentation to explain reproduction described women as passive in the creation of life with all the valuable genetic material found in the sperm. The woman was only a space for incubation. Martin (1991) has examined science texts from the Enlightenment era to the late 1980s and found that even as scientific understanding of the body and reproduction changed, the descriptions continued to rely on traditional stereotypes of men and women. In most accounts the sperm or male genetic material was described as powerful, active, and productive. The fact that males continue to produce sperm throughout their life span

appeared to be applauded as useful and important. The ova or female contribution to reproduction were described as passive as they lie in wait for the sperm to find its way to her (much like a fairytale of a damsel in distress). Additionally, when the texts explained that females are born with their complete collection of ova without the possibility of increase, the ovaries were described as non-producing (Martin, 1987, 1991).

Historically, scientific writings that differentiate between the male and female body have reified the patriarchal norms that construct men as leaders, protectors and conquerors and women as passive and in need of protection. Given that the traditional role for women in an Indian household is somewhat passive and submissive, according to Donner (2008), to her husband's needs, working as a surrogate steps out of that position into something more powerful, while doing it through the feminine site of the womb. As feminist theory has attempted to defy these constructions, a number of new explanations and definitions of the body have emerged. Unfortunately, as Grosz (1994) points out, many unwittingly accept a continued dualism of mind vs. body rather than an approach that recognizes personhood.

Defining the Body

Grosz (1994) describes three major feminist schools of thought with regards to the body. She is critical of what she sees as an acceptance of some of the flawed understandings created by a patriarchal legacy. The first approach she terms "Egalitarian Feminism," and cites Mary Wollstonecraft and Simone de Beauvoir as examples of this theoretical perspective. Egalitarian feminists see the biological female body as an inherent limitation to equality between the sexes. While they recognize there can be

special insight from the experience gained living in the materiality of womanhood, they believe equal social and political participation will always be unachievable with the burden of bearing and raising children (Grosz, 1994, p. 15). The second school she describes is the “Social Constructionist Feminism,” which is born out of a Marxist philosophy. This theoretical perspective positions the body as secondary at best, when looking to achieve gendered equality. They would consider the terms *gender* and *sex* to be virtually interchangeable. The critical aspect in understanding limitations imposed on women is the social definition and interpretation of what it means to be male or female in a given society (Grosz, 1994, p.17). The third perspective is what Grosz calls “Sexual Difference Feminism.” Notable scholars from this point of view would include Judith Butler and Gayatri Spivak. From a sexual difference standpoint the biology of male and female is critically important and not given enough specific attention in most feminist theory. They argue that the goal should not be to eliminate difference, but to eliminate differential treatment that leads to oppression (Grosz, 1994, p.18). The female body and its unique abilities should be celebrated and seen rather than disguised or lost in the effort to gain social, political, or legal equality.

An additional school of thought that rejects the many problematic binaries leftover from the Enlightenment is found in eco-feminism (Mies & Shiva, 1993). As one theoretical branch of the ever-expanding tree of feminisms, it perhaps contributes the most relationally grounded thought to the positioning of the body. Eco-feminism defines the relationship between people and nature differently than the traditional masculinistic approach that leads to dichotomous thinking (Plumwood, 1993). Rather than a perspective that sees man vs. nature, reason vs. passion, mind vs. body, sense vs.

sensibility, logic vs. emotion, or control vs. chaos, the eco-feminist position is one of connectedness. While not without its flaws, it does unearth many taken-for-granted assumptions regarding women (and people in general) and their experiences. It questions the definitions of what is natural and unnatural and the aspects of modern society that limit and discipline the female body.

Balsamo (1996) sets out to explicate the contemporary position of the body in regard to modern culture and technology. She argues,

...the body can never be constructed as a purely discursive entity. In a related sense, it can never be reduced to a pure materialist object. Better to think of the dual 'natures' of the body in terms of its 'structural integrity.' (p. 278)

She defines four types of post-modern bodies in contemporary culture (Balsamo, 1996). The first is the laboring body, which can be seen in a variety of forms from the worker in a multi-national factory to a woman carrying a baby in exchange for payment. The second is the marked body. While each body is marked by aspects of race, gender, sexuality, or other cultural markers, today a person can control this, to some degree, through cosmetic surgery or other modifications they deem valuable. The third type is the repressed body and is seen most clearly in computer-mediated-communication or virtual reality. The physicality of human relations has shifted dramatically with the advent of the Internet. A body can be completely absent through the use of email or represented with an avatar in worlds like that of Second Life. Finally, the fourth is the disappearing body. This is particularly salient when looking at new technologies and the relationship to the contemporary person. Technology is subtly changing what societies view as a natural body. Whether genetically engineering the traits of your future baby or

connecting an individual's brain directly to a computer—the corporeality of the human body is less significant as science learns to mimic and create body parts.

The post-modern bodies show an increasingly complex understanding of corporeality and the imposition of globalization increases that complexity. One such area is that of new reproductive technologies. Many argue that these "advancements" are an effort to gain more control over the female body through science and policy, but Sawicki (1991) takes a slightly different view. She argues that these technologies, while perhaps having the side effect of more regulation and discipline, are more about making the female (and laboring) body even more useful in a world increasingly dependent on developing "new capital" for the global marketplace. These technologies include fertility treatments, egg collection and donation, embryo creation and storage and gestational surrogacy. Sawicki (1991) says,

Among the individuals created by these new technologies are infertile, surrogate and genetically impaired mothers, mothers whose bodies are not fit for pregnancy (either biologically or socially), mothers who are psychologically unfit for fertility treatments, mothers whose wombs are hostile environments to fetuses, mothers who are deemed 'negligent' for not choosing to undergo tests, abort genetically 'deficient' fetuses, or consent to Caesarean sections... They link up with the logic of consumerism and commodification by inciting the desire for "better babies" and by creating a market in reproductive body parts, namely, eggs, wombs, and embryos...making women's bodies useful to agencies that regulate and coordinate populations. (p. 194)

Many of these technologies first became well known in the late 1980s and early 1990s. Ikemoto (1996) describes the discourse at this time as reflecting uneasiness with "messing with mother nature" and a dislike of the direction reproductive medicine was heading. As stories of women having children well into their fifties emerged or stories of women of one racial identification carrying babies of a different one emerged, the discomfort rose. She explains that women at that time seemed to be defined as either too fertile, infertile, or dysfertile (Ikemoto, 1996). Women deemed too fertile were teen moms, single moms, mothers on public assistance and often women of color in general. Infertile was a term only attached to women, and never men, when discussing the rise in fertility problems that doctors claimed to be treating. Finally, the dysfertile were those who could never naturally conceive or produce children on their own—mainly referring to gay and lesbian individuals and same-sex couples. Traces of these perspectives can still be seen in some of the stereotyping of women around the world.

The discourses around the female body and specifically the female body of color have been influenced by the colonial legacy left by Western imperialism and the era of Enlightenment (Merchant, 1980). The contextualization of current understandings of the body requires an examination of those influences and inheritances of the past.

The Post-colonial Body

When examining the socially constructed definition of female bodily experiences, it is important to recognize the historical influences. The patriarchal ideology of objective knowledge and experience is commonly found in the realm of discourse regarding women's bodies and freedoms. This is an oppressive conceptual framework that "functions to justify the subordination of women by men" (Warren, 2000, p. 46).

It is critical to discuss the harm and exploitation that can and has occurred in the development of industries centered on the body. It is important to note the current push from global feminism and feminists of color for the acknowledgement of past abuses of the female body—especially in scientific and medical realms. These exploitations and acts of violence can be described as body-colonizing moves. Smith (2005) describes a very long list of transgressions against indigenous or native groups in North America and Mies (1993) reminds us of the exploitation of women in the global South. In pursuit of better reproductive technologies for middle/upper-class, white women in the West, many pharmaceutical and medical companies have performed early human experimentation of their products without appropriate informed consent. In India, intra-uterine-devices (IUD's) were implanted in large groups of women before the side effects had been properly evaluated. This resulted in making many women very ill and ultimately sterile. In Mexico, women were involuntarily sterilized during routine visits to the gynecologist and Native American women have suffered violently for decades due to experimental drugs they were given in the 1980s (Smith, 2005). Many of these stories are never told, hence are difficult to confront. However, feminist work on the body maintains an important place in research and writing, these important narratives can become part of a larger public discourse to raise consciousness and in some cases call for action.

Technology and medical advancements are changing what we see as a "natural body" everyday. As a result there is no doubt that the body will continue to be a central part of feminist scholarship. The complexities and problems that exist at this "colonial present" (Gregory, 2008) require investigation and visibility in the interest of women worldwide. It is critical, however, to heed Mohanty's (1988) warning regarding Western

feminism's proclivity to represent "third-world women" as the quintessential victim of physical and ideological violence perpetrated by patriarchy and colonization. Global alliances can be formed to further discover how corporate interests and public policy still defines, regulates, and disciplines the female body. As the fertility industry advances through technology and globalization, feminist scholarship can engage in a discussion of what that means for the connection between *Woman*, a constructed, ideological fabrication and *women*, the corporeal, material, living individuals at the center.

In the pursuit of such dialogue feminist and other scholars will be called upon to produce work that captures the nuances of the embodied experience. This is no a simple task. It will require new ways of thinking and writing. Writing that is situated, complex, and varied, relying on the voices of those living whatever the issue of the day may be.

Writing the Body

In order to examine the body more effectively, theory continues to push for an elimination of the continued and flawed dichotomy between mind and body. Grosz (1994) explains that corporeality should be for all bodies; that women should not have to take on the body for men in order for them to transcend it. In other words, the bodily experiences should not be only defined for women, allowing men the opportunity to focus on the mind. There can be no one norm for the human body. Feminist scholars must continue to strive for better positioning through history and writing situated knowledge so as not to re-create the colonial gaze upon difference (Mohanty, 1988). Perez (1999) describes the future of third-space feminism, where we look at the past and evaluate history through the lens of the present in order to imagine a de-colonial future.

Trinh (1999) elegantly claims that "we do not have bodies, but rather we are our bodies; that we are both ourselves and the world at the same time" (p. 258). She argues that we must write our bodies into theory in order to gain a fuller understanding of experience and accept new epistemological processes. The body as a site of discourse and a location for the manifestation of events of lived experience is critical in this analysis. The body recently has gained more significance in the popular and academic realms, but it is a difficult entity to define. While every person has one, its value, position, and theoretical importance are contested. Longhurst (2005) describes the body as "a surface of social and cultural inscription; it houses subjectivity; it is a site of pleasure and pain; it is public and private; it has a permeable boundary that is crossed by fluids and solids; it is material, discursive and psychological" (p. 91). All experiences are written onto bodies. The body is gendered and racialized and representative of larger socio-cultural processes and formations.

The body can be located as a home for the core of what makes us human—whether that is a soul, a spirit or a mind. The body carries with it the experiences we have had, and those experiences are often written upon us internally. As such, the process of being positioned as "other" can have material effects on the body of that "other" (Fanon, 1963). The effects are not limited to the individual but also make that body disposable or easily ascribed as many of the events in this analysis will show.

The body complicates the notions of physical and symbolic borders—recurring themes in postcolonial literature. As Paasi (2003) explains, "borders and boundaries are increasingly understood as 'zones of mixing, blending, blurring and hybridization' where both material and symbolic dimensions and power relations come together" (p. 463). The

body becomes this liminal space where boundaries may or may not mark limits of sovereignty, ownership and agency. The body becomes a liminal space in the realms of private and public spheres. The body can be seen as its own counterpublic or alternative discursive space. Birke (2000) argues that the body has always been a site of examining difference and abstraction. In a similar line of thought, the body is a visual representation or performance of choices made by and for women within the private arenas as well as public discourses and policies. The female body in particular is often categorized as a private space as seen historically in the removal of women from public sight/sites during various times (such as menstruation or pregnancy). This is evident in much of the discourse about women's experiences, specifically when violence is perpetrated against them.

By placing the female body and thus a woman's lived experience in private, which is often, but not always the case, there is little room to claim empowerment over the body. It is a challenge to locate power over one's own body in the early conceptualizations of what "femaleness" embodies. Birke (1998) argues that,

Ascribing agency and transformativity to organisms/bodies works against the social devaluation of the body and its interior that contributes to women's (and others') oppressions. Moreover, it works against simple dichotomous classifications of mind/self versus body, for both exemplify the same or overlapping agencies. (p. 47)

The complexities housed in the material body lead to implications for individual autonomy and agency. The women at the center of this study embody the work they are doing—carrying a baby in public and private spaces. Surrogates negotiate the physical

experience with the emotional, intellectual and, personal aspects of the work. The choice to become a surrogate is a complex one. The many choices about their bodies and their lives, that the surrogates make in the process reflect a complicated construction of their agency. The construct of agency is nuanced, yet critical to questions of how policy impacts the regulation of and positioning of the female body. The next section explores conceptions of agency related to this study. There continues to be work that re-defines and re-imagines agency in creative ways that will be on-going beyond the scope of this project.

Agency

When discussing the embodied experience of women, the construct of agency, as Birke (1998) exemplifies, emerges as an important consideration in both contemporary critical and feminist theory connected to the body. Agency as a term is defined in many ways and can be applied to a number of questions and problems. It is a word that is probably used far too commonly today, so that the multiple meanings can become lost in translation or too problematic to define.

A significant critique of earlier social scientific explications of agency is the reliance on what is essentially internal efficacy for an individual. This understanding places too much responsibility on the individual and not enough recognition of situational or structural forces. If agency is only what we believe we are capable of, then literally every person who believed they could enact something in their lives could and would. This perspective is problematic in its Eurocentric, individualistic, and masculinist trappings. This definition of agency positions it as part of the traditional humanist project because it places all action, and thus the good of society, within the individual (Gergen,

2005). However, this is only one, limited, explanation of agency. As this study will show, many individuals are able to imagine their own conceptualization according to their environments and experiences.

Early conceptualizations of agency rely on the Enlightenment legacy of the value placed on rationality in thought. According to these psychological perspectives agency only belongs to the rational, and Cosgrove (2007) cautions that we must allow for an accounting of the "extra-rational" in order to include the act of resistance in agentic orientations. Work like that of Friere (1970) has more room for an articulation of the connections between internal agency and the context in which one lives that either limits or expands that agency. Additionally, feminist scholars such as Anzaldúa (1990), hooks (1984) and Spivak (1988) include the importance of the intersectionality of identity (through race, gender, economic position, geographical location, etc.) in the understanding of individual agency.

A more textured and nuanced description of agency requires that we recognize the location of individuals and the tensions they experience in unique positionalities. Contemporary communication scholars provide additional elements of agency that increase its meaningfulness in the context of issues of globalization and new sites of discourse. Agency is an ongoing negotiation of enabling and constraining forces that dictate interaction between people and actions of individuals (Shome, 1996). As Collier (2005) explains, agency is institutionally and discursively produced. This is an important dialectical counterpoint to the belief that all agency is located in the personal efficacy of each person. An additional conceptualization places the power of agency in the individual's interpretation (Foss & Foss, 2009). From this perspective, agency can be

harnessed through creativity, brainstorming, and re-framing of any specific circumstances one experiences.

Agency will continue to challenge the way we engage critical theory and our understanding of discourse and action. In order to further expand the construct in ways that are useful it must be dis-articulated and re-assembled to capture the complexity and contradictions that both enable and constrain people's lives. There has been a significant focus on individual agency as the ability to enact change in one's own circumstances, and I believe a shift towards larger instances of agency is the next step in extending this theory appropriately.

Agency, like everything else, is not value free. It is also not consequence free. If, for example we consider the typical classroom in an American college there are illustrations of the challenges of enacting agency on a day-to-day basis. Regardless of lengthy discussions of rules or expectations delineated in a syllabus, students can essentially do whatever they want—come to class or not, turn in an assignment or don't, learn something new or not—however, part of the responsibility of choice is accepting the outcomes that we understand to be consequential to our behavior. This example, also illustrates the subtle tensions between agency and structure. The societal and institutional definitions of a "good student," of education, of civic participation and the mechanisms in a university that control those constructions, all become limits to personal agency.

Specifically, agency is almost always partial or constrained for most human beings, and particularly for women in many contexts. The question of how choices are made and who gets to make them is in the forefront. Choice, in particular choice regarding the female body and reproductive processes, has historically sparked debate

about agency and the systemic constraints that limit full agency. Traditionally, feminist discourse had followed the dominant line of freedom versus emancipation (Mies & Shiva, 1993). This dualistic perspective limits the complexity in women's lives that allow for both the ability to choose as well as multiple constraints on those choices. There is considerable benefit to patriarchy in essentializing or reducing women to their role as producers. This "dividuation" challenges the notion of freedom or agency as the whole subject begins to disappear into an infinite number of parts (Mies, 1988).

Within global body-economies, or the industries that profit from forms of commodification of bodies or parts of bodies, the material conditions of individuals and their positionalities are critical to an understanding of choice and the limits experienced by various decision makers in the context of location, gender, race and class. The cultural and global powers are always in a state of flux, changing the nature and scale of economies at a rapid pace. These changes create "new planes of dis/empowerment" unique to each moment in history (Shome & Hegde, 2002, p. 175). For women in these selections of postcolonial literature they are often commodified in ways that further limit their access to education, literacy, or other competencies that would give them increased power in the patriarchal systems they inhabit.

Often, the question has been whether or not women are coerced or exploited under male domination or if they are willingly entering into certain situations, professions or marriages as economic opportunities (Raymond, 1993). This dichotomy of victim versus full agent emerges when looking at the historical positions of women in regards to reproductive rights. The "so-called choices" that are available to women are always within the context of a larger social system that necessitates certain action for survival

(Raymond, 1993). From this perspective, agency afforded to women can remain partial in that the other participants (including institutions) are active agents as well. The focus remains narrow in examining only the agency, or lack of for women and not identifying the actions taken by the other players that influence power inequities and overall outcomes. Chavez and Griffin (2009) argue,

there are times when our individual identities matter very much, and there are times when agency is or is not granted as a result of those identities... the ways that agency can be granted, held on to, taken away, or simply demanded, is as tied to institutional structures and relationships with others as much as it is to the individual—and these ties are as complex as they are simple and as elusive as they are obvious. (p. 3)

It is often the biggest task of an analysis such as this study, to avoid the trap of a victim/empowered subject dichotomies when looking for evidence of agency in a particular discourse. By expanding the definition of agency to include multiple perspectives this limitation can be mitigated.

Sawicki (1991) is critical of women for never fundamentally questioning the technologies that are produced to “enhance” their body’s functionality and rather focusing on implementation as if their appropriateness is a forgone conclusion. Mies (1993) explains that these new reproductive technologies do mark the body in an extreme way. They are expensive, difficult and invasive. She also cautions against the continuing "dividuation" of women into parts that can be used, abused, rented, sold, and colonized without recognizing the person they are in fact connected to. Issues of ownership of these parts, in the realm of the body are complicated by transnational partnerships. For

example, when a couple in California pays Circle Surrogacy to broker an agreement with a woman at a fertility clinic in Anand, India to carry their embryo, which is part genetic material from the intended father and part genetic material from an anonymous egg donor found in the International Sperm and Egg Bank, who is entitled to what? Each participant is a stakeholder in a complex process of negotiation, exchange, production and consumption in the reproductive marketplace.

Sawicki (1991) has said, "'motherhood' is both a place of empowerment and enslavement for women" (p.197). While one can argue that each player is benefiting through this partnership there is only partial agency at any given moment as each is completely dependent on the other to accomplish the ultimate goal—producing a baby. Many are uncomfortable with the idea of babies as business; however the parallel with other global commodities processing is undeniable.

The global and economic positions of women have always been differential to that of men (Sowell, 2008). This has been in part to ideological frameworks that limit women's participation in the labor force. With macro-level shifts in this perspective, women have begun to participate in many fields that have changed the landscape of women's economies. One way to create labor opportunity for women has been to engage the body in production. When capitals are limited and opportunity scarce various new forms of bodily economies have been constructed and managed (Mies, 1993b).

The complexities of the identities of various agents within a society and the tensions that exist along the chaotic continuums of societal participation deserve critical attention. These relationships of self to society and agency to structure are particularly salient in the realm of postcolonial work. The boundaries of public versus private in the

realm of a discursive space or of decision-making power are permeable, if not completely artificial. At this colonial present (Gregory, 2008), there is a tremendous opportunity as well as challenge to continue to question and explore a more sophisticated and nuanced vision of power relationships in various spaces.

The spaces construct the boundaries in which individuals negotiate their identities. Identities are dynamic and contextualized. By further exploring this process of identity formation we can begin to understand the positionalities and perspectives of the various participants in the surrogacy process.

Identity

The many relationships that are created through complicated processes across cultures, borders, industries and individuals contain continual negotiations regarding position, role and understandings of interactions. The physical body is important as the location that houses these experiences and agency describes the range of actions those bodies can take, but beneath that is the more internalized and intangible self-conceptualization within these relationships. When discussing the intersections of the many stakeholders in the surrogacy process it becomes important to look at how each participant is defining themselves and their role as well as how that is reflected in the interactions with those relational counterparts.

Complex cultural investigations require a more textured and layered understanding of identity. The business of surrogacy positions each actor; the surrogate, the intended parents, the doctors, the agency, and the nation in particular ways. The definitions of those positions are all in relation to one another. As Hegde (2009) explains, cultural identity is not a neutral space, but one marked by ongoing

contestations. In order to effectively explore the identity politics of surrogacy one must engage in analysis that recognizes contextual and structural elements beyond the surface of visible relationships. Identity is multi-layered; it is at once seen and unseen, historical and contemporary, lived and represented and it is communication practices that frame identities. Identity is a dialogic site of both power structures and resistance (Martin & Nakayama, 2000).

In examining the locations of agency and the body in an international context the concept of culture is important for the identity negotiations that inevitably occur. Bhaba (1988) argues that critical theory is about cultural difference, not cultural diversity. He defines diversity as an object and difference as "the process of the enunciation of culture as knowledge" (p. 155). Difference is at the heart of cultural exploration where culture is often contradictory and ambivalent.

The present moment allows for a number of unique investigations with regard to cultural identity and the discourses around intersectionality and location. Rapidly changing global economies and transcultural contact challenge identity formations in new ways. These commercial and cultural relationships create changing material conditions for individuals as well as cultural "groups." Exploring these positionalities is critical to the challenging work of expanding our understanding of the tension between agency and structure in various sites of discourse.

Paradoxes of Identity Constructions

The subject of gender and specifically globalization's effects on women's lives is absent in much of the discourse regarding the current blurring boundaries (Hegde, 2006). Questions of choice and the construction of changing identity positions requires

acknowledgement that the individual bodies that are raced and gendered differently by an external gaze experience the world from unique locations. It is not simply a question of freedom vs. emancipation, but rather what constraints and opportunities simultaneously impose decisions for people caught in the web of the global marketplace.

When looking at the construction of gendered identity, women's stories are rich and personal and can show a great deal about enactment of identity from their cultural location. Contradictions and tensions are present in framing of choices in all perspectives including ones from a postcolonial and/or feminist position. The position of individual women themselves and the structures that monitor and regulate (or do not) their laboring bodies are in flux. These are tied to context, positionality, and subjectivity of each actor and the different understandings of providing or preventing women with access to these reproductive alternatives

Mendoza, Halualani, and Drzewiecka (2002) argue that identity is better engaged when you include cultural, historical and political aspects of being, through communication practices (p. 312). Like many other interpretive and critical scholars they see identity as dynamic in that it changes with context. They explain that referring to identities as "positional locations" creates an image of something that is fixed, rather than a "directional location" that describes movement towards something. I find this explication useful when trying to capture the depth and breadth of experiences and connections in the complex site of surrogacy. When the multiple voices of community, family, culture, nation, technology and more are simultaneously enacting and deconstructing an individual location the importance of economics, history and context is

clearly seen. The norms and relationships present in context influence the way identities are enacted and read in any given encounter.

The identities of the actors involved in transcultural networks of relationships are structurally produced in many ways. The business of surrogacy is often linked to other commodities exchange where there are producers (the surrogate), distributors (the clinics and agencies) and consumers (the intended parents). Appadurai (1986) argues that relationships like these are a function of social practice, not a mysterious reflection of human need. This socially constructed process creates boundaries for each relational participation that has been pre-determined through the existing economic, political and cultural systems. In work that centers on cultural identity the position of the researcher must also be acknowledged. The very presence of an "outsider" disrupts the flow of communication and the "directions of location," and the act of writing culture will always be seen as subjective, personal and partial (Hegde, 2009).

Through my own subjective lens I attempt to explore the tensions that emerge when policy and structure influence autonomy and identity as well as the embodied experience. The discourses will point to the inherent contradictions in the surrogacy process and agreement.

Research Questions

The previous literature review has synthesized conceptualizations of the body, agency, postcolonial location, identity, and policy in the realm of commercial surrogacy. Surrogacy provides a unique context to investigate the contemporary issues associated with how women's bodies are positioned in commercial and scientific locations. The body is a critical source of knowledge and modern technology is changing the way we

experience our bodies. The changes in bodily experiences influence the way in which individual identities are constructed. In the case of surrogacy this impacts notions of motherhood and family.

While the site of the body often provides an individual and local understanding of various processes, analysis of policy can offer insight into the structural implications of particular regulation. The intersections of these constructs inform the choices of participants in a process like surrogacy. How these participants communicate about their decisions and identities reveal a great deal of information about the societies in which we live. This study has been developed to fill in some of the current gaps in connecting these areas of communication research. The lexical choices of the participants reveal the dominant and de-centered discourses that continue to exist along the landscape of surrogacy in India.

Based on the previously detailed theories and the contextualization of the surrogacy industry in India this study aims to increase understanding of the surrogacy process in India through the following research questions:

- RQ1: How is the process of surrogacy enacted in India?
- RQ2: How is the position of the female body constructed in surrogacy discourses?
- RQ3: How do the surrogates enact and communicate their identities?
- RQ 4: How do the current guidelines and absence of law constitute the rights of participants in the surrogacy process in India?

Chapter 3: Method

The purpose of this study is to explore the intersections of agency, identity and policy as they emerge in the practice of surrogacy in India. In order to address these complex issues, the study was conducted through qualitative interview methods. By traveling to India as well as examining the discourse surrounding surrogacy this study also addresses a larger goal of understanding the burgeoning enterprise of contemporary reproductive technologies. Specifically, the fieldwork included opportunities for participant observation, semi-structured interviewing, and cultural immersion. Surrogacy services are rapidly growing in popularity in India and as such I am able to address the complexities and paradoxes that occur as a result of outsourcing fertility. This chapter will detail the methods employed to answer the research questions posed in this study. The sections of this chapter include: (a) overview of methodology, (b) research design (c) field visit, (d) data collected, (e) and a summary including the structure of the following chapters.

Overview of Methodology

In complex investigations that combine several approaches, questions of method are often secondary to questions of paradigm. The philosophical assumptions that underlie each perspective shape both the questions we ask as researchers, as well as the strategies we employ in attempts to answer them. It is not a question of general approach, such as the dichotomous conflict of quantitative vs. qualitative, but rather the theoretical grounding that leads to the engagement of unique processes of inquiry. Two of those paradigms found in contemporary communication research are the interpretive and the critical. While not necessarily mutually exclusive the two perspectives have

differing viewpoints in ontological and epistemological commitments as well as tendencies to rely on certain techniques over others.

In the following sections I will explain how I rely on both the interpretive and critical paradigms to inform the structure of the study. I also include information on how a feminist framework drives the research questions and data collection methods.

Interpretive Paradigm

The interpretive paradigm sees knowledge as something that is located in interaction between people. Individual lived experience can shed light on how relationships work. How people choose to describe themselves, their interactions and the world around them has meaning. An interpretive frame contains the underlying assumption that people co-construct their reality through interaction. Interpretive scholars look for shared meanings in these interactions. As Mason (2002) explains, “What is distinctive about interpretive approaches is that they see people, and their interpretations, perceptions, meanings, and understandings, as the primary data sources (p. 56). In order to examine communication events interpretively, you must have a solid theoretical foundation for the context you are looking at. Additionally, the words and conversations of the participants become the centerpiece of your findings.

In many ways all qualitative research is interpretive in nature (Denzin & Lincoln, 1998). All research is guided by certain beliefs and practices. Interpretive research strives to gain an inside view of a particular experience, location, or relationship (Mason, 2002). Interviews, observations and group discussions are all methods by which the narratives of experience can be explored. In this study, I spoke directly with people who are a part of the surrogacy process in India in order to gain an understanding of that

perspective. For example, in conversations with the surrogates themselves, I was able to ask them why they agreed to be a surrogate rather than try to read between the lines of a website blurb. In conversation there is rapport, nonverbal communication, and context. The stories become more complete, allowing for that ‘inside view.’ In the first couple of interviews I was able to learn more about the complexity of the regulation and lack of law with regard to surrogacy in India. I was also able to see the challenges the surrogates face in negotiating their identities. Their responses were thoughtful and the tensions that exist for them in the various roles they fill emerged through their body language and emotional expressions. While this is a foundational perspective for this study, it runs along side and along with a critical and a feminist framework that provide the backdrop for the interpretations that are created in the data analysis.

Critical Paradigm

The critical perspective is centrally concerned with the tension that exists between individuals ability to change their circumstances and the social, cultural, and historical constraints to enacting that change (Kincheloe & McLaren, 2005). Critical theorists are interested in relationships of power within the structures that people live and operate. Context is a major component of any critical investigation. Issues of privilege and oppression as well as social justice tend to emerge through this paradigm. In communication, a critical perspective means that language is much more than words and interaction is more than a series of patterns. Language is powerful and can discursively construct reality. As Kincheloe & McLaren (2005) explain,

Critical researchers have come to understand that language is not a mirror of society. It is an unstable social practice whose meaning shifts, depending upon

the context in which it is used. Contrary to previous understandings, critical researchers appreciate the fact that language is not a neutral and objective conduit of description of the “real world.” Rather, from a critical perspective, linguistic descriptions are not simply about the world, but serve to construct it. (p. 310)

Critical work aims to unearth subjugated knowledges, subaltern realities and structures of domination that are taken-for-granted (Thompson & Collier, 2006). It is through this lens that I interpret data that is not directly part of an individual’s lived experience. In the example of policy and regulation of surrogacy in India, I look at the construction of language and how it positions each participant. This perspective can work to reveal ideological components of the policy and how they might impact the agency of surrogates. This emerged in interactions with doctors and health officials. I often had to push more directly to gain information about the potential problems associated with surrogacy.

In order to gain a more holistic and nuanced understanding of the issues of identity, agency, and policy, I relied on multiple methodological frameworks. While there are elements of both interpretive and critical frameworks in this study, there are also strong commitments to using qualitative methods and relying on discourses as the location of information. Additionally, feminist perspectives guide the motivation for and the interpretation of this project.

Feminist Framework

Among other methodological frameworks outlined in this study, I am also operating from a feminist perspective. Selection of particular strategies to answer research questions are born out of the assumptions we hold within the methodological

frameworks we align ourselves with. This perspective includes several beliefs and assumptions that I want to explicate to understand the method and process I have selected. The most general and simple definition of feminism has been proffered by bell hooks (2000) who says, “Simply put, feminism is a movement to end sexism, sexist exploitation, and oppression” (p. 1).

However, there are competing discourses from different groups of women that point to the politics of location (Carrillo Rowe, 2008). Many differences can be found along racial, ethnic, socio-economic, sexual, and generational lines (hooks, 2000). These perspectives born out of lived experience contribute to a variety of feminisms. Regardless of the differences, there are areas of overlap and agreement in feminist theory. Most perspectives have a goal to end gender-based oppression and unearth experiences that have been left in the margins due to the privileging of patriarchal processes and discourses. Feminist scholarship aims to voice the narratives of women who have been discouraged, dismissed, and ignored amid the tensions between agency and structure.

When attempting to bring to light the lives of women through a feminist lens, it is important to remember that all women are specifically situated in historical, political, social, and cultural spaces and there is no homogenous experience simply by virtue of being a woman (Cannella & Manuelito, 2008). This is where the body, autonomy and colonial histories begin to complicate feminisms. Women live multiple realities that are located in their specific positionalities. As Code (1996) points out feminist scholarship has not always recognized this. She argues for a shift from the patriarchal legacy of Western subject being able to *know* “othered” object, to creating a space for subjective voices. This is a critical component of contemporary global feminisms, but it has taken a

significant and lengthy struggle to move toward a more situated knowledge construction. By incorporating this perspective into research the study takes the ontological position that individual's views, knowledge and stories are meaningful properties of social reality (Lindolf & Taylor, 2002).

According to Foss & Foss (1994) feminist research is done to “empower women—to assist them in developing strategies to make sense of and make choices about the world in which they live” (p. 42). Feminist research is grounded in experiential knowledge and is reflective. It puts women at the center, providing space for their voices and experiences.

The interviews with surrogates specifically addressed the goals of feminist research. The women commented on how no one had yet asked them about their experiences and feelings about surrogacy. It was important in this study to have the voices of these women represented as much as possible. Their decision to participate as surrogates houses many contradictions. It is impossible to begin to understand their positionalities without directly asking them.

A feminist method requires engaging in a reflective practice (Naples, 2003). There are always contradictions between traditional implementations of research processes and the recognition of ethical accountabilities to the actual people participating. A feminist framework calls for strong reflexivity to recognize issues of power and privilege when engaged in fieldwork. This in no way removes all potential distortion or problematic representation. When deciding to engage a topic that asks questions about individual experiences that are physical and emotional, there are many critical reflections that must take place. Constructing surrogates as an object of study rather than a (perhaps)

subaltern subject can allow for the trappings of what Hegde (2009) calls the "inherited vocabularies and structures of institutional language" (p. 279). Hegde's (2006) own recounting of an attempt for feminist ethnography in Southern India is a good example of allowing for the complex story of oppression to be captured through the narrative of the subject rather than constructing her as a stereotypical victimized "third-world woman." It is problematic to assume that all women are "sisters in struggle" and Western feminists have been criticized for representing problematic homogeneity of women as an oppressed group (Mohanty, 1988). The historic mis-representations of Indian women as universal dependents and colonial victims are important discursive and situational components to recognize when writing about surrogacy. As Collier (2009) explains, when common (mis)representations are reinforced in discourse the power differences and subjugation can also be reinforced.

The history of colonization and the context of the oppressor have traditionally been written from the male perspective. With continued work towards voicing the experiences of women from their varying locations new understandings of how one form of oppression is influenced by and influences how another is experienced can emerge (Oyewumi, 1997). Poststructural theory points to the international division of labor as one way the Western subject and the objectified object have been defined in relation to one another (Spivak, 1988). Ideological frameworks that have limited women's participation in the workforce contribute to these constructions of female identities as subjugated. When the identity of women is conflated with the identity of a nation, women's experiences shift from a private patriarchy to a public one, where both women and that nation should be protected. Kandiyoti (1991) says the global debate about the

position of women is really over their souls, through hegemonic ideas of "we must educate them," *and* their bodies, through fertility control and reproductive technology. She challenges researchers to find a language of identity, which "allows for difference without making women its hostages" (p. 441).

Feminist approaches to theory and research in the field of communication are relevant in that it not only centers the lived experiences of women, but looks at where those discourses are placed and what that means for women. Grosz (1987) explains, "Feminist theory seems to be crucially engaged with the question of language and representation in terms of their material and political effects" (p. 479).

International Fieldwork

International fieldwork presents unique ethical challenges. The process of globalization fundamentally raises the question of the location of the transnational (McKinnon, Chavez, & Way, 2007). As the lines between local and global grow increasingly blurred, interaction between individuals involved in these global industries is commonplace. An interpretive framework allows for personal engagement in the field while also recognizing the importance of self-reflexivity when analyzing the data.

An additional challenge for international fieldwork is what Alcoff (1991-1992) calls the "crisis of representation" (p. 5). When reporting interview data or observations it is important to rely on quotes from the participants to speak rather than to speak for them. The meaning can be altered when researchers speak in place of, rather than about other's experiences or cultures. Again, I look to the surrogate interviews as an important example of this. As a cultural outsider and a stranger, I cannot begin to comprehend their

unique experiences. Even with significant preparation the nuances of a culture and a country only make sense through experience.

Researcher reflexivity can at least attempt to minimize the problems that can occur once you have left the site of research and immediate accountability to participants. By acknowledging our paradigmatic orientations we can more carefully select research questions and methods to engage in ethically responsible ways. I believe that "my life and the life of the world are deeply intertwined" (Abram, 1996) and that we leave a footprint on the earth and on those with whom we interact in every communicative act. By relying on strongly theoretical grounded processes and engaging methods of generating data that are flexible and sensitive to context we can make positive contributions with our work and our lives.

There cannot be apolitical research and there can be no ahistorical or acontextual investigation. With knowledge a social construction it follows that complex situated understandings will create dissonance. Historically, Western positivistic paradigms have been uncomfortable with what is not containable and ordered—ordered to the desire to control women's bodies. A response of resistance can be in what Fee (1989) calls radical writing, or struggling to rewrite the dominant ideology and produce new and different versions of realities. When a researcher is reflexive in their role in relation to those they are co-constructing an experience with (Collier, 2005) the result can be authentic even if coming from a place of difference. Authenticity is relative and context-bound like everything else and is not only found in autobiography (Suleri, 1992). As Bhaba (1988) says, "there is no location of culture, culture is located in you."

These theoretical assumptions are the foundation for the design and implementation of the study. The voices of the surrogates and other participants should be privileged based on an interpretive approach but the location of power and the influence of structure should not be ignored, hence a critical paradigm. Finally, the feminist approach ensures as much as possible that I maintain awareness of my own subjectivity and continue to unearth stories that reveal inequitable conditions for women around the world.

Research Design

Mason (2002) describes qualitative investigation as "problem setting" rather than "problem solving." This is particularly appropriate for interpretive and critical designs where there is no pre-conceived hypothesis that needs to be tested, but rather some theoretically grounded background on a situation leading to the investigation into an aspect of interaction or discourse. The information gathered prior to entering the field was incomplete

There is an array of websites advertising fertility services in India that provide information for potential clients in the U.S. These sites provide an introduction to the process including logistics, costs and policies. However informative the advertising is, it is only one piece of the story. This investigation is centered on the lived experience and perspectives of some individuals and communities in India. It is important to gather data that can provide a more holistic picture of not only the process of surrogacy, but the effects of this new international market. A critical piece of this holistic picture is how different participants to the surrogacy industry, process and locations construct their own participation and roles. Understanding of the relational intersections requires

perspectives from doctors, clinic staff, local community members, government officials and surrogates themselves.

projects.

Field Visit

In order to move beyond what has been available on the Internet and in newspapers and to gather first-hand information that contributes to various discourses surrounding surrogacy, I traveled to India to speak directly to the people involved in the process on several levels. In this section I will detail the planning, my experience in the field, and the individuals who were critical to my research in India.

Planning Stages

In early Fall of 2009, I began contacting clinics and organizations in India that I thought might be useful in my study to alert them of my planned trip and desire to speak with them. This process had several challenges including cultural understandings of time, the lack of previously established relationships, and difficulty of explaining my study in a concise and clear manner. As these were cold contacts, I relied heavily on information found in Internet searches and news stories about surrogacy. I would begin with an e-mail introducing myself and my work and request a meeting if possible during my stay during the months of November and December, 2009. Most responses were polite and people expressed willingness to speak with me, but encouraged me to contact them once I actually arrived in India. I continued to gather information and make initial contacts until a colleague was able to make on-the-ground connections during a trip in October, 2009. While e-mail has become a primary means of communication in the U.S., I quickly learned that phone contact is critical in India to gain access to people.

In the Field

I arrived in Mumbai for the first time at 11:00 p.m. on November 29, entering the heat and chaos of the city with excitement and anxiety. For the first week of fieldwork, I was in Ahmedabad and Anand in the state of Gujarat and visited clinics, health officials, activists, and surrogates. During the second week, I traveled to Delhi and Jaipur to access local research resources and participate in cultural experiences such as a Hindu wedding. In the third week I traveled to Mumbai for several site visits and then came back to Ahmedabad and Anand for a follow-up visit to the clinics and the health officials. I entered the primary research site, Ahmedabad, on my second day in India and was eager to begin the data collection process. I quickly learned that the business day is organized differently in the locations I visited with most offices opening around ten in the morning and staying open later in the evening. With this schedule I was able to spend time reflecting and preparing in the morning, allowing for flexibility in appointments with the busy medical professionals and government officials. Quickly I learned that appointments *had* to be flexible with little expectation to be ‘on time’. I realized that it was very cultural and quickly adapted to this expectation. Table 3.1 details the itinerary of the field visit.

Table 3.1

Travel and Appointment Schedule for Fieldwork in India

Date	Description
November 29	Arrival in Mumbai
November 30	Travel to Ahmedabad
	Meet with Jigna Ben at the Gender Resource Center
	Meet Dr. Manish Banker at Pulse Women's Hospital
December 1	Visit Gujarat Ministry of Health, interview Officials [how many?]
December 2	Second visit to Gender Resource Center Return to Pulse Women's Hospital to interview four surrogates
December 3	Travel to Anand and Akanksha Clinic Meet Dr. Nayna Patel and interview three Surrogates, Interview commissioning parent from Australia
December 4	Interview Dr. Ameer Yajnik, Central Government Counsel in Gujarat
December 5-7	Travel to Delhi for research in local libraries
December 8	Visit Jagori, feminist organization
December 9-12	Travel to Jaipur for cultural immersion in Hindu wedding ceremonies
December 13	Travel back to Mumbai
December 14	Visit Malpani Clinic, interview Dr. Malpani Interview Dr. Nandita P. Palshetkar Visit Surrogacy India, interview Dr. Sudhir Ajja and Dr. Yashodhara Mahatre
December 15	Travel back to Ahmedabad
December 16	Third visit to Gender Resource Center Second visit to Gujarat Ministry of Health Visit Civil Hospital and interview Dr. Desai
December 17	Return to Anand & Akanksha Clinic Visit Jagrut Mahila Sangathan, interview Ashaben
December 19	Travel back to Mumbai Visit Trivector Scientific International, Interview Dilip Patil

Ahmedabad. The first region on my itinerary was the state of Gujarat. Gujarat is a unique area located on the Western Coast of India bordering Pakistan. A majority of the population here resides in rural locales and almost 90 percent are Hindu (www.gujaratindia.com). Ahmedabad has a population of almost six million (2001 Census <http://india.gov.in/knowindia/districts/andhra1.php?stateid=GJ>). Gujarat boasts an 80 percent literacy rate and Ahmedabad is the financial center of the state (http://www.vibrantgujarat.com/district_profile/snapshot/ahmedabad.pdf). One of the most unique aspects of this state is the existence of many government directed initiatives to aid in development of business, agriculture and the welfare of women and children.



Figure 3.1. City traffic in Ahmedabad. (source: author)

The city itself is a mix of modernism and traditional lifestyles. Rows of motorbikes, auto-rickshaws, and SUVs find their way through narrow streets and the occasional ox eating garbage on the side of the road. Sprawling malls are as popular as the roadside fruit stands. The older and newer parts of the city are divided by a river. While not as chaotic or expansive as a city like Mumbai, Ahmedabad has a busy rhythm

of its own. Ahmedabad was also home to Mahatma Gandhi for many years. His life and work are honored at the Sabarmati Ashram.



Figure 3.2. A shepherd along a street in Ahmedabad. (source: Karen Foss)



Figure 3.3. Sabarmati Ashram where Mahatma Ghandi spent many years in Ahmedabad. (source: author)

Mr. Kiran Chabra. When I arrived in Ahmedabad, I was greeted by Dr. Saumya Pant and Mr. Kiran Chabra (Kiran bhai). Kiran bhai² is a critical character in the story of my time in India. He worked tirelessly as a liaison to every key visit and interview in the state of Gujarat. The relationship with Kiran bhai is part of a larger connection to Mrs.

² *Bhai* is a Hindi term that means brother and is added to a man's first name as a sign of respect.

Vijaylakshmi Joshi, the Health Commissioner of Gujarat. Mrs. Joshi, a relative of Dr. Pant, was able to provide assistance in reaching key individuals in the surrogacy industry in the state of Gujarat. Kiran bhai describes his job as a “lobbyist” and he has a strong relationship to many prominent people in Ahmedabad. He has three cell phones just to manage his day-to-day activities and networks.

With Kiran bhai as a point of contact each day was more efficient and productive than the last allowing for quick progress in scheduling and made the short time there fruitful. Kiran bhai set appointments and assisted in navigating the landscape of Ahmedabad and Anand. He often acted as a translator when the Gujarati dialect was spoken. As an outsider I was able to access a large amount of information in a matter of weeks instead of months or years through this informal network. Time is more fluid in India, and cell phones are a critical tool of communication. Appointments are best scheduled the day before, and it is very important to be continually available by phone. Mrs. Joshi and Kiran bhai made maneuvering my way through Gujarat possible.



Figure 3.4 Mr. Kiran Chabra busy with his three mobile phones (source: author)

Gender Resource Center (GRC). Because of this process, a schedule was already in place when I arrived in Ahmedabad, and I was able to begin interviews immediately.

During my time in Ahmedabad I was able to visit the Gender Resource Center, which is a well established not-for-profit that works toward the improvement of women's lives in the state of Gujarat. The modest building houses many resources and programs for women in the area (Figure 3.5). It was created in 2003 through funding of the Department of Women and Child Development (DWCD), Government of Gujarat, and the United Nations Population Fund (UNFPA). It is an autonomous agency charged with promoting gender equity in Gujarat. The GRC has lobbied for various state initiatives and the inclusion of women in key leadership roles in the government. There I spoke with Ms Jigna Surkar (Figure 3.6), Programme Officer for Gender & Training.

Jigna ben³ has a strong presence with a gentle demeanor. She is passionate about improving women's lives in Gujarat. She was very informative about the current state of women's empowerment in the region. While not directly involved in any aspect of surrogacy she is well aware of its presence in the area. Our conversation was very casual and comfortable. She has been working in the realm of women's empowerment most of her life. I was able to meet with her a total of three times during my visit in India. She has firsthand knowledge and experience about the struggles and salient issues for women in Gujarat. She also offered a valuable perspective on the implications for women's lives and their roles in society.

³ *Ben* is a Hindi word that means sister and is added to a woman's first name as a sign of respect.



Figure 3.5. The Gender Resource Center in Ahmedabad (source: Stephen Littlejohn)



Figure 3.6. Jigna ben at the Gender Resource Center in Ahmedabad (source: Stephen Littlejohn)

Pulse Women's Hospital. While in Ahmedabad I also visited Pulse Women's Hospital, a state-of-the-art medical facility that provides a wide range of health services for women. A significant part of the available medical care revolves around infertility and in vitro fertilization with surrogacy as one potential treatment. The hospital itself is four floors of modern architecture and waiting rooms filled with patients. On the ground floor lobby there is a digital sign that counts the number pregnancies that were a result of in vitro fertilizations at the hospital (Figure 3.7). There I interviewed one of the founders

and directors, Dr. Manish Banker about the practice of surrogacy. While it is not his main treatment he was part of the group at the Indian Council of Medical Research that created the guidelines for clinics that provide assisted reproductive technology.

Additionally, I spoke with several surrogates who were at the hospital to be interviewed by a commissioning couple.



Figure 3.7. Sign counting IVF pregnancies at Pulse Women’s Hospital (source: Saumya Pant)

Anand. Approximately one hour outside of Ahmedabad is the smaller and more agricultural town of Anand that is in Kheda District of Gujarat. Known as the “milk capital of India” it has a population that nears two million people (http://www.vibrantgujarat.com/district_profile/snapshot/anand.pdf). It is the home of the National Dairy Development Board (NDDB) and Amul (Anand Milk Union Limited) dairy. It continues to see growth as the Ahmedabad-Vadodara Highway has reduced travel time between the two cities by half. Anand is about two-thirds of the way to the city of Vadodara. The road was India’s first expressway and was opened for travel in 2004.

Akanksha Infertility Clinic. Anand is also the location of Dr. Nayna Patel's Akanksha Infertility Clinic. The clinic has been noted in international press about surrogacy, including a feature on the Oprah Show in 2007 and Dr. Patel is known as the pioneer of the practice in India. The clinic is located in a hard-to-find, yet crowded alley in the middle of town. The waiting room at the entrance was crowded with women and buzzing with activity. The facilities appear somewhat run-down and in need of renovation. Dr. Patel was inundated with patients and phone calls, but I was able to sit down with three surrogates and later speak with a commissioning parent from Australia in her second surrogacy cycle. Each of the surrogates was advanced in the third trimester of pregnancy, one even scheduled for a cesarean section the following day. They all lived together in the surrogate house near the clinic but were from very different home locations.

In a second visit to the clinic there was enough time for a lengthier conversation with Dr. Patel. She was embroiled in a controversy over the documentation of German twins born to a surrogate at her hospital two years earlier and I was able to watch her engage in a media interview and several reporters' phone calls during the meeting.



Figure 3.8. A recovery room at Akanksha Clinic in Anand (source: author)

Jagrut Mahila Sangathan. During my time in Anand, I also visited Jagrut Mahila Sangathan, a local not-for-profit dedicated to the welfare of women and children in the region. Asha ben Dalal, the founder and director has a very pragmatic approach to helping women feel empowered to make decisions that are best for their lives. Asha ben appears to be an institution in Anand and she is able to wield considerable influence in her community. The organization itself has a safe house above the administrative offices where women live while transitioning from an abusive environment to independence. They learn skills, such as sewing and sell their wares at local markets.

Gandhinagar. Less than an hour away, Ahmedabad's sister city, Gandhinagar is the administrative capitol of Gujarat. I traveled there to visit The Ministry of Health Offices and Civil Hospital. At the Ministry of Health I interviewed a couple of officials who work under Mrs. Joshi. They provided information about the current guidelines and policy, but were clear it is still a developing area, as there are bigger issues on their agenda than surrogacy. Not far away, at Civil Hospital, one of the largest government hospitals in the region the hallways were crowded with patients waiting in line for treatment. The sprawling campus is home to Dr. A. N. Desai, Associate Professor of Obstetrics and Gynecology. Dr. Desai views surrogacy as a public health issue and has many concerns about the process.

Delhi. During the second week I traveled north to Delhi. The modern city of New Delhi is the capital of India as well as a financial center of commerce. Although a planned city with a metro system, it can be very difficult for an outsider to navigate in Delhi. Delhi was a valuable part of my field visit not only to experience a different region of the country, but as the center for academics and research there were many

useful resources. I stayed at the India International Centre, where lectures, conferences, performances, and research are all part of the organizations objectives. There I attended a lecture on the status of the girl-child in India where a panel of governmental officials, academics, and community activists talked about the direction India is headed in order to improve the conditions for young girls. In addition to making contact with some local scholars, I found the lecture very informative and useful to provide context to my research agenda. The IIC also housed a library that contained valuable resources from local and international scholarship. I thoroughly enjoyed reading some of these journals.

Jagori. During my time in New Delhi I visited Jagori, a women's organization "with the aim of carrying feminist consciousness to a wider audience using creative media (www.jagori.com). Jagori, which means 'awaken women', was founded in 1984. Some of their key issues addressed by Jagori include taking action about violence against women and improving public health of women. They are a self-proclaimed feminist organization advocating for gender equality in India. Jagori's staff engages in action-research that focuses on advocacy and intervention. They also provide a lot of literature and documentation on the status of women's lives in India. These documents and other resource materials such as books, journals, and videos are open for public use. Bookmarks distributed at the library read, "...since history has ignored us, we're writing her story!" During my visit, the staff was very busy with the implementation of a local campaign on harassment of women at night in the city of Delhi. To address this crucial safety campaign, a hotline was being launched to provide information about safety for women. This visit was an important opportunity for me to see how feminism is being

applied in the Indian context and also access information that is not easily available in the U.S.

Jaipur. Following a few days of research in Delhi, I traveled by bus to Jaipur to participate in a Hindu wedding celebration. This became an important piece of my personal journey in India, which gave me a unique perspective that would not have been learned from just reading literature on cultural praxis in India. I stayed at the wedding house where all of the members of the groom's family were gathered and participated in several events. I was warmly embraced by the family and welcomed into the wedding rituals. It was the perfect opportunity to observe and participate in an extended family unit to contextualize the stories I heard from surrogates and medical professionals. I was able to personally observe the interactions and roles of members of an extended family unit. I was a temporary part of the groom's family for the weekend. The value of children and the importance of motherhood could be seen in the various rituals performed during celebrations that lasted for several days. On the first night of the celebrations, all of the women performed songs that introduced the family members to the bride's family in a ceremony called ladies' 'sangeet' (musical sitting). It is a time of song and dance exclusively for women from both sides of the family.



Figure 3.9. Women from the groom's family performing at the ladies' sangeet (source: author).

During my short stay in Jaipur, I was never alone and I was always surrounded by family members and children. I shared a room with four other women spanning three generations and a bathroom with a total of eight individuals. Everyone would stay up late talking and singing and preparing for next ritual. Though I could barely speak a few Hindi phrases and only a few family members were fluent in English, I was able to learn so much from this family and experience the nuanced interaction of this large group. I received direct education in the function of marriage, family and motherhood in typical Indian society. Everyone was willing to explain to me the significance and history of each ritual. Unlike most weddings in the U.S., the environment was very open and informal.

The respect for the elderly members of the family was apparent in the greeting every young person gave them and how they were looked after at each event. The collective participation included caring for children regardless of who they belonged to. The kids would run around the wedding venue playing and dancing and listened to any adult who was in the area keeping an eye on them. The women had many important roles in the ceremonies and often the status of marriage or motherhood was identified during the numerous rituals.



Figure 3.10. Married women from the groom's family bathe him in turmeric as part of a cleansing ritual in preparation for the wedding ceremony (source: author)

Much of what I learned during my participation in the wedding is difficult to define or quantify. It was an embodied, immersive experience that brought me closer to the culture and people around me. I was forced to address my own cultural definitions of space and privacy as well as of family. Coming from a small and divorced nuclear family that has very little extended connections, this was a unique and at times uncomfortable place for me. However, this time was invaluable in expanding my perspective and increasing my understanding of family and social roles in India.

Mumbai. Following the wedding, I returned to Mumbai for a different perspective on the surrogacy process. Mumbai is the world's second largest city with a population of over 14 million (<http://india.gov.in>). It is the commercial center of India as well as home to Bollywood, India's booming movie industry and the largest film industry in the world (<http://india.gov.in/knowindia>). While surrogacy is not a huge business in Mumbai, the city is often a port of entry into India and I met with several key informants with important perspectives.

Malpani Infertility Clinic. While in Mumbai, I visited The Malpani Infertility Clinic. Dr. Aniruddha and Dr. Anjali Malpani are a married couple whose small clinic provides a number of assisted reproductive technologies to patients from around the world. They believe patients need to be informed to the point of becoming an expert on their own condition. They have performed over 300 IVF cycles a year and have created educational publications like *The IVF Comic Book* and *Getting Pregnant—A guide for the infertile couple*. While surrogacy is not a treatment at the Malpani Clinic, the doctor has been very vocal in the medical community about how and when it should be used, arguing it is most appropriate when a woman has no uterus.

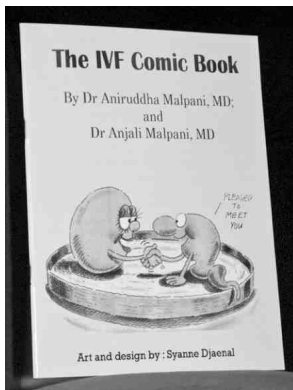


Figure 3.11. Cover of the Malpani Clinic’s patient education publication about in vitro fertilization (source: Stephen Littlejohn)

Dr. Nandita Palshetkar. Dr. Nandita Palshetkar has a slightly different view than Dr. Malpani. She has a private practice in Mumbai and consults for a number of hospitals in India. She is most well known for achieving pregnancy for a 60-year-old woman and for delivering the first assisted laser-hatching twins in India. She does not think there should be many limits on how a woman can conceive and believes every couple has a right to have children. She has garnered some controversy throughout her

career focusing on pregnancy for women over 40, but remains a prominent figure in the medical infertility community in India.



Figure 3.12. Patients checking in at Dr. Palshetkar's busy clinic. (source: Stephen Littlejohn)

Surrogacy India. For a completely different perspective, I visited Surrogacy India which is a third party agency that provides no fertility medical treatment, but only the management of surrogates and egg donors. It offers comprehensive services including interpretation, legal counsel, documentation, travel and tourism, transportation in India, communication with the surrogate during pregnancy and even passport or visa assistance. Dr. Sudhir Ajja manages the business aspects of Surrogacy India and Dr. Yashodhara Mhatre works personally with the surrogates and egg donors. They have different requirements for the surrogates than other locations I visited, including documentation, literacy and a home location near Mumbai.



Figure 3.13. Interview with Dr. Sudhir Ajja at Surrogacy India (source: Stephen Littlejohn)

Trivector Scientific International/Cryobank. A final site visit in Mumbai took place at Trivector Scientific International. In addition to having a sperm bank, Trivector supplies assisted reproductive technology clinics with software and equipment. After years of being on the technical end of infertility services, Director Dilip Patil plans to expand his business to provide egg donors and surrogates. He believes a third party agency is best suited to avoid problems or exploitation of the surrogacy process.

Each person I interviewed and each location I visited in India provided a unique fragment contributing to a larger picture of the discourse about surrogacy. The time in the field, while brief, was crucial to my understanding of the process and motivations involved. Based on previous research that I conducted which focused on websites and online information, I realized that I had a narrow and an incomplete view of surrogacy. While the information is still incomplete given the short time surrogacy has been a practice in India, a more nuanced depiction emerges in the data collected throughout the trip.

Role of the Researcher

It is always a large responsibility when a researcher enters a field to which they are an outsider. Based on my own feminist framework, I recognize and embrace the fact that the research process is always interactive and my presence and questions impact the terrain upon which I travel. Not only is a feminist researcher held to the standard professional and ethical codes of conduct in the field, but also to her own positionalities and privileges. As Friere (2001) has said, “The accomplishment of critical consciousness consists in the first place in the learner’s capacity to situate herself in her own historicity...” (p. 14). This means that part of feminist work and consciousness raising entails grappling with the myriad of social, political, and historic contexts that frame us as subjects. It means becoming aware of, accountable to, and willing to respond to these exigencies from a space of critical engagement. This important component of this study is reflected consistently beyond the confines of this section.

While my composite identity of being a highly educated and white American is implicit in my interaction with the participants, it is not most critical in gaining the confidence and trust of the participants. Many of the interviewees were highly educated professionals with international experience. However, in my interaction with the surrogates, other aspects of my identity emerged as salient. What singularly separated my lived experience from theirs was the fact that I am not a mother. By traditional Indian standards, I am a little old to be unmarried and be without children; I have never been pregnant and have made a conscious choice to privilege a career and education before starting a family; and I come from a small family that is separated by distance with no in-laws. This may have distanced me from the surrogates in some regards, but also allowed me to view this piece of surrogacy discourse with a different emotional sensibility. The

ability to critically understand the experiences of the surrogates as a woman, as a daughter, as a sister, or friend but not just as a mother. As the analysis will show, the surrogates privilege their identities as mothers and find value in that position. Through personal conversations with people I met during the field visit and through endless self-reflection, I came to realize how my identity as a non-mother may have impacted my own questions and interactions with the surrogates.

This study relies on the assumption that an outsider who is sensitive to context and reflexive in defining her identity can be effective in understanding dialogue and finding meaning across cultural boundaries.

Data Collection

The challenge of being an outsider was managed through the assistance of Mrs. Joshi, Kiran bhai and Dr. Saumya Pant. I will explain the basic process I used during site visits and interviews highlighting the differences that existed based on who I was meeting and what language they were most comfortable with. Each interview lasted approximately 60-90 minutes (occasionally longer) and was tape-recorded. Since each meeting was set through a prior email or contact from Kiran bhai, the participants had an introductory understanding of why I was there. Once I arrived at a site or appointment, I would thank the participants for taking the time to meet with me personally. I would then explain that I am a graduate student at the University of New Mexico working on a study about international surrogacy. I would explain that I am interested in how the surrogacy process works in India and that I would be talking to people from all aspects of the industry. Then I would let participants know that I have been approved to conduct the study by UNM and would be following strict ethical guidelines regarding privacy and

confidentiality. Though I did receive approval to waive a signed consent form I provided a consent letter that included information about the study and how to contact me or UNM if needed at any time after the interview. Finally, I would ask permission to record the conversation. Interviews with surrogates were all conducted through Hindi translation by Dr. Saumya Pant. All other interviews were in English.

The interviews were semi-structured with an emphasis on allowing participants to share their experiences and views in their own words. The approach allows for more flexibility in the information a participant provides and can be especially useful if you are only able to speak to an individual one time (Mason, 2002). Semi-structured interviews rely on open-ended questions and the ability to make an interviewee feel comfortable speaking about the topic at hand. It can often lead to unexpected information and appropriate follow-up questions can help the interviewer delve deeper. I created the interview protocols, which include prepared questions, based on the research questions and background research for the study (See Appendix A for Interview Guides). I also adjusted the questions according to whom I was speaking with. The categories of participants included: surrogates, healthcare professionals and service providers, government officials, and leaders of women's organizations.

The Participants

Surrogates

Special consideration was taken when speaking to surrogates to maintain confidentiality and privacy as well as make sure none of the questions would be stressful on them. Surrogates have often been projected as a vulnerable group requiring more protection than others. The Institutional Review Board at UNM was concerned with their

privacy, their pregnancy, and their agency. While these are important concerns, they are not universally applicable in every cultural context. They preferred to speak in small groups with other surrogates that they were sharing the experience with and the interviews had a conversational tone. The women often had a connection with another surrogate like a sister, cousin, niece, or friend and they frequently lived together during their pregnancy. By using a small group approach they were more at ease. Each woman was strong in her own way and had a voice in which she was able to tell her own story. All of the surrogates were most comfortable speaking Hindi, thus Dr. Pant translated the interview protocol and interpreted the conversation. I made it clear that at any time they could end the discussion or choose to leave the interview as well as refuse to answer a question that made them uncomfortable. In addition to basic background information I asked questions such as, *“How did you decide to become a surrogate? Tell me about your experience so far... and How do you explain to friends and family members what you do?”* (See Appendix A)

Healthcare Providers

In order to understand the medical and commercial elements of surrogacy, I spoke with several fertility doctors who are knowledgeable about the practice. Through an Internet search, I located several prominent practitioners and commenced communication months before arriving in India. Once I was there, I was able to make specific appointments for interviews and tours of their facilities. I would ask doctors questions about their practice as well as the national discourse around surrogacy. I would ask, *“How does the surrogacy process work at your clinic? Why do you think international patients choose India? Why do they choose your clinic? and How do you select*

surrogates?” (See Appendix A) Doctors are the ones currently responsible for the surrogacy industry in India. They have not only pioneered the practice, but also constructed the current guidelines and ethical standards in the field.

Government Officials

I was able to speak with several individuals in the Health Ministry of Gujarat. They were cautious in their responses to my questions and appeared somewhat uncomfortable with the general inquiry. They were in the midst of a controversy about the immigration of two twins born to a surrogate in Anand. Also, without any legal regulation of the industry the government’s hands are tied in many ways with regards to surrogacy. In interviews with officials in the health ministry the questions focused on the role of government in surrogacy practices. I would ask questions such as, “*Why do you think India is such a popular choice for fertility tourism?”*, “*What policies are in place to regulate surrogacy?”*, and “*What are the potential challenges or legal complications with the process?”* (See Appendix A)

Women’s Organizations

The purpose of interviews with leaders in the not-for-profit sector was to contextualize the other data in terms of the understanding the challenges faced by women in modern India. I visited Self Employed Women’s Association (SEWA) as well as the Gender Resource Center (GRC) in Ahmedabad, Jagori in New Delhi, and Jagrut Mahila Sangathan in Anand. Each organization had a unique role in the community they served, but all were dedicated to improving the lives of women in India.

I would ask for detail about what their organization does as well as questions regarding women’s health and women’s rights. I would also ask questions like, “*What is*

your opinion of the surrogacy industry in India?”, *“How might being a surrogate impact a woman’s life in India?”* (See Appendix A)

The interview protocol would serve as a guide during the conversations, but I would often follow up a statement or story with additional questions to gain deeper understanding. The semi-structured format allowed me to follow the participants lead and focus on what seemed important to them rather than having the conversation rigidly driven by my own assumptions. For example, I might say, *“Can you tell me more about that?”* or *“Earlier you spoke of...what did that experience mean to you?”* After the interview I would explain that I would be transcribing the interviews and using the information in my study. Then I would offer to answer any additional questions the participants had of me and explain that they could contact me anytime about their interview. Finally, I would again thank them for their time and willingness to share their perspectives and stories with me.

Each participant had a unique personal experience and interest in surrogacy and as such each interview was different revealing a wide range of information. The face-to-face contact was critical to uncovering the gradations of meaning that exist below the surface discourse about surrogacy. The exploration of lexical choices by participants exposes the subtle beliefs and values that contribute to the way we understand the process of surrogacy.

Data Gathered

The field visit resulted in a wide variety of data used to address the four research questions. I interviewed 22 individuals including eight surrogates, two health officials, one attorney, seven doctors, three directors of women’s organizations, and one intended

parent. Additionally, I took extensive field notes during the trip that covered the interview experiences, cultural immersion, and general observations. During the visits to each organization, photographs were taken to document the location as well as during travel and other cultural excursions. Over 500 photographs exist of the trip and 25 are used in this manuscript to aid in the description of the experience.

Qualitative Inquiry and Discourse

I approached data collection from a qualitative perspective applying my broad interpretation of discourse. Differing realities and cultural constructions of experience can be examined by looking at discourse. Discourse can describe many types of communication including conversations, texts, narratives, language, interaction, or the production of a society. Unfortunately, discourse cannot be defined in a simple and concrete manner. Fairclough (2003) describes discourse as “ways of representing aspects of the world—the processes, relations and structures of the material world, the ‘mental world’ of thoughts, feelings, beliefs and so forth, and the social world” (p. 124). Discourse reveals the meanings given to a subject in a particular context.

I wanted to capture as many perspectives as possible across the various stakeholders involved in surrogacy. My visit to India was primarily purposed with having recorded conversations with surrogates, healthcare providers, business people and policy-makers about surrogacy. Additionally, I wanted to see firsthand how the clinics operated instead of relying on their websites that were created with the intention of appealing to potential patients.

The data that resulted from this study included interviews, taped conversations and reflections, as well as printed materials provided by the participants. The result is a

broad range of discourse around surrogacy. It is appropriate at this stage of investigation and awareness and will provide an important baseline to future studies. In addition to the interview data, key documents include *The Assisted Reproductive Technology (Regulation) Bill of 2008*, a PowerPoint presentation on Assisted Reproductive Technologies created by ICMR, and news articles from *The Times of India* regarding current controversies surrounding surrogacy in India in 2009.

In examining the interview data, I identified themes and categories that reflected the landscape of opinions I encountered. The analysis heavily relies on quotes from the individuals I spoke with in India. The information I gathered directly from participants brought to light entirely new understandings of surrogacy that I did not encounter in any online forum or other documentation collected prior to the fieldwork. A general and holistic understanding of surrogacy was a necessary starting point in this investigation. While I focus a great deal of analysis on the interpretation of qualitative data there is also a critical component to the research I conducted.

Analysis of the Data

The tenets of Critical Discourse Analysis (CDA) influenced my approach to reading the interview data, and specifically my examination of the policy document in Chapter 6. In more recent discussions of CDA it has been described as less of a specific method and more of a way of interacting with issues of power and the positionality in framing persons and actions (van Dijk, 2008). This is due to the increasingly broad nature of discourse and the variety of approaches to examining it in the social sciences. There are many commonalities among the various approaches that make it a common and useful tool for critical scholars.

CDA approaches language as a social practice. It stems from the fields of sociolinguistics, pragmatics, and semiotics in the 1960s and 1970s. The evolution of this type of analysis has moved away from looking at single words or grammatical structures to examining entire texts and communicative events. Discourse is more than language it is also the action and interaction involved in communication (Phillips & Jorgensen, 2002).

Discourse analysis from a critical framework sees discourse as creating ideology and ideology as a means through which social relations of power are reproduced (Fairclough, 1992). CDA enables the study of the role of the social, cultural and cognitive contexts of language use. According to Foucault, one of the philosophers attributed with early use of CDA, texts constitute versions of reality in ways that depend on positionality in social structures and the objectives of those who produce the texts. Power is both produced by and produces discourse and it constitutes knowledge, bodies and, subjectivities. While, I do not claim to have fully engaged the CDA process in most of this analysis, it was an important foundation for my approach in subtle ways.

The first step in analyzing the data collected for this study was to transcribe the critical interviews and code those transcriptions for statements and themes that provide insight and answers to the research questions posed (Phillips & Jorgensen, 2002). The transcriptions were reviewed for accuracy and for critical passages that were then organized into large, general themes around the research questions (including categories for process, surrogates experiences, policy information). Once the information was organized and structured appropriately the texts were examined for *frequency* and *intensity* (Foss, 2008), particularly when looking at the surrogates' emotional expressions

and the guidelines in the policy document. This process is grounded in rhetorical theory. Frequency simply refers to the number of times a concept was discussed in the data. Frequency is especially useful in identifying themes and general feelings from the interviews. Then the data was screened for the intensity or strength of language participants used when referring to specific ideas. Some of the labels and constructs interviewees used to describe the process or stakeholders in surrogacy were so unique or they were so emphatic about a concept they deserve considerable attention. For example, Dr. Malpani's use of the term "reproductive exiles" was distinctive from any other interview with medical professionals.

When examining the data for information about the process of surrogacy many participants used language that confirms previous theories about how surrogacy is constructed in discourses (Kroløkke, Foss, & Sandoval, 2010). These frequently mentioned aspects included the medical intervention/service surrogacy provided, the demand for more options because of increased infertility that lead to a booming business, and the altruistic importance of giving the gift of a child to a couple who desired one. These eventually became the thematic/organizing categories for Chapter 4.

The interviews with surrogates themselves were more difficult to systematically arrange around themes because their original discourse is in Hindi. Though careful translation attempted to capture the meaning in their stories, there may be some lost nuance in my reading. They did, however, express strong feelings around the certain aspects of their experience. Most notably, they spent considerable time discussing their roles as mothers and their desired for the lives of their children. They also spoke

frequently about the legitimacy of the work of surrogacy and how it is “dignified work.” These themes are reflected in Chapter 5.

Finally, the analysis of policy information in Chapter 6 took a decidedly less interpretive turn as I examined the text for larger systems of control and power (Fairclough, 1992). I looked for multiple signs and symbols that positioned the participants of surrogacy in specific ways with regard to rights and responsibilities in the process. It is a subjective reading that was certainly influenced by my experience in the field and interviews with various individuals with different roles in the surrogacy process.

The cultural situatedness of any discourse or text is an important part of the historical context (Fairclough, 1992). Additionally, the researcher must be aware of their own position in society as well as their reasons for being involved in the topic they investigate. The researcher is the instrument in this method and must engage self-reflexivity systematically and continually throughout the process. CDA typically has fewer logistical challenges than international fieldwork, but it does present its own ethical dilemmas. While interpretive work tends to be descriptive, critical analysis explains. It is also highly dependent on a very specific piece of much larger issues and is therefore not particularly generalizable. This is typically not the goal of a critical research study, but it can make gaining credibility from other field more difficult.

CDA also runs the risk of using positions of privilege to speak for those we often presumptuously, define as oppressed. Alcoff (1991-1992) offers several ways to reduce these problems. First, the researcher must question and account for their location in relationship to what they are saying. Secondly, the researcher should always carry within him/her accountability for what they say and who they say it to. Finally, the researcher

should evaluate the material and probable effects of his/her contribution to the discourse. In critical research, particularly when addressing issues of globalization or postcolonialism, the researcher's relationship to their own bodily location and the bodies of others as well are enormously complex. There are competing and sometimes contradictory meanings and countless layers of historicity and power that create challenging and dissonant relationships (McKinnon, Chavez & Way, 2007). However, there is no methodological guarantee regardless of the strategy or process that a study can ever truly account for one's own influence and disruption in pursuit of our academic projects.

Summary

In this chapter I detailed the qualitative approach to this study that is influenced by interpretive, critical, and feminist paradigms of thought. I detailed my field visit to India and my experiences in the cities of Ahmedabad, Anand, Delhi, Jaipur and Mumbai. By using a critical discourse analysis approach I privilege the examination of language and meaning as it is constructed by the various participants. By attempting to reach different stakeholders in the surrogacy process I collected a group of data that creates a small, but comprehensive collection to information to answer the research questions posed in this study. Finally I examined my own identity and role as researcher and the impact that has on my interpretation and framing of data in the following chapters of analysis.

Structure of Following Chapters

The following chapters are organized according to research question. Each chapter explores the story of how I came to answer the proposed inquiry, details the data

analyzed, and a discussion of my findings. This structure enables a careful consideration of the multi-faceted responses salient to each questions. In order to do justice to the participants and the information collected, each question is given its own space of exploration. It is my hope this organization increases the clarity and lucidity of the complex analysis as well as defines boundaries for each area.

Chapter 4 examines how surrogacy is enacted in India as an enterprise by including information that I gained from interviews with doctors who consider surrogacy to be a medical treatment. I look at conversations with business owners about how surrogacy is an ethical and profitable enterprise, and how surrogacy is contributing to a burgeoning medical tourism industry. Chapter 5 focuses on the stories of the surrogates' themselves. Key components include the positioning of their bodies, their motivations to work as surrogates, and the emerging identity of these complex women in the context of contemporary India. Chapter 6 investigates the guidelines and policies that apply to surrogacy and the rights of the various participants. This chapter examines current case studies and controversies as well as provides suggestions for future policy implementation. Finally, Chapter 7 offers synthesized conclusions around the paradoxes of surrogacy in India and outlines future questions to be answered as the life cycle of the practice continues to move forward.

Chapter 4: Surrogacy in India

Surrogacy is complicated territory that brings charged emotions and strong opinions out in a great deal of discourse. In order to fully understand the process and the experiences of the participants involved it is crucial to take an in-depth look at who and what is involved in this process. There are many participants with a variety of interests. There is a lot at stake for the participants, but in differing ways. The doctors must find the right treatment for patients facing infertility while also maintaining a profitable practice. The patients are looking for a treatment that meets the needs of their own physical abilities, lifestyles, and financial positions. The health officials must protect the participants from exploitation, abuses, or negligent practices, while understanding the risks and challenges of new technologies in medicine. The surrogates take a physical and emotional risk to engage in a surrogacy in order to make a living. The activists and social organizers are the least invested in the success of surrogacy, but add a useful perspective from outside the experience. Their work with women and their connection to the contemporary issues in Indian society allow them to consider the work of surrogacy in a unique way. Since transnational surrogacy is still developing in India, there are many questions about how it operates and how it is regulated. In this chapter I will address the first research question, which provides the background of the process of surrogacy in India.

RQ 1: How is the process of surrogacy communicated and enacted in India?

In order to fully address this question, I use information provided in interviews with fertility doctors, a surrogacy agency, government officials, and not-for-profit leaders. These discourses reveal three primary ways that surrogacy is currently working in India:

the first is as medical intervention; the second is as commercial enterprise; and the third as altruistic exchange. I further explicate these categories by providing rich data that I collected during fieldwork in India.

While answering this question, I also provide a rich account of the clinics and organizations that I visited during my stay in India. I also describe the people I talked to so that the stories of these individuals can be contextualized to their own environment and can be better understood. I begin by talking about the medical institutions that I visited and the people that I met in these places. These accounts are based on my experience and interactions with the people and as such the narrative is my own. I take full responsibility of the descriptions I present.

Medical intervention

As expected, the doctors involved in fertility treatment and surrogacy focused on the medicalization of the process and its benefits. Above all else these doctors considered surrogacy a possible solution for couples who experience difficulties with pregnancy. In fact, many doctors added that surrogacy should only be used in the case of a true medical need. In the field of fertility, surrogacy is a treatment; a treatment that should be considered by fertility specialists and offered to patients in need. However, it ought to be the last stop for patients on the infertility treatment path.

Akanksha Clinic

The story of surrogacy in Gujarat, India begins with the Akanksha Clinic. Akanksha Clinic is situated in a small and crowded alley in the rural town of Anand about one hour outside the city of Ahmedabad in the state of Gujarat lining the Indian west coast. On my visit to Anand, I noticed a group of men sitting outside the clinic

walls smoking tobacco while cars edged their way in between the narrow space along the side. The building is modest, with a small sign that identified the clinic as part of Kaival Hospital. Rows of dusty sandals lined the front entrance to a small and busy waiting room.



Figure 4.1. Sign for Akanksha Clinic where Nicolas and Leonard were born (source: author)

While the clinic may not look like much from the outside, Dr. Nayna Patel, the director and founder at Akanksha is widely considered the pioneer of surrogacy in India. She is very popular in the Indian medical circles especially connected to fertility treatment. She has gained international notoriety with an appearance on the Oprah Winfrey show, given keynote addresses at international conference, and attracted frequent media attention both locally and around the world. She is an obstetrician gynecologist who began a specialty in fertility when her sister-in-law could not conceive. When Dr. Patel began her practice in 1998, she did not even consider surrogacy as a treatment option because of the challenges of finding qualified surrogates and the management of the process. She explained,

I always thought my job was just to diagnose, but I never thought of what that couple will go through. There are many couples who divorce or try to commit suicide when they cannot have a child.

Dr. Patel believes surrogacy is a popular choice of treatment because parents typically get to have a genetic link to the child.

So many couples are enrolled at the same time at an adoption center, maybe they want their genes, but they want a baby more than anything. Surrogacy is always wanted more because it is their genes, but if not then they get joy of parenthood through adoption.

Since she began incorporating surrogacy in her practice to meet the medical needs of her infertile patients, over 185 babies⁴ have been born to surrogates at Akanksha Clinic. As mentioned, I was able to speak with three pregnant surrogates during my visit to the clinic to learn more about their experience at Akanksha Clinic and how the clinic operates. The surrogates were all in their third trimester, one about to give birth any day. The building looked old and there was a lot of activity in every sector. Interviewing the surrogates in a small office upstairs, I watched assistant doctors and nurses rush through the halls with test tubes filled with embryos to be placed in a small room used as a lab. I walked past the recovery room where surrogates rest after a C-section as well as a delivery room where the C-sections are performed. All of the necessary medical procedures can be performed at the clinic, from egg retrieval, to implantation, and finally the birth. The rooms looked disorganized and unimpressive. The equipment appeared to be modern and the labs well stocked. While the facilities looked very ordinary, there

⁴ Data shared by Dr. Nayna Patel at her clinic.

were smiles on the faces of surrogates and the medical staff enjoyed hearing the interests of the surrogates.

Akanksha Clinic might be a culture shock to international patients if compared to high-end private practices. However, Dr. Patel is personally involved in almost every step, which seems to provide comfort to the surrogates and consistency to the process. The amount of time she spends making interpersonal contact with surrogates and patients is unusual when contrasted with the brief interactions common in the United States.



Figure 4.2. Exam room at Akanksha Clinic (source: author)

During my visit to Akanksha Clinic, I was able to speak with a woman who was in the process of beginning her second surrogacy cycle with Dr. Patel. Millie, from Australia, was visiting the clinic to complete her egg extraction and meet her surrogate. She explained how surrogacy was the answer to her medical challenges with becoming pregnant. She also told me why India was the right choice for her family.

I'd been trying IVF for about three years back then, without success and it just comes to a point where we had to look for other solutions. So out of desperation I looked up surrogacy, you know on Google, and a couple of places came up. One

in the U.S. and one was India. Surrogacy is not allowed in our state, which is Victoria. So it's almost impossible at home.

Millie also described her initial impression of Anand and the clinic:

So Anand was a bit of a cultural shock I suppose. We have traveled to other places like Cambodia, but never the less it is different you know. You see cows in the road. The good thing is once you get into the clinic you actually see other foreign couples who have come all this way, traveled half-way around the world to seek treatment, so you think maybe we are on to something.

I was very lucky to be able to speak with Millie and get her invaluable perspective. There were intended parents at all the clinics, but most were not willing to be interviewed due to time constraints and privacy concerns. Millie's story added to my understanding of the process and the experience for foreign couples coming to India for surrogacy.

Pulse Women's Hospital

One hour away from Akanksha Clinic at the Pulse Women's Hospital in Ahmedabad, Dr. Manish Banker also prescribes surrogacy as a treatment for infertile couples in need. The Pulse Hospital is also located in a hard-to-find corner of the city. It is very different from Akanksha in structure, environment, and climate. It is a modern building with state-of-the-art equipment and clean, contemporary interiors. There are four floors at the hospital. Each floor has offices, treatment rooms and waiting areas for patients. The building is only about two years old. Upon entering the hospital there is a large digital sign that tracks the number of IVF pregnancies they have successfully achieved. When I visited the hospital the sign displayed 1551 pregnancies. There was a

large reception desk where you check in and are directed to the appropriate floor.

Everything seemed very professional and organized.

When I arrived, I was directed upstairs to a large waiting area that was packed with couples waiting to see a doctor. Many patients appeared to have been waiting for a long time, and the number of people did not decrease even late into the evening. After waiting for some time I was taken to Dr. Banker's office. He appeared to be a physician who shows compassion to his patients. Dr. Banker was the first fertility specialist with whom I met in India, and his insights were helpful in leading to my future interviews. He provides a number of services and is dedicated to women's health. He was soft spoken, but direct. He was extremely happy to share his views on surrogacy in India. Later I met his partner, Dr. Pravin Patel, who appeared much older. Together they have formed a very successful practice where surrogacy has become a reasonable option for infertile couples.

Dr. Banker explained that surrogacy should be used only in circumstances where the commissioning party cannot carry a fetus to term (e.g. lacking a uterus because of hysterectomy). He saw his role as purely medical. His participation in the process was dramatically different from Dr. Nayna Patel's approach. He did not get involved in the various procedures required to secure a surrogate or arrange the contract. There were a few women visiting the hospital who were interested in becoming surrogates. Dr. Banker arranged for me to meet these prospective surrogates who were going to be interviewed by a foreign couple.

When Dr. Pant and I arrived for the appointment with the surrogates a nurse directed us to a small office. This nurse managed the surrogates' interviews and looked

after their needs. Shortly after, we had to move to a different floor and were seated in a small, private waiting area for international patients. There appeared to be an entirely different section for these couples away from the large waiting areas where local patients congregated. The three women had not worked as surrogates before, but were hoping to be selected by a couple soon. One woman had brought her aunt with her and another had been recruited by a field worker in her town. They were at the very beginning of their experience as surrogates and appeared not to have all of the information about the process.

After a final discussion with Dr. Patel and Dr. Banker I was able to visit the dormitory where a pregnant surrogate was staying. She was the only one living on the premises at the time of my visit. This tour of the surrogate home was an introduction to the differing values of privacy in an Indian medical practice. The guide who took me to the home walked right into the surrogate's room without knocking or announcing my arrival. The surrogate was resting on her cot in her private room that had a small television and a closet. There were a few colorful decorations, but overall the room was modest. The surrogate could only speak Hindi, and Dr. Saumya Pant acted as the interpreter. When I asked her questions about her agreement and the process of making a contract she quickly handed over her entire medical file to me. I felt uncomfortable with access to all her records and gently turned it down and thanked her for her trust in me.

The visits to Akanksha and Pulse highlighted the contrasts in the type of services available to international patients in India. Two clinics with similar goals, but different approaches sit just miles away from one another; one casual and relational, the other professional and contemporary. This contextualization of the two clinics is useful when

analyzing the doctors' perspectives on why surrogacy is an appropriate choice for some patients and not for others.

Mumbai Clinics

The medical advancements that allow for IVF treatment and thus surrogacy are seen as remarkable achievements for fertility medicine. No perspective is a greater indication of that than Dr Aniruddha Malpani's. He and his wife Dr. Anjali Malpani have been in practice with Malpani Infertility Clinic in Mumbai for 20 years.

My interaction with Malpani clinic began in summer of 2009 when I found the clinic's website during an online search about fertility tourism in India. I contacted Dr. Malpani to learn more about his work and inquire about the possibility of meeting during my field visit. On reaching Mumbai, I visited the clinic and was surprised to see the small sign for the clinic in a very discreet courtyard that you cannot see from the street. The clinic's reputation and online presence caused me to expect a much larger and grander location or appearance. Once I located the clinic, it did meet many of my expectations. The interior was modern and professional, however small. There was a lot of literature available for patients to access at the clinic in the form of easy to understand comic books or web resources.



Figure 4.3. Jennifer Sandoval, Dr. Saumya Pant, Dr. Karen Foss, Dr. Karen Hvidtfeldt Madsen, and Dr. Charlotte Kroløkke, at the Malpani Infertility Clinic. (source: Stephen Littlejohn)

Dr. Malpani had initially agreed to a 15-minute appointment; however he talked to me and my colleagues for over an hour. He appeared informal and relaxed and was frank with his opinions. Dr. Malpani also included adoption on a list of possible solutions for infertility. Both the Malpani doctors had studied at Bombay University as well as Harvard and Johns Hopkins. While surrogacy is not a part of their current practice, the Malpani's are well known for their fertility treatments to a large foreign patient base. They focus on the latest technology and patient education. During the interview Dr. Malpani explained,

My wife and me are both gynecologist and one of the things which happened while we were training was the first test tube baby was born and that was quite exciting and cutting edge. Gynecologists had very little to offer for infertility at that point and this was something that could actually make a differences in

people's lives. It's been an exciting field. It's one of those things in medicine that is great for the patient and it is great for the doctor because you are touching people's lives and it is a little bit technology and science, and a little bit psychology. You know you have to hold patient's hands when they are crying and they didn't get pregnant. It allows you a wide variety of skills and at the end of the day you have a tangible outcome. You are talking about couples in the prime of their life and you are changing their lives and impacting their family.

Dr. Malpani discussed how technology has changed the possibilities of medical intervention.

Most people will still need the bread and butter IVF. There is a significant portion that needs third party reproductive service. Lots of things have changed—things we didn't think we could do 5 years, 10 years back. Nature has let [patients] down and we are trying to help them.

I have this big thing about patient autonomy and I think that patients should be allowed to decide for themselves. Especially for reproductive issues. Who am I to tell them?

Dr. Malpani's focus on patient education and the use of new media can be seen in the structure of his website as well as his plans for the future. He is very enthusiastic about the use of technology in his practice. He has many interactive components available, including "ask the doctor" where an avatar with his voice talks about fertility treatments. He is now in the process of creating a virtual fertility clinic in Second Life, "the Internet's largest user-created, 3D virtual world community" (www.secondlife.com). He explained,

We are putting up an IVF clinic on Second Life. We need to devil up a receptionist with information and we will have a support group. We want to include information about life in an IVF clinic. Like suppose you were an egg, what would your life be like in the clinic? The world is becoming flat and it's always helpful to do these things.



Figure 4.4. Dr. Malpani with Dr. Saumya Pant and Dr. Karen Foss. (source: Stephen Littlejohn)

The geography of Mumbai differs greatly from Ahmedabad and Anand. It is a more cosmopolitan city with a focus on industry and a lot of international traffic. Dr. Malpani's unique perspective with attention to technological advance and patient communication provides an important comparison with the other clinics. You cannot look into fertility medicine in India without running into information about Dr. Malpani. His knowledge of the Indian Council of Medical Research Guidelines and his lack of desire to include surrogacy in his practice is valuable in contrast to the other doctors who make surrogacy a priority.

To continue with the comparison, I visited another private clinic in Mumbai directed by Dr. Nandita Palshetkar. Dr. Palshetkar is well known for pushing the limits of reproductive medicine. She has performed IVF successfully for a 60-year-old woman

and remains one of the few fertility specialists to work enthusiastically with women over 40.

The visit to the clinic began with a walk up five floors in a dingy and dusty building that was under construction in some of the areas. The elevator was not working because it did not run during certain times of day, such as lunchtime. The office itself was well cared for with a large, comfortable waiting area. Pictures of babies and smiling parents covered the walls along with cutouts of articles about Dr. Palshetkar. The room was packed full of anxious patients trying to get in to see the famous doctor. While we had an appointment, we were waved off for some time. The patients looked at our research team with suspicion, worrying that we would intrude upon their time. One patient was so angry about the wait she continually threatened the receptionist, arguing that we should not be allowed in before her.

Finally, in an effort to keep the days schedule on track, we barged into her room requesting a few short minutes of her time. Dr. Palshetkar was dressed fashionably with a youthful appearance. She was very honest about her opinions and wanted to impart to us how most people get it wrong with regard to surrogacy. She was very proud of her accomplishments and the medical field as a whole in India.

For Dr. Palshetkar surrogacy and IVF are not only good fertility options, but they are very successful in India.

A couple failed 3 times in Paris, came to us had a child, came 5 years later and she conceived again. India is reaching the level of technology. I do not have results yet equal to American results, but we are getting there. Most of the things – even other forms of medicine a lot of technologically available here.

According to Dilip Patil, the director of Trivector Scientific International in Mumbai, there is a large medical need for these types of fertility services in India. He explained,

Everyone always knows somebody in their family or someone they know going through fertility treatment. In India, with a population of 1.2 billion there is always someone who is infertile.

Dr. Yashodhara Mhatre of Surrogacy India describes the clients they serve, *There are two types of patients—one who knows surrogacy is the only option available to them to have a baby and one for whom surrogacy is the last option. Some who have no uterus or they have had a cancer, they are younger patients. Others they have had multiple failures, multiple IVFs and they have tried. They have to show they had multiple IVF failures. It cannot be just one.*

We need reports from the lab where they have had cycles.

Dr. Sudhir Ajja, of Surrogacy India speaks to the need for medical reasons to select surrogacy,

Cosmetic surrogacy is not encouraged. We have had patients who have approached us, but we are here only to help with medical reason. If a medical graduate who wants to do surrogacy because she is too busy with studies to have a baby—If you are so worried about your body and your figure and time can you really take care of a baby. Surrogacy should come out of a treatment option—came out of treatment options. We have a sleep tonight where we are satisfied. There are genuine couples who want to have three babies, they have two, very

lovely children, so let surrogacy be a chance for someone who does not have a baby or only has one.

The bio-medical component of surrogacy is well documented since the availability of IVF in the 1980s. The demand for medical options and an increase in fertility technology has constructed a specific industry that meets the needs of a small, but mobile population.



Figure 4.5. Mr. Dilip Patil of Trivector Scientific International and Cryobank in Mumbai. (source: Stephen Littlejohn)

These illustrations of medical practitioners along with their stories shed light on the status of IVF related medical facilities in India. The industry is growing and the key fertility experts are pioneering many new technologies. India is emerging as a leader in the growing medical industry of fertility. There are no firm statistics about how many women are working as surrogates in India. Many countries in areas largely considered part of the developed world do not allow surrogacy in a commercial context. India is breaking ground in making this fertility option available to patients who may otherwise be rejected in their own country (for age or lack of resources for example).

The discourse of medical intervention was prominent, but it also emerged as part of private fertility practices. The services that are offered for infertile patients are time consuming and come with a lot of costs attached. The next section will narrow in on the pieces of the conversations that revealed the business motivations of participants.

Commercial Enterprise

Commercial surrogacy was created in response to the ever-changing needs of infertile patients and the quickly changing technologies available. In an effort to stay competitive in a growing field, doctors are working to provide more options to patients. In order to provide this service, additional people have to become involved and compensated for their work, risk, and time. This exchange often includes complicated breakdowns of costs and a number of groups benefit from this. Some of these groups are doctors, surrogates, tourism industry, and the local economies. The concept is not new, but continues to evolve as technology removes barriers that previously existed. The advancement of IVF has created a new industry where human genetic material can be extracted, re-constructed, and deposited in doctor's offices and labs. Families are being created in brand new ways and reproduction has been commodified in unimaginable ways. Additionally, people in need of babies are crossing borders and moving between nations to avail of technologically driven reproductive services. In 1950, Schumpeter posited,

The outsourcing of family production...as an evolutionary process of 'creative destruction.' In this process the existing modes of production must endlessly compete with new commodities, new sources of supply, and new types of organization, which command a decisive cost of quality advantage. It is not so

much price and quality competition among firms as the continued cycle of new markets, new products, and new organizational developments that revolutionizes the economic structure from within, incessantly destroying the old one, incessantly creating a new one. (p. 161)

While the commercial end of surrogacy is often at the root of discomfort with the arrangement found in some feminist literature, (Brinsden, 2003; Berkhout, 2008, Gilbert, 2008) it is a growing trend. The use of women's bodies for production and low-paying labor has been a concern for several decades (Chodorow, 1978; Grosz, 1994). Much of this resistance is found in the concern for potential exploitation, mistreatment, and unfair compensation for the surrogate. The commercial component is as complex as the medical one. There are many legal and ethical guidelines to account for as well as document in order to carry out the agreement effectively. The clearest example of the commercial aspect of surrogacy is that of Surrogacy India.

Surrogacy India

Surrogacy India is located in the suburban outskirts of Mumbai, far away from the corporate high rises and middle-upper class apartment buildings. The office is not large, but it is well equipped and staffed. Their business is currently one-of-a-kind in the realm of surrogacy. They claim to be the first and only third party facilitator of surrogacy agreements in India. The company is a partnership between Dr. Sudhir Ajja, the business manager and Dr. Yashodhara Mhatre, a fertility specialist. They founded their company over five years ago as medical tourism began to grow in India. They had the first international surrogacy patient in 2004. They began the business to meet a potential need they saw in the field of fertility medicine. Their mission is to provide comprehensive

services to couples seeking surrogacy and full support for the surrogates throughout the process. According to Surrogacy India, ICMR guidelines (further outlined in Chapter 6) say that doctors should not get involved with hiring or choosing a surrogate. Dr. Ajja explained,

We are facilitators, and we have a unit here, but we have outsourced everything.

We take care of everything from hiring the surrogates, monitoring the surrogates, evaluating the surrogates, to finding the intended parents, and letting the intended parents choose their own surrogate. We have a lawyer who does the agreements.

We have two lawyers—one representing the surrogate, one representing the parents. We take care from the point somebody is getting off of flight to the time they take the baby home.

Surrogacy India has a unique service to offer, but they have thoroughly considered many of the financial dynamics of the surrogacy process. According to Dr. Ajja,

Every breakdown of the cost is shown to the parents. We show the breakdown of what happens if it is twins, if you want to cancel the first cycle, if there is miscarriage. We have complete transparency and stick to those costs. We take installments at every step. The payment for surrogate is set and it is specific in agreement which week they will receive which amount. At four weeks you are paid this much, at 16 weeks you are paid this much, at 29 weeks you are paid this much. What happens if it is stillborn—it is not the surrogate's fault, this is a normal condition that happens so there is still payment made.



Figure 4.6. Dr. Karen Foss, Dr. Saumya Pant, Jennifer Sandoval, Dr. Sudhir Ajja, Dr. Yashodhara Mhatre, Dr. Karen Hvidtfeldt Madsen, Dr. Charlotte Kroløkke, and Dr. Stephen Littlejohn. (source: Surrogacy India)

Specialized medical treatment has extensive cost associated with it and the cost difference in India is often what drives people to go overseas. Surrogacy India manages the details from start to finish. They are connected to multiple industries and employ a tourism agency, a sonographer, and even a cab driver for the foreign clients. A number of people and businesses are impacted by the influx of patients who otherwise would not be in India. According to Dr. Ajja, 99 percent of their clients are from overseas with a large percentage hailing from the U.S. and Australia.

Surrogacy Leading to Medical Tourism

The international tourism aspect of surrogacy is a significant part of the commercial surrogacy industry. Many patients are traveling from overseas to take part in the process in India. Medical tourism is “the travel of patients from their home country to another for the primary purpose of seeking medical treatment” (Cohen, 2010, p. 11). Reed (2008) adds that the travel is often to less developed countries than the country of origin. There are a number of relational arrangements that are possible between doctors

and patients. A doctor in a patient's home country may give pre-travel counseling and post-procedure follow-up. On the other hand a home doctor may never be involved and all communication may take place via email between the patient and overseas doctor before and after the procedure.

Cohen (2010) identifies three types of medical tourism: 1) for services that are illegal in both the patient's home and destination countries, 2) for services that are illegal in the patient's home country but legal in the destination country, and 3) for services legal in both the home and destination countries (p. 11-12). When the procedure is legal in the home country, the reason for travel is usually financial considerations. If a patient does not have insurance or is paying out of pocket for a procedure, it is often cheaper in the destination country. This is certainly true of surrogacy in India. The Confederation of Indian Industry (CII) estimates that India had 150,000 medical tourists in 2005, "accounting for \$22.2 billion in United States funds (USD) or 5.2% of the gross domestic product of India" (Reed, 2008, p. 1434).

The number of medical tourists is increasing by an estimated 25% each year since (Sinha, 2008). There are several initiatives to continue to grow the medical tourism industry in India including a provision for an "M" visa that would allow these visitors priority. It will no doubt experience "growing pains" as business models emerge, quality is better defined and the value proposition to customers improves.

An entire surrogacy cycle usually requires two trips to India (See Figure 4.7). The first is to sign any documents related to surrogacy, to select a surrogate, and to extract genetic material if necessary. The second is to pick up the baby. Each trip has duration of approximately two weeks, or sometimes more. This creates an opportunity

for additional spending on the part of the travelers. For example, one intended parent named Millie, who was visiting from Australia, described planning a vacation around her first trip to Akanksha Clinic.

Figure 4.7 Outline of surrogacy process in India based on author's data



Millie explained the process of coming to India,

I emailed [Dr. Patel] and we corresponded about 15 times and then we set a date to come here, and the evening before we were leaving I said to my husband, 'I don't know if this is real, it could be a con I don't know, but let's just go and have a holiday anyway.' So we took a tour around India and saw the Taj Mahal and all that. We just spoke to her and then we communicated and it sounded real and we thought we would have a holiday here.

Dr. Malpani's practice is also an example of reproductive medicine bringing tourists into India.

Our practice has changed, we get a disproportionate number of patients from abroad, but a large part of that group are Indian nationals living abroad.

I don't call them tourists, I call them reproductive exiles because they are being forced to go somewhere else because whatever you want to do for some reason you cannot do in your own country or you cannot afford it – there's a long wait list or the government does not approve of certain technologies.

While there are financial benefits for the doctors, the intended parents, and the local economies, the surrogates are also parties to the commercial transaction. This earning potential is often part of the motivation for participation from surrogates. From the surrogacy payment itself to gifts of appreciation the surrogates receive compensation in many ways. Dr. Ajja gives his perspective on their experience,

After the birth they have some group counseling so other surrogates who have given birth can be like a support group. It's a lot of fun for them. They are always traveling in cars and visiting. They live the life of a queen for a very small

time and they feel very proud of that. At least for nine months of their life they have lived a life they could not dream. It's a goal for them. They need to achieve something. They have a goal. They need to buy a house, they need to start a career, they need to invest in their children's education. There are more benefits to giving the baby away than to keeping the baby. The goal is not the baby.

Dr. Patel also speaks of the financial motivations for surrogates,

When I decided to do this I had a lady who came for egg donation and decided to do this because she needed money and she had so many financial troubles. She asked for help because she has one son.

Dr. Malpani calls this *an alignment of interests*. He explains that the surrogates are working for themselves in pursuit of something.

The whole attitude is oh she is a poor woman. That doesn't make her stupid. You know she can survive in conditions that you could not survive in for 24 hours.

She is street smart and she will look after her own interests. Maybe she cannot speak as articulately as I can and express as well, but there is lots of mechanisms.

Some of the concerns I understand—is it fair for her to be earning 2 lakhs, when the doctor is earning 3 lakhs. Who's to decide any of those numbers? You could argue whatever you want.

There is often concern about exploitation of surrogates in a commercial context.

A number of feminist authors have argued that commercial surrogacy challenges the assumptions about the organic nature of pregnancy and women's work in the domestic sphere (Sistare, 1994; Shalev, 1989; Vance, 1984). In response to some of these criticisms the doctors describe the situation as win-win. Dr. Patel asked,

When you can bring happiness to the couple and to the surrogate how is this wrong?

Ashaben Dalal Founder of Jagrut Mahila Sangathan

Not everyone is equally concerned with these potential problems. Ashaben Dalal, the founder and director of the not-for-profit, Jagrut Mahila Sangathan in Anand argues that commercial surrogacy is a viable option for women to participate in economic growth and personal empowerment. Specifically, she identifies the state of Gujarat (the location of Akanksha Clinic and Pulse Hospital) as particularly enterprising.

Money is very important in empowerment and particularly in this region women are prepared for surrogacy because our region is more commercialized minds.

Here is more commercialized. It's in their blood. Every transaction because they are largely bonded with land and whatever you put on land it will yield you with something—that is in their mind all the time.

So many times people ask why this area for surrogacy because surrogacy requires boldness because it is not a simple thing you need so many procedures and then depart with baby. Because she knows she has entered into commercial contract and she is getting money that is sufficient for her so the departure is smooth

I one hundred percent believe that surrogacy empowers. No one is forcing her and you cannot empower everyone in every way. All have a capacity that they can then cash. Why inquiring about ethical problems? She has entered into commercial contract and right from the beginning she is knowing that this is not my child, I've rented my womb so you are renting a room or your womb—it's the same.

The commercial considerations, while significant, are tempered with discourse about the value of the service of surrogacy. It is not only a product, but a gift. Most participants I spoke with brought up an element of altruism, sacrifice, or giving in their discussion of surrogacy.



Figure 4.8. Ashaben Dalal of Jagrut Mahila Sangathan in Anand (source: Stephen Littlejohn)

Altruistic Exchange

Underlying the medical and commercial discourse is the value of altruism associated with surrogacy. Most critics are unable to believe that money could be the primary drive for such a sacrifice of physical and personal autonomy. Kroløkke, Foss and Sandoval (2010) found the concept of gift giving to be prominent in discourse around motherhood and reproduction in general and surrogacy specifically. “An individual is able to give something to another—sperm, egg, womb, child—to help the other become a parent” (Kroløkke, Foss, & Sandoval, 2010, p. 98). Because a baby is the ultimate outcome of a surrogacy agreement there is a lot of sentiment and emotional connection involved. The discourse of gift giving was also significant in the interviews completed for this study. For example, Dr. Palshetkar explained,

The surrogacies we have done are really things to talk about. Surrogacy is helping. I need you to understand that surrogacy is not commercial. Surrogacy is not a lifestyle. Whatever surrogacy is being done today is because those people do not have children.

Dr. Ajja talks about the way both parties are helped,

Surrogacy is a very different situation you are giving the patients a baby and improving the life of the surrogates so everything is fine then.

No one identified the giving aspects of surrogacy more than the surrogates themselves. Uja, a surrogate at Surrogacy India described her connection to the intended parents,

When I looked at them they were weeping and they were crying so they were very glad I would be their surrogate. They told me that I'm like god for them and that really touched my heart for them.

Kapila, a surrogate at Akanksha Clinic said that she would be happy to also do surrogacy altruistically without concern for compensation.

If I have all the pleasures of the world, I have the money – it would be my duty to help you. You need a baby so I will give you a baby. Doesn't matter if I am rich—if I have money or not it does not matter I will help you. I would still give you a baby.

In further evidence of this component of the discourse Dr. Patel spoke of her exchange with a woman who came to her for treatment,

One woman who came and said she had always been advised surrogacy, but she did not want to do and she did not really believe in it, but when she realized she

would be helping a woman in India who does not have very much it was ok for her to come.

This woman was unable to participate in the process until she felt that her presence in India and the act of hiring a surrogate would not be just for her, but helping another. Dr. Patel addresses many of these aspects through interpersonal means developing relationships with her patients and the surrogates at Akanksha Clinic. She believes surrogacy is more than just helping one or two individuals.

I would say that surrogacy in India I would consider as India's gift to the world. The world should not look down on India. In fact, like you know the Indians are very helpful people all over the world and if by doing surrogacy the Indians are trying to help infertile couples inside the country and outside the country it should be recognized as such.

As surrogacy emerges in India it continues to develop in a complex way. The relational aspects continue to influence the discourses surrounding the business. It is at once medical, commercial, and altruistic. These three aspects meet across a web of human connection, business savvy, and technological advancement. It is impossible to reduce the process of surrogacy to one realm or category.

Surrogacy as a Process

Surrogacy continues to grow as a part of fertility medicine in India because it is legal, cost effective, and widely available. In the last eight years since surrogacy became a practice, doctors and clinics have streamlined the process and found a way to connect with potential patients using the Internet. While surrogacy is often described as the “last stop” in terms of fertility options, India is becoming a center for overseas patients.

Continued media coverage in newspapers, magazines, and television shows like Oprah bring attention to the trend. While there is typically some critique or question regarding the ethics of medical tourism, there are also human interest stories focused on successful experiences and the satisfaction of the new parents.

As patients become more informed through their own use of the Internet and personal research, they demand additional options when faced with fertility challenges. Surrogacy as a medical intervention for women without the capacity to carry a child is considered completely legitimate by the doctors engaging in the treatment. The commercial side of surrogacy includes a burgeoning lucrative industry that benefits many business sectors—particularly that of tourism. Medical tourism is estimated to bring in \$40 to \$60 billion USD to India by the year 2012 (Reed, 2008, p. 1434). Doctors, like Dr. Banker and Dr. Malpani advertise impressive IVF success rates that sometimes surpass those of fertility doctors in the United States. Parents who are happy with their experience are connecting with others online and sharing their stories of hope and joy. Millie exclaimed,

I couldn't recommend this experience enough to people having trouble having kids....I couldn't pay her [the surrogate] enough to be honest, the joy she has brought to the family. It is really beautiful for us – we had a really, really positive experience. We are very, very thankful.

Surrogates continue to look to this work as a means to an end. They have goals for their own families and children and the income from surrogacy can help them achieve these goals quickly. Their agency is supported by some voices in Indian feminism like Ashaben Dalal who said,

Surrogacy is empowering because the woman has their own child. That is totally commercial transaction and she has a right to enter into commercial transaction.

Why do we have to stop her because she has capacity to bear child? Whatever skill she has she has right to. Whether skill or physical capacity she has to use it.

Surrogates like Sunita at the Akanksha Clinic explain what they do with their income,

I made fixed deposits for both my children.

Ganga, another surrogate at Akanksha Clinic agreed,

This is also dignified work, because it will solve my problem and solve their problem also. They don't have a child, I don't have the money so it solves the problem. This is good for them because they get a baby. That is why I want to do it and that is why it is dignified work.

In the next chapter I will examine more closely the surrogates' descriptions of their decisions to carry a baby for another couple. Their perspective on the importance of the work and its altruistic components are part of their rationalization for participation. Their experience creates a tension between where they come from and who they are becoming. It also redefines their identity as mother. This complex identity negotiation emerges in the dialogue I had with the each of the surrogates at Akanksha Clinic and Pulse Hospital.

Chapter 5: Being a Surrogate

While surrogacy can be described through the lenses of medical intervention, commercial enterprise, and altruistic exchange, it is also at the heart of human processes. Additionally, the greatest physical work of reproduction is located in the female body. Surrogacy is part of a new assisted reproductive technology and as Engberg (1999) explained, “Given the current technology, women are now called upon as never before to control their reproductive destinies.” (Chapter 1, paragraph 1, line 9-10).

In this chapter I explore the position and experiences of the surrogates and attempt to address two research questions:

RQ 2: How is the position of the female body constructed in surrogacy discourses?

RQ 3: How do the surrogates enact and communicate their identities?

The Surrogate Body

While the emotional experience of identity formation is critically important, the placement of the physical body deserves unique attention. The body is the site of lived experience and thus a location of knowledge. Balsamo’s (1996) description of four types of post-modern bodies reveals many of the tensions found in the discourses related to surrogacy. The laboring body, the marked body, the repressed body, and the disappearing body can all be found in various constructions of the surrogacy process.

The laboring body becomes both metaphorical and literal in the act of surrogacy. “Perhaps the most obvious form of the laboring body is the maternal body which is increasingly treated as a technological body—both in its science fictional and science factual form as ‘container’ for the fetus, and in its role as the object of technological

manipulation in the service of human reproduction” (Balsamo 1996, p. 282). Pregnancy and giving birth is the oldest form of labor women have engaged in.

RQ 2: How is the position of the female body constructed in surrogacy discourses?

In order to address research question two I examine the language used by the doctors, policy makers and surrogates themselves to locate the body and positions of the surrogates and their work. There is no simple way to explain or define the world of surrogacy. It is a complex agreement with many various competing interests. However, there has been little that describes the lived experience of the surrogates themselves. They are the party that is truly connected to the process of surrogacy from beginning to end. These women are dynamic and strong, working to care for their own families while participating in the creation of another family.

During my visit to India, I was able to speak with surrogates in different settings and at different stages of the process. Three who were in the process of applying to work as a surrogate for the first time, three who were in their third trimester of pregnancy living at a clinic, one in her eighth month at a third-party agency and one in her first trimester living at a surrogate house. Each clinic had their own process and rules for the surrogates, but there were remarkable similarities. The conversations with these women revealed tensions between the identities they had already internalized and those emerging through their experience as surrogates.

At Akanksha clinic in Anand, I spoke with three women. We sat together in a small office in the upstairs quarters of the clinic. They were most comfortable speaking in Hindi, so Dr. Saumya Pant translated during the group interview and during the

transcription process. In the conversation they frequently used “we” and referred to their experience in the plural, thus some of their answers appear to be speaking for everyone even if the conversation was led by one woman. The three women appeared close and tended to agree with each other frequently. Their connection is understandable after living together in close quarters for so many months and sharing such a significant experience.

Akanksha Surrogates

The first surrogate I met at Akanksha Clinic was Kapila. She is 26 years old with a seven-year-old son. She lives in the state of Gujarat about an hour away from the clinic. She was due to give birth any day when I met her. Among the surrogates I interviewed at Akanksha Clinic Kapila spoke with the most confidence and responded to every question or discussion point. This was her first surrogacy, and she was very passionate about her experience.

The second surrogate that I interviewed at Akanksha Clinic was Ganga, who was only 22 years old and came all the way from Nepal. At this young age, Ganga already is a mother of a six-year-old daughter and like Kapila, Ganga was due to have the surrogate baby any day. Ganga heard about the clinic from her own sister, who was a surrogate at the Akanksha Clinic and had delivered a baby girl only 15 days earlier. Ganga was very petite and youthful looking. She was quiet and spoke in a soft voice, often not making eye contact. She had been working in Kuwait as a housemaid for a year prior to coming to Anand at the suggestion of her sister-in-law. Ganga was sent to Kuwait almost two years ago and had been exploited for her labor. The people she was working for never paid her for her work, which compelled her to leave her employers and head to India. It

was then that she was advised by her sister-in-law to come to Anand and be a surrogate to recover the money she had promised her family. Ganga felt there was no other way to get enough money to meet the family's expectations so she came straight to Akanksha Clinic to sign up to be a surrogate. Ganga had not seen her own child in several years.

The third surrogate joined the conversation a little later. Sunita, who had already worked as a surrogate once in 2007 for a couple who lived in Delhi, has one son of her own. She had also learned about surrogacy from an older sister-in-law who she described as educated. Additionally, her sister worked in Akanksha Clinic. Sunita was expecting twins in several weeks. Sunita appeared a little older than the other two women and had stronger opinions based on her previous experience. She was quick to point out that she was a Christian and so were the parents-to-be of the baby. For Sunita, religion was an important factor.

When addressing Sunita, Kapila, and Ganga during the interviews, they typically responded with "we," reflecting a communal identity. The women lived together in the surrogate quarters at the clinic and were at very similar stages of their pregnancy. They explained that they talked to each other about how they felt and what they were going through as surrogates. This shared experience appeared to bond them intensely. For example, when I asked Sunita if she would ask for more money because she was pregnant with twins, Kapila responded,

Nobody will give us more unless they want to give out of their own good will.

The conversation was comfortable with the surrogates. They appeared as interested in me and Dr. Pant (who was translating) as much as we were with them. Kapila explained that they never go out to the front of the clinic, and they never get their picture taken.

Towards the end of the interview we asked her why were they willing to spend time talking to us and Kapila promptly replied,

We enjoyed meeting with you and talking with you. It felt like someone from the family. No one in our life has asked us any questions about us and how we feel.

The private interaction with these women was vital to understanding their motivations and experiences working as surrogates. The women appeared to be candid, but thoughtful in their responses to my questions, and I quickly developed a deep respect for them.

Community Support

In addition to the surrogates dialogue I also examine the discourse provided by Ashaben Dalal, founder and director of Jagrut Mahila Sangathan, a not-for-profit organization in Anand. Asha ben's organization primarily exists to assist and advocate for women in the local community. She began her work over 25 years ago and has continued to help women in need. She is a powerful force in the community who has been working to expand the choices for abused, uneducated, poor, and neglected women of the community. She explained,

We will help victims in every way... if they need certificate from revenue officer our social worker will help them. In every department – if they are not getting property from their in-laws we will go help and tell them they have to according to laws and we will get work done for them. We are helping them in each and every corner, we are not only giving them lip service or guidance, but actually supporting them and going with them. Even if they are not educated, but they

have some capacity then we will help and encourage her, train her and also provide support.

We are always supportive of the woman's choice.

There is a saying in Gujarati, 'God's wish is the greatest,' but I will say the woman's wish is the greatest!

Ashaben provided a unique perspective as a member and leader in the community with no direct vested interest in the business of surrogacy. Her point of view provides insight into the status of women in Anand and of women in India as a whole. She quickly recognized the corporeal components of surrogacy and defined them in her own way. She pointed to the bodily work of surrogacy as a capacity that only exists within a woman's body. Her specific work with women and her commitment to their health and well being provided an important grass roots outlook.

Similarly, Jigna ben from the Gender Resource Center also provided crucial insight into how women might continue to carry the surrogate experience with them in their communities and lives. However, Ms Pratibha ben Pandya of the Self Employed Women's Association (SEWA) said, "Surrogacy should not be encouraged. It is not good and it will not last."

While there are diverse opinions about the work of surrogacy, the surrogates' voices should be privileged in order to understand the process. This study is not concerned with whether surrogacy is good or bad, but rather how the process is lived out. The surrogates' decision-making and their bodily work in the pregnancy are critical components of a full picture of surrogacy in India. They have spent considerable time

weighing their options. The surrogates frame their work in specific ways that reveal their own embodied experience.

Embodied Experience

The surrogates described the bodily work of surrogacy by disclosing their fears about delivery, the discomfort of pregnancy, and concerns about how others see their body. They even described how being pregnant brought sympathy and concern from their husbands due to the physical toll and their separation from each other for nine to ten months. Kapila explained,

My husband keeps asking how I am doing. He asks after my health and how I am feeling.

My husband always says you should not just sit at home, you should go and prove yourself and do something.

My relationship has improved with my husband because of surrogacy...because he knows how sad I am in doing this. My health is not well, I'm not feeling good and my feet are swollen.

Kapila added,

I much believe I should have come earlier, because his love has increased for me, because of the distance and we are living separately.

The laboring body is often found in the gendered division of labor, domestic work (both paid and unpaid) and in the historical use of women's bodies in development of new technologies. The laboring body can also be an asset to women as they seek independence from patriarchal systems that have deemed them naturally inferior, keeping

them in the lowest paying positions. Ashaben described pregnancy as a bodily ability that a woman can use for her benefit:

It is a capacity. It's not simple to have a pregnancy and to have treatment.

If there is a couple and they have children and they don't have any particular resources to educate their kids or money to educate their children, if that mother wants to become a surrogate and wants to use her own womb, what's the problem with that?

Ashaben's perspective reveals more about the complexity of "choice." She explains that it is the woman's choice, but also talks about the circumstances that may lead a woman to make that choice. While she seems to imply that the womb can be a resource, the statement also shows how the decisions are never without context and history. Ashaben added,

Money is very important in empowerment and particularly in this region women are prepared for surrogacy. Because our region⁵ has more commercialized minds so once they know the woman is bearing the child for other people they will naturally have less attachment and they can easily depart from it (the baby) without attachment.

The laboring maternal body provides a pathway for empowerment or the ability to change life circumstances. However, toll taken on the body in surrogacy can be a large cost for this possibility of empowerment. Women's bodies as laborers are not often described in contemporary discourse about work. Because of the shift women have

⁵ Kheda district is one of the most prosperous regions in Gujarat (Vibrantgujarat.com, 2011).

experienced in the West into higher education and white collar jobs, there is a lack of recognition of the ways many women continue to employ their bodies to thrive or just survive. Dr. Patel posited,

How is this work different? If you hire a woman, you are making her do physical work – you hire as maid or cook. Here this lady is not able to carry because her system does not work. This is also physical labor. Every year women die of poisonous gas because they have to go in and clean it – if you allow this for your own convenience, why not allow this to help others

The labor of surrogacy may also lead to the creation of a marked body in several ways. The marked body bears signs that reveal a particular identity (Balsamo, 1996). The surrogates also experience a marked body because of the visible nature of their condition. After a certain point it is very difficult to hide a pregnant body. The physical change identifies the female body in a particular state. Additionally, the body changes after delivery of a baby. Perhaps in minor ways, but also in permanent ways as scars are left behind by complications or C-section births. The marks of pregnancy are often seen as an important component of the transition into motherhood. In one conversation with Dr. Patel, she described an example of this from her own practice. She treated a couple who were both obstetrician gynecologists themselves. They had opted for surrogacy when the woman had to have her uterus removed. After the birth, the intended mother asked her husband to make an incision on her body that would look like she herself had undergone a C-section birth of their surrogate baby.

The bodily cultural inscriptions that are identified with motherhood are increasingly contested with emerging technologies. “The marked body signals the fact

that bodies are eminently cultural signs, bearing the traces of ritual and mythic identities” (Balsamo, 1996, p. 280). The mark of pregnancy brings a corporeal identity to the process of mothering. Carrying a child manipulates the bodily structure in a dramatic way that signifies the changing role of the pregnant woman.

It is this marked pregnant body that limits the movement and visibility of the surrogate for many months. Depending on the clinic, surrogates may or may not be required to stay on site for the duration of the pregnancy. Regardless, many surrogates explain that they do not want to be seen in their community because of the criticism they will draw from neighbors, community and family members. While they are experiencing a certain level of individual empowerment through independence and financial earning, they are still partially constrained by particular societal structures and values. The public gaze they are avoiding is controlled by repressing and hiding their bodies. While the surrogates were confident of their choices, they spoke about how they cannot share with their families and communities about what they have been doing in Anand. Ganga explained,

Society is very conservative at home. They will not understand this.

Kapila agreed,

Even if I try to make [people at home] understand they will not be able to, therefore it is not worth telling them about surrogacy.

Similarly, Ashaben of Jagrut Mahila Sangathan explained the cultural implications of being a surrogate out in the open,

These surrogates are not sharing with extended families. They cannot tell in-laws because in-laws in India are not always positive. In-laws do not like that

daughter-in-law is working even when they are hungry. They don't appreciate surrogacy.

The surrogates themselves confirmed that they often must keep the pregnancy hidden. Sunita said that her in-laws would tell people in the community that she was visiting her mother, while Kapila said she was away working in Singapore. Ganga had already been sent to Kuwait to work so she just did not tell her family she had returned to India. Kapila added,

Although my house is very close by, for a year I have not visited anyone. So in the initial phase when I had to come for check ups, I had to hide and come and could not tell where I am going. Now I cannot be seen out in the open because I've told them I've gone.

When I go back to my home I can't even share this experience with anyone... that is why I feel helpless. For example, my parents think I'm in Singapore so I can't even share with them.

While the surrogates discuss the difficulty of having to hide their work, they also express their belief that being a surrogate is dignified work. When comparing surrogacy with other types of work, each woman commented in some way about the legitimacy of their choice to be a surrogate. This contradiction revealed some of their internal struggles with how they live out the decision to carry a baby for someone else.

The need to hide from family and friends is not the only form of bodily repression that takes place in the sphere of transnational surrogacy. Due to the distance between the intended parents and the clinic/surrogates most communication during the pregnancy takes place online. E-mail is a popular form of mediated communication for the health

practitioners. Additionally, they send scans of the various sonograms which allow the intended parents to see the progress of the fetus, but not necessarily the state of the woman acting as the surrogate. Surrogacy India works to avoid this disembodied connection by arranging video chats between the surrogate and the intended parents.

Even by engaging in video communication the body is still compartmentalized with a focus on the mark of pregnancy—the surrogate’s belly. A nurse at Surrogacy India described this interaction,

We are trying to create a bond between the couple and the surrogate and make the couple feel a part of the pregnancy. The Skype is very emotional—they make her stand and say they want to see the baby belly—it is wonderful seeing them happy.

The surrogates at Akanksha described a similar experience,

They are very excited throughout the pregnancy that we are having their baby. When they come they touch my belly. They get ecstatic about our bellies.

Not only does the surrogate body fall into the category of repressed (Balsamo, 1996), but it also becomes a disappearing body through the use of technology. A surrogate is defined as, “one appointed to act in place of another or one that serves as a substitute” (www.merriam-webster.com). Because we cannot replace the parts of the body required for successful reproduction yet, a substitute must be provided. While the material body is often replaced by technology, in this instance it must be replaced by another body. However, the work of reproduction makes the pregnant laboring body vulnerable to discipline and invasive surveillance in the name of protecting a fetus. This

is further complicated by carrying a fetus that is not your own. The intended parents and the doctors then have the ability to monitor in a way that erases the surrogates.

As an assistant doctor at Akanksha Clinic explained,

All the surrogates live here under our observation 24 hours.

We do 3D, 4D ultrasound and email every 15 days to a month and as the due date gets closer we update and they will email and ask about the surrogate. We scan all the ultrasounds and we send them.

Additionally, the very language used to describe the participants in surrogacy has worked to repress and erase the surrogate's body. According to each of the doctors I interviewed, the intended parents were referred by the doctors as the patient as surrogacy is a treatment for their infertility. Despite the fact that the surrogate's body is receiving most of the care and monitoring, she is not given the attention that she deserves and her body is not considered primary in the process.

Dividuation of the Surrogate's Body

The commercial nature of surrogacy discussed in Chapter 4 provides evidence to commodification of the surrogate's body and its various parts. However, the corporeal experience of the surrogate is as complex as any post-modern bodily experience. In the descriptions of the surrogate's experiences, the body emerges as a site where technology can be used to further the goals of various parties. The female body is again made useful by modern science creating a site of "new capital" (Mies, 1993) in the global marketplace.

The surrogates become dividuials, rather than individuals (Mies, 1993) made up of useful reproductive parts for the consumption of others. Sawicki (1991) has argued that

surrogates have been created by new technology. The market has been created for reproductive body parts and women are the primary contributors to these materials.

The laboring, marked, repressed, and disappearing bodies of the surrogates provide an important framework for understanding some of the more troubling aspects of surrogacy. It is not however a complete picture of how the women define this embodied work. They also have complex ways of defining themselves emotionally and socially in the context of surrogacy. The next section will further identify ways in which the surrogates imagine themselves.

The Surrogates Identities

RQ 3: How do the surrogates enact and communicate their identities?

Just as there can be no one female experience, there can be no one surrogate experience or identity. This is not intended to essentialize or generalize, but rather impart a glimpse into the lives of these women as they define their motivations and the challenges of their work. During the interviews, surrogates described their decision making process and their experiences. The complexity of their feelings was apparent not only in their language, but in their nonverbal communication. Their dialogue reveals several identifications that co-exist, simultaneously both in concert and in tension with one another.

In order to answer this research question, I focus on the ways in which surrogates talk about themselves. It is their lexical choices and reflections that reveal their identity negotiation processes. In their discourse three major themes emerged. The women simultaneously see themselves as mothers, as earners, and as givers in their work as surrogates.

Amma (Mother)

The surrogates spoke about two primary identities—that of mother and that of working women. While the economic opportunity is certainly a motivation for the women to choose to be surrogates, it is important to understand the hidden motive behind this choice. Each surrogate explained that they were interested in this work in order to provide a better life for their own children. The women most strongly identified with the role of being a mother to their own children. This identity is then complicated by the temporary mothering role as a surrogate.

The act of mothering is carried out by the surrogate not only in the pregnancy itself, but also in what drives them to do this work. “Motherhood is rooted in much more than a biological or genealogical relationship or even a specific role and stage in the life cycle; rather it emerges as part of historically specific family structures and the power relations produced” (Donner, 2008, p. 35)

When discussing her motivation to work as a surrogate, Kapila said,

That’s why we thought even if we were to work all our life we could never make this much money and once I can become a surrogate mother I can make so much money that I can improve the quality of my child’s life.

Everybody has a different way of thinking about their choices. Everyone is independent in the choices they make. I want to give my kids a good life – that was my thinking.

Similarly, Sunita said,

It’s our helplessness, I have a son, and I need to give him a good life.

They explained that they take their own children into account in their decisions about work and surrogacy. One of these decisions is whether or not to tell their children about what they are doing. Kapila explained that her husband stopped bringing her son to visit her during the third trimester.

My son will ask what is wrong if I am expecting. I thought, what effect will this have on my child? I don't want my child to think I am selling babies and what if he thinks [mother] wants to sell me?

When asked what she thought would happen if her child found out when he was older, she added,

Of course, they should understand that whatever mama has done has done it for me. They should understand that if mom worked her entire life, she could never make this kind of money. When they are mature enough they should understand. There are surrogates who have older kids who come in and out to see them because they are already old enough to understand their mom is doing this for them.

The surrogates' identity as mother did not end with their biological children. Every woman explained that they would have difficulty giving up the baby they carried. They described a connection and a sense of responsibility toward the fetus. I asked, "Do you feel any difference between your own and this baby you are carrying?" Kapila replied,

There is no difference at all. It's the same. We think of this baby as also our own, there is no difference at all. The amount of discomfort that I had to go through in

my first pregnancy is the very same as the discomfort of this pregnancy. So there is no difference. So when I give the baby I will feel very sad (with a slight laugh).

The experience is both physical and emotional for the surrogates. While they refer to the bodily pains (Sunita mentioned her swollen legs and feet several times), they also spoke of the feelings of loss and sadness. As Chodorow (1978) has explained, “Historically, the actual physical and biological requirements of childbearing and child care have decreased. But mothering is still performed in the family, and women’s mothering role has gained psychological and ideological significance, and has come increasingly to define women’s lives” (p. 4). Kapila stated,

For nine months I enjoyed being a mother, but now during delivery I don’t like it. I like the baby being inside my womb – I like that feeling.

But she also said,

Of course I feel sad when I give up the baby. I’ve kept it in my womb for 9-10 months but I keep telling myself it is not my baby and I have to give up this baby when it is born.

She explained how some of the surrogates cope with the loss:

Some people ask for a picture of the baby to remember the baby.

There are contradictions in the complex emotions that the surrogates expressed. The process of carrying the baby is filled with both joy and pain on more than one level. The women have become comfortable in their role, but are challenged by the feelings of loss that they know they will experience. Being a surrogate is described as empowering because of what they can do for their children, but also a choice they make out of helplessness. They have considered the choice carefully, yet also worry about how their

children will react. They are proud of what they are doing for their families, and also feel compelled to hide it from most people. These contradictions are found in many of the explanations the surrogates give.

Worker and Earner

Though they privilege their connection as mothers they also offered their own perspectives on the economic opportunity of a job as a surrogate. It is an exchange and a legitimate job for these women. Kapila was being paid Rs. 3 lakhs (one lakh is equal to Rs. 100,000 rupees or approximately \$2100 USD). Ganga explained she was getting Rs. 2 ½ lakhs because it was her first time. Sunita explained that she would receive Rs. 3 lakh for this pregnancy as it was her second. The first time she only received Rs. 1 ½ lakh.

The first time everyone was getting Rs. 2 ½ or Rs. 3 lakhs and Rs. 1000 a month for food. I went and talked to Madame (Dr. Patel) because I was upset. Second time I have become wiser and I want more so I told Madame.

Sunita effectively illustrates how the experience of surrogacy has changed her and has boosted her confidence in her ability to negotiate for what she feels she deserves. As she has been a surrogate previously, the other women look to her for advice. While the experience of surrogacy may alter the consciousness of the women, they clearly have their own perspectives on the work they have selected to do. Kapila stated,

This is not unethical work. It is not a wrong thing to do because it is my hard work and besides it is another couple who does not have a baby and if they are giving me their money to have a baby then I will give them a baby.

They have considered other work, but the benefits seem to outweigh the costs involved in the act of surrogacy. Kapila added as she laughed quietly:

Well, see the problem is we are not that educated right, so the options are limited.

Well let me tell you even if we were to work one year constantly we could not accumulate this much money. So after thinking about all this we make this decision

If I worked hard all year I would not even be able to make Rs. 50,000 and in this I make Rs. 3 lakhs.

Ganga added, *This is also dignified work, because it will solve my problem and solve their problem also. They don't have a child and I don't have the money so it solves the problem. This is good for them because they get a baby—that is why I want to do it and that is why it is dignified work.*

Kapila also said,

Well, I have already done a job before. I worked in a company as a packer. So this is much better than that, I will probably have discomfort for nine months, but it is better discomfort.

Again, while the women make sure to explain that they do not see the work as problematic or unethical, they frame the decision by explaining a lack of alternatives. While the money is an important factor for the women, there are other conditions that limit their willingness to work as a surrogate again. Sunita is not allowed to have a third surrogacy cycle because she has had Cesarean section births. However, she said given the option she still would not sign on to be a surrogate again. She explained, *“Now I must pay attention to my own kids.* “In addition to demands at home, the women

described their communities and families as potentially critical of surrogacy. Kapila explained,

You have to understand the poor people really value the dignity of work. They work hard with their hands. Sometimes they make Rs. 20, some days Rs. 50 (\$.40, \$1.00 USD). They spend within their means and that is how they live so they can never understand surrogacy and this issue to make so much money in such a short time. Even if I make them understand, they will not be able to therefore it is not worth telling them about surrogacy.

Ganga added,

The society is very conservative at home. They will not understand this.

While these identities of mother and breadwinner are centered in the responses of the women, it is also apparent that they release some of their autonomy by entering into a surrogacy agreement. They often defer to other decision makers in the process. At Akanksha, the women refer to Dr. Patel as Madame and explain her role in their lives.

Madame chose me, she makes the decision for me that these are good people for me, I did not even meet the party.

What Madame has done for me, nobody else can do for me.

The party has to deposit the entire amount to madame up front and she gives us the money throughout the pregnancy.

Madame makes us show us all the expenditures we do with this money. After seven months we get Rs. 25,000 and then she asks us what did we do with that money. We show her our passbook and show that we put it in the bank.

Madame is the one who wrote up the agreement.

In addition, the surrogates refer to the decision-making power of the intended parents. After the baby is born, the next steps are determined by the parents. The women also discussed the possibility of getting more money at the end of the pregnancy than what was put in the initial agreement.

If they tell me to stay here with them I will stay otherwise I will go home.

If they tell me to stay and feed the baby I will stay – it depends on them.

Kapila's response shows the dissonance she feels about the arrangement and the expectations that surround it.

They should think about our plight and our suffering. I have carried their baby for nine months and they should understand my feelings. Madame gives us the whole money, but if the party is happy they give extra. My party has not brought anything until now, but I hear of others who give. Those who really want to give, give a lot of stuff.

Sunita added, *Like my friend got Rs. 1 ½ lakh extra.*

While the surrogates expect gifts, their self-esteem is high and they don't want to appear as needy. They quickly become defensive and protect their pride. Kapila continued,

The party brought me a saree and then they brought gold chain, and chocolates for my child. They never met me until last month, so the first time they brought the gifts and the next time they did not bring anything. She will ask if there is anything I want to eat for them to bring and I say I don't need anything. They should bring something from their own heart. I will never stretch my hands in

front of anyone. I have all the facilities here. If I am hungry I will eat with my own money.

The surrogates did talk a lot about why the job is good for them by describing the payment they receive compared to other types of work. This cost/benefit analysis is a dominant part of their explanations, but they also see their role as much more than doing a job.

Giver

While the women grappled with their need for money and the work of surrogacy, a third identity that emerged—altruistic giver. While money was a strong motivating force, the act of giving someone a baby seemed to hold some meaning for the women as well. Kapila explained that she would still be a surrogate if she did not need the money for her own family.

If I have all the pleasures of the world, I have the money – it would be my duty to help you. You need a baby so I will give you a baby. It doesn't matter if I am rich. If I have money or not it does not matter. I will help you. I would still give you a baby.

She talked about why it would be ok to be a surrogate if she was a wealthy woman,

Because when I am rich I don't have to worry about implications about being pregnant with someone else's baby because no one will ask. It is easier to be pregnant if I have all the comforts of the world then now.

In another example, when the surrogates were asked what they would do if the intended parents did not come for the baby, they described a sense of responsibility for

the child. Though they thoroughly believed that it is not possible for the child to be abandoned by the intended parents, in the event it occurred they said they would take on the job of mothering the baby. Kapila said she would take the baby home with her.

Don't worry if ever that situation arises, then the money that madame gives us for surrogacy we will manage to raise that child with that money.

In response to whether or not she would be able to care for the child, she said,
Yes, I will have to do it, there would be no choice, and after all it is my child also.

Ganga also said she would manage to care for the child,

I won't abandon the child.

Intersections of Identities

The roles of mother, earner, and giver intersect in a complex web of relationships in the surrogates' lives. The surrogates are examples of an emerging or transitional identity for women in India. As Narasimhan (1999) points out, "In the post-independence years, India has undoubtedly seen significant progress on the economic and industrial fronts, but this progress has been inequitable, with disparities widening between the urban and rural sectors, and between the privileged upper classes and the socially disadvantaged groups" (p. 198). In a society where 300 million people live below the poverty line and women disproportionately experience social handicaps (Narasimhan, 1999), these women have turned their social roles into a source of economic empowerment.

The Surrogates' Location

The surrogates are located in a transitional space where they are forming new identities while embodying a specific experience. They negotiate this space together to

arrive at the understanding of their roles as mothers, as working women, and as people who are helping others. They temporarily must locate themselves in a new environment, all the while retaining the identities they have carried with them from home.

The surrogates are motivated to change the conditions they find themselves in and their ability to enact that change inevitably changes their identity. The surrogates are major contributors to the financial well being of their families. They also often live independently of their families for a time, existing in a liminal space where their identities are emergent and dynamic in the midst of many contradictions. The surrogates were clear about where they come from and what they want, but there remains some ambiguity in where they will go from here.

The women that I spoke to were taking on a large amount of responsibility to help their families. They enacted agency in taking on this level of accountability. It is clearly difficult for them to be away from their own children and while they may enjoy a few perks of being cared for, the tension between that freedom and the connection to home is apparent. They made extreme sacrifices that their family members and husbands could not, in their decision to work as a surrogate.

The challenges of the identity of a working mother have been a hot topic in the Western world for several decades (Ireland, 1993). The inherent difficulties continue to change and grow in new industries and locations around the world. The surrogates are participating in a modern process grounded in new technology, but are bound to tradition and their duty to their families. These tensions push and pull the surrogates in various directions, but they have found a way to be comfortable in their decisions through their individual perspectives and community bonds.

The glimpse of a surrogate's journey here is incomplete. Still, it is an important exploration into the internal and external components of their position in the surrogacy process. As technology continues to change the path of reproduction, women's roles in the reproductive process will also change. These evolving roles will impact the identity of a mother and of a woman. "Body parts are objectified and invested with cultural significance. In turn, this fragmentation is articulated to a culturally determined 'system of differences' that not only attributes value to different bodies, but 'processes' these bodies according to traditional, dualistic gendered 'natures'" (Balsamo, 1996, p. 288). The reproductive body maintains a place of value to the extent that one can now purchase another's capacity to bear children as she in turn can be compensated for that labor.

Surrogacy re-defines motherhood as well as re-values the position of mothers in both the physical and cultural roles. The "natural" process of pregnancy is challenged by the new technologies that allow for individuals to produce children through "unnatural" means. Surrogacy confronts and re-configures a woman's identity not only as a mother, but as a participant in financial earning and a contributor to the larger social circumstantial needs of others. Not only are they working for their family, they are doing work for another family by bringing their baby into being.

The next chapter will turn towards the critical component of policy with regards to surrogacy. A recurring theme in conversation with health care providers and government officials was the concern of ethical implementation of a surrogacy agreement. There is much to be discovered. But the initial attempts at codifying such ethics and the effects on the various participants are valuable additions to a fuller understanding of the sphere of surrogacy and its role in ART.

Chapter 6: Policy

When I began this study, I read many news items online which prompted my research on surrogacy in India. The information that I gathered led me to believe that surrogacy was legal in India, as India has become a center for this market. However, very early on during my time in India I realized the complexity involved in the legal concerns for surrogacy. While surrogacy is an accepted practice in India, there is no official regulation at the time of this writing. In order to better understand the positioning of the various participants in this process, I examined the guidelines currently in place as well as the transcripts from interviews with doctors and officials in India. The law defines the rights of individuals in relation to the government structure that monitors behavior of people and quality of services. In order to address this I have posed a final research question:

RQ3: How do the current guidelines and absence of law constitute the rights of participants in the surrogacy process in India?

To effectively address this question I begin with a detailed account of two of the most recent and most controversial cases in India that are setting a precedent for any future issues. I then explore the perspectives given by the doctors and health officials as told to me in interviews. Finally, I closely examine the proposed legislation and argue that the potential policy has serious implications for those involved in surrogacy in India.

Precedent Setting Cases

The German Twins

In January of 2008, twins Nicolas and Leonard were born to an Indian woman named Martha in the city of Anand, India. Now two years old, the twins are at the center

of an international media controversy regarding where they belong. For months, the Indian news were flooded with headlines such as “Surrogate twins not Indians” (Times of India, December 1, 2009), “Nowhere to go: twins without nationality” (Times Now TV, December, 2009), “German or Indian? Surrogate twins in legal no man’s land” (Times of India, December 1, 2009), and “Centre working towards a happy ending for German surrogate twins” (Times of India, January 5, 2010).

After discovering that they could not have children on their own, Jan Balaz and Susan Lahole traveled to India to hire a surrogate at the Akanksha clinic because surrogacy is not a legally recognized form of parentage in their home country, Germany. When the twins were finally born, they were not prepared for the challenges that emerged in trying to take the boys home.

Jan Balaz, a freelance photographer, maintained residence in India to stay with his sons for over two years. His wife Susan, however, remained in Germany for work and visited when she was able. They pursued several options to secure travel documents for Nicolas and Leonard during the two-and-a-half years in India. Due to a lack of clarity in Indian law, and restrictions by the German government the boys had no legal citizenship in either country. Initially, the Gujarat High Court ruled that the twins would receive passports as Indian nationals because the surrogate mother was Indian. This ruling was stayed by the national government because there was no consensus on whether or not the Indian surrogate mother actually had parentage that allowed the twins citizenship under the Indian Citizenship Act. They were registered as children of foreign citizens when they were born. In India, unlike in the U.S., you cannot become a citizen by being born

within the country. The twins have no citizenship because Germany does not recognize their births and neither does India.



Figure 6.1. Nicolas and Leonard Balaz (source: ibnlive.in.com)

The family drama has played out in the national media complete with emotional pleas from Jan Balaz and commentary from his attorney. If the Indian government issued passports for Nicolas and Leonard, Jan and Susan would then have to adopt the children when they arrive in Germany. The issue moved into the international diplomacy realm with German Ambassador Thomas Mataussek explaining to CNN-IBN that Germany would consider giving the twins visas if the Indian government approached them. He added, “We have to be very careful. We don’t want to set a precedent. We don’t want to encourage people to go down this path. This is not the way to put children into the world.” (as reported by the Indo-Asian News Service, IANS, www.ians.in). In June of 2010 the German government issued travel visas for the family. The Balaz’s did have to navigate the complicated inter-country adoption system, but are now residing together in Germany.



Figure 6.2. Dr. Nayna Patel being interviewed by Zee News about the German twins (source: Stephen Littlejohn)

This story exemplifies the current challenges and complexities that exist within the commercial surrogacy process. While not the first major case to take center stage in India, it will in many ways set precedent for future problems as the legal landscape changes with regards to surrogacy. Certain ambiguities in law and regulation contribute to confusion and inconsistency in the responses to issues as they arise. Surrogacy complicates the definition of parentage, nationality, and family itself. An important aspect of this new industry is the developing laws meant to regulate the industry and protect the people involved.

Baby Manji

While commercial surrogacy has no law on the books in India, it is not illegal either. In 2008 the Supreme Court of India upheld a surrogacy agreement in *Baby Manji Yamada V. Union of India (UOI)*. In the case of baby Manji, Ikufumi and Yuki Yamada, married doctors from Japan, hired a surrogate in Anand, India after being unable to conceive on their own. Japanese law does not recognize surrogacy, thus prompting them to seek the service outside of their home country. Working with Dr. Nayna Patel at the

Akanksha clinic, they hired Priti ben Mehta to carry their child. An additional complication was the use of an anonymous egg donor, whose identity is in speculation (Nepali or Indian). The sperm was Ikufumi's, which left the father as the only genetic parent. Once Priti ben was pregnant, the Yamada's returned to Japan to await the arrival of their child. However, during the months between conception and birth of Manji, the Yamadas divorced. At this point Yuki no longer wanted the baby who was not hers biologically, genetically, or legally. While Ikufumi still wanted to father his child, he ran into India's *Guardians and Wards Act of 1890*, which prohibits single men from adopting girls (Point, 2009). Even though he was the genetic parent, he was still required to adopt Manji because she was born to an Indian woman in India.

In the meantime, Manji contracted an infection and was moved to a hospital in Jaipur where a family friend became her wet-nurse. The law was not prepared to handle the mounting questions regarding Manji's nationality, travel documents, and parents. Indian law required the mother's name to be on the birth certificate, which in turn is required to issue a passport. No one seemed sure about who the mother actually was. Would it be Yuki, the intended mother; would it be Priti ben, the surrogate mother; or the anonymous egg donor that provided the genetic material? In many ways Manji had three mothers instead of none. In fact, a fourth mother yet emerged when Emiko Yamada, Manji's paternal grandmother went to India to care for her after Ikufumi's visa expired. After quite a legal battle, the Indian government agreed to issue a birth certificate with only the father's name and Emiko took her granddaughter home to Japan. Manji received a one -year visa on humanitarian grounds (Point, 2009), and it is unclear what her current status in Japan is.

The baby Manji case remains a cautionary tale of the complications of surrogacy as it ignited strong responses from many directions. One vocal opponent to surrogacy is Satya, a not-for-profit located in Jaipur that filed a petition with the court for custody of baby Manji (Point, 2009). They claimed Dr. Patel was engaging in child trafficking and that due to lack of surrogacy laws there was no clarity about who Manji's parents really were. Because of this petition the case went before the Supreme Court who ultimately dismissed the claims and explained the passport decision was up to the Union government. This "passing of the buck" occurred throughout the precedent setting case as no one wanted to make a decision without a guiding law. The problem became clear—India needed a law.

International Surrogacy Law

India is not alone in their lack of clarity about the legalities involved in international surrogacy. Many countries around the globe have also struggled to define a process for people who are crossing borders and finding loopholes in their own systems. There is no unifying agreement on how surrogacy should work or whether it should even be allowed at all. The table below summarizes several key locations and their laws that address surrogacy.

As the table illustrates, surrogacy laws can be very complicated and difficult to decipher. Many people from Australia, the U.S. and Japan find their way to India to avoid the barriers presented by their home country. As surrogacy continues to expand in India, the government is faced with the challenge of adequately addressing the rights and responsibilities of many parties in one policy document.

Table 6.1

International Surrogacy Law

Country	Law
England	Surrogacy is legal in the United Kingdom. However, there are very strict guidelines according to the Surrogacy Arrangements Act 1985. A surrogacy agreement is not enforceable and it is illegal for a third party to broker a commercial surrogacy agreement. Any payment to a surrogate is delineated as expense reimbursement.
Canada	Surrogacy is legal, but similarly to the U.K. there can be no commercial payment to a surrogate via the Assisted Human Reproduction Act
Australia	Varies from state to state. No state recognizes commercial agreements and considers them unenforceable. Tasmania and Queensland also outlaw altruistic surrogacy. Federal law requires states to follow the 2004 Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research
Germany	Commercial surrogacy is illegal by 1990 law German Embryonenschutzgesetz
Japan	Surrogacy is technically allowed in Japan, though the health ministry tried to impose a ban in 2001. The practice is not supported by the Society of Obstetrics and Gynecology.
United States	Varies from state to state. California recognizes surrogacy contracts. New Jersey has said commercial surrogacy agreements are illegal and unenforceable. Illinois passed the Gestational Surrogacy Act in 2004, requiring a medical need for surrogacy among other specific requirements of both the intended parents and the surrogate.

The Law in India

Due of the lack of clear law with regard to the status of children born through surrogacy, India may be setting precedent on an international level in the next few years. Currently, the *Assisted Reproductive Technology (Regulation) Bill* is before the Parliament. The bill was constructed based on the Indian Council of Medical Research's (ICMR) guidelines for ART clinics. The bill includes forms for surrogacy agreements, pre-conditions for surrogacy, as well as regulations about how to manage the surrogacy process. The bill has not been approved yet, but many feel it is an important step towards

legitimizing surrogacy in India. Dr. Desai from the Civil Hospital in Ahmedabad explained,

The private sector is flourishing on surrogacy. So it's not a public health problem and private sector is unregulated. The public health is the concern of the state so it is regulated, private sector is not. [India's] a very large country with a lot of people and it's very difficult to regulate everything. Surrogacy is becoming huge. Surrogacy is now becoming a big thing with big legal problems. It is creating a lot of issues that even private sector people have not experienced. Public health people however have to be more focused and look after all aspects of surrogacy that unregulated sector [private] does not have to look at. There are regulations available in ICMR—these are guidelines that need to be converted into law.

Indian Council of Medical Research (ICMR)

The Indian Council of Medical Research (ICMR) became an important character in the story of baby Manji as well as the twins, Nicolas and Leonard, because of the aforementioned guidelines. ICMR claims to be “one of the oldest medical research bodies in the world” (www.icmr.nic.in). It has 29 different research centers throughout India focusing on the public health of India. According to their website,

The Council's research priorities coincide with the National health priorities such as control and management of communicable diseases, fertility control, maternal and child health, control of nutritional disorders, developing alternative strategies for health care delivery, containment within safety limits of environmental and occupational health problems; research on major non-communicable diseases like

cancer, cardiovascular diseases, blindness, diabetes and other metabolic and hematological disorders; mental health research and drug research (including traditional remedies) (<http://www.icmr.nic.in/abouticmr.htm>).



Figure 6.3. Cover of presentation created to explain the ICMR guidelines (source: Stephen Littlejohn)

ICMR is an increasingly important player in the dynamics of surrogacy in India today. In 2002 ICMR created *the National Guidelines for Accreditation, Supervision & Regulation of ART Clinics in India*. They then updated the guidelines in 2005. These guidelines are recommendations or suggestions from medical professionals, but there is no legal requirement to follow them and no legal consequence if you do not. While the guidelines were referred to in arguments in both the baby Manji and the German twins cases they are not enforceable as law. In 2008, after the Manji controversy, the health minister, Mr. Ambumani Ramadoss called for surrogacy legislation (Point, 2009, p. 7). He expressed concern for future problems and possible exploitation. Surrogacy has had a place in the spotlight ever since. Even the national law school moot court (simulated

court proceedings for law students) competition in 2008 created cases that centered on issues around surrogacy (The Economic Times, August 25, 2008).

The Assisted Reproductive Technology (Regulation) Bill, 2008.

ICMR used its National Guidelines to create a draft bill entitled *The Assisted Reproductive Technology (Regulation) Bill, 2008*. The bill is broad in scope and often vague in critical areas of concern. While this study focuses primarily on the aspects of the bill that affect surrogacy, an outline of what the bill can be found in Table 5.2.

Table 6.2

Outline of The Assisted Reproductive Technology (Regulation) Bill, 2008

Chapter	Contents
Chapter I	Preliminary (definitions of terms)
Chapter II	Constitution of Authorities to Regulate Assisted Reproductive Technology
Chapter III	Procedures for Registration and Complaints
Chapter IV	Duties of an Assisted Reproductive Technology Clinic
Chapter V	Sourcing, Storage, Handling and Record Keeping for Gametes, Embryos and Surrogates
Chapter VI	Regulation of Research on Embryos
Chapter VII	Rights and Duties of Patients, Donors, Surrogates and Children
Chapter VIII	Offences and Penalties
Chapter IX	Miscellaneous (includes maintenance of records, power of the Central Government to make rules, power of State Government to make rules)
Appendices	Agreement Forms (including Form-J Agreement for Surrogacy)

The bill is a prominent part of the discourses surrounding surrogacy. While not present in the discussions with surrogates, it was frequently mentioned when interviewing

the other stakeholders. The next section explicates the various stakeholder positions and how their interests are defined in the proposed legislation.

The Stakeholders

It takes many people to create a baby through the process of surrogacy. It is a complex web of relationships and interests. These interests define what is at stake for each participant. In order to understand the implications of any law created to regulate the industry, it is important to understand who is involved and in what ways they participate. While chapters 3 and 4 address some of this basic information, here I further explore the strengths and weaknesses of each position in the policy. By closely examining the rights and responsibilities of each group of participants one can determine who is and in what ways they are privileged. The participants present in this study reflect most of the categories including (a) lawmakers, (b) healthcare providers, (c) surrogates and donors, and (d) commissioning parents.

Lawmakers

The bill calls for the formation of a national advisory board to carry out the regulation of ART clinics. It should have a maximum of 21 members including a chairman appointed by the Ministry of Health and Family Welfare (MHFW). Additionally, it will include an officer of ICMR, a representative from the Ministry of Health and Family Welfare, a “member of an Indian professional society concerned primarily with assisted reproduction” (Clause 3.2d) and up to 16 other experts nominated by the MHFW. The bill requires that a minimum of six of the board members be women. Each state is then required to form a similar, but smaller board. Most interestingly, any proceeding before a state or the national board will be deemed judicial, similar to a civil

court. These bodies will be responsible for the formation, modification, regulation, and enforcement of the ART regulations. It is a powerful central location that does not necessarily have representation from groups that are most directly impacted – the surrogates, donors, and parents. It is primarily comprised of members of the scientific biomedical field, while ignoring the implications for social, political, and cultural areas.



Figure 6.4. Dr. D.M. Patel, Registrar of Birth and Death and Dr. N.B. Dholakia, Deputy Director at Gujarat Ministry of Health (source: Stephen Littlejohn)

All ART clinics will then need to register with the boards for accreditation. The bill states, “The State Board may, subject to such terms and conditions as may be prescribed, register any assisted reproductive technology clinic on the basis of the techniques and procedures of assisted reproductive technology practiced at such a clinic” (Clause 13.3). It leaves an open ended responsibility for the state boards to determine the conditions without any uniform information regarding requirements for gaining accreditation or ways in which a clinic may lose said accreditation. The bill does not provide a checklist of preconditions required for accreditation. Neither does it include clear information about the process of losing accreditation. One would assume that there

is a list of infractions that may incur a fine, while other more serious problems would entail the closing of the clinic or other legal consequences. It would be useful for these details to be included in the ART bill to synthesize all critical information for these businesses.

These boards will adjudicate the penalties for any lack of compliance in accordance with the bill. There is very little that specifically identifies these penalties or how the process of adjudication will look. The information on offences namely addresses the issue of pre-natal sex determination. This is illegal under all circumstances in India and will also apply to foreign patients receiving ART treatments. The offenses are listed as punishable by imprisonment and/or a fine without any specificity regarding amounts. Presumably the boards would also determine that during a judicial proceeding.

The health officials I spoke with in Gujarat were mostly concerned with the documentation and immigration of the babies that are produced through surrogacy. That has been the central issue in the two major cases that have been publicized thus far. Any further complications would presumably also be addressed after a problem emerged. Dr. Desai of Civil Hospital explained.

In our country the issue comes first and then the law. In other countries the law comes first and then the issue. It's a large country with a large population and every state has its own issues and health concerns.

Healthcare Providers

The clinics duties revolve mostly around record keeping, gaining consent, and informing patients about risks related to procedures. However, with regard to surrogacy there are specific and sometimes contradictory rules. Clause 20.10 states, “No assisted

reproductive technology clinic shall consider conception by surrogacy for patients for whom it would normally be possible to carry a baby to term.” However, Form J – Agreement for Surrogacy opens with the surrogate stating, “ I _____ (the woman), with the consent of my husband _____, of _____ (address) have agreed to act as a host mother for _____ who are/is unable (or do not wish to) have a child by any other means.” This is a problematic contradiction about the fundamental decision as to whether or not surrogacy is appropriate. The bill would seem to require a medical need for surrogacy as a fertility treatment rather than simply an alternative for a woman who does not want the physical strain of pregnancy to interrupt her life. However, with people coming into India from other countries to hire surrogates it is difficult to ensure this need if they bring their own records or refuse to be examined by a local doctor.

In one interview with surrogate Sunita, she explained that she believed the commissioning mother in her case could in fact have her own baby. In other words, she did not have a medical need for surrogacy. Sunita speculated about why she might make the choice to hire a surrogate instead by saying,

Madame (Dr. Nayna Patel) explained to them, why aren't you having a baby on your own? So I will ask them why they are hiring me.

Well you never know, maybe she has a job and doesn't have time to have a baby.

The proposed bill prohibits ART clinics from recruiting surrogates for their patients. It does, however, allow patients themselves to advertise as long as they do include “details relating to the caste, ethnic identity, or descent of any of the parties” (Clause 34.7). In this instance Dr. Nayna Patel would have to revamp her entire

enterprise, while a third party organization like Surrogacy India may receive an onslaught of potential clients. At Akanksha Clinic, Dr. Patel oversees every aspect of the surrogacy process including the assignment of a surrogate to her patients. The patients pay the complete fee up front and then she distributes the money incrementally to the surrogate. She is also the sole line of communication between the surrogate and the commissioning parents throughout the pregnancy. Because Akanksha is a clinic, Dr. Patel would not be able to be directly involved in the recruitment and management of the surrogates. With this stipulation, third party agencies such as Surrogacy India would be in high demand. Surrogacy India is not an ART clinic. They strictly deal with services associated with the international surrogacy process including travel, legal agreements, qualified surrogates, egg and sperm donation, and assistance finding a clinic to work with.

The bill is silent with regard to any outside organization or business, such as medical tourism agencies, and their involvement with any aspect of surrogacy. Clause 26.6, however, allows for semen banks to advertise for surrogates, “who may be financially compensated by the bank.” Interestingly, the bill does not include semen banks under the category ART clinics, thus not requiring the same adherence to the rules of the bill.

Dr. Malpani of the Malpani Infertility Clinic in Mumbai agrees strongly with this clause saying,

A better way is to let the doctors do the IVF, but to let the surrogacy be handled by an adoption agency. We already have a network of adoptions agencies around the country run by social workers who are not commercial, who understand the issues of family building and can counsel people. If you give them the

responsibility they will counsel the surrogates and open the bank account for the surrogate. There would be a professional who is guarding the surrogates' interests.

The doctors I spoke with all insisted that they worked within the current ICMR guidelines and that they would only continue as long as the law allows. Dr. Patel of Akanksha Clinic stated,

Lots of people want to do this, but don't want to be known in the open. I am doing it and I am doing it in public the way the government wants it done, but the day they say it is illegal, I will not do it.

The doctors at Surrogacy India also said they would close their doors the minute the government said it was illegal for surrogacy. Dr. Ajja spent a lot of time incorporating all of the ICMR guidelines into the structure of their business. The documentation and the stringent adherence to the guidelines differentiated their company from the clinics I visited. Dr. Ajja explained his areas of concern,

What happens is when laws are passed it is a big deal and they are at the macro level but the guidelines are still incomplete. It does not really say who's responsibility to choose the couple—whether the clinic, a third party. There has to be a need, a medical reason for surrogacy and if you don't satisfy that we will not take you. It is unclear in guidelines. It is said it is not clinics responsibility to provide documents for baby, but whose responsibility is it? Couples are very emotionally charged. They want to have a baby, first ray of light they just jump, they say let's have a baby and then see what to do, so who guides that? We have taken our own steps. We take a stand and we guide our patients.

The guidelines and the growth of surrogacy have initiated debate within the medical community in India. Dr. Patel described a public forum that occurred a week before my interview with her,

We had a debate in Mumbai that was going on ninth of December where there was one patient of mine who had done surrogacy. The auditorium was full. When the whole thing was over when the audience was asked if they thought surrogacy should be done—95% agreed it should be done. But those same people walk out saying India is portrayed the wrong way and why should Indian women be surrogates?

Mr. Patil of Trivector and Cryos International agreed with the general consensus at the meeting,

Last week we had a conference called Ovary 2009 and everyone agreed that it is helping everyone involved. It is helping the surrogates' family getting some livelihood and she may be able to pay the school fees of her child or something like this.

However, he is not convinced that the guidelines are complete enough to protect surrogates:

There are a lot of grey areas yet—one of the reasons I'm not comfortable yet.

Surrogates

Most absent from the bill are specific protections for surrogates. While there is an agreement form in the appendices of the bill, it mostly focuses on what the surrogate is doing for the commissioning couple rather than what might be required for her own well being. For instance, the form reads, “I have worked out the financial terms and

conditions of the surrogacy with the couple in writing and appropriately authenticated copy of the agreement has been filed with the clinic, which the clinic will keep confidential” (See Appendix B). Nowhere in the bill are there guidelines for this negotiation or for compensation and care for the surrogate. The agreement itself is in the surrogates’ voice, with no additional form for what the commissioning parents are agreeing to. The agreement states, “I have been tested for HIV, hepatitis B and C and shown to be seronegative for these viruses just before embryo transfer.” In other words, the surrogate is stating that she has no contagious diseases that could be transferred to the baby she will carry. However, there is not additional form where the parents providing the genetic material for the embryo that will be placed in the surrogate have been tested for such diseases. The agreement also speaks to a contingency in case the commissioning parents die or are unable to pick up the child, but has no information about the death of the surrogate. The bill is silent with regard to health insurance and legal assistance for surrogates.

The surrogate is, however, guaranteed her legal right to terminate the pregnancy up to 20 weeks. She will not be compensated if it is her choice and may have to return any payment already made, but if the termination is recommended for medical reasons she will not have to turn payment over.

While a few of these individual rights remain intact, the surrogates themselves appear relatively unaware of the ICMR guidelines or any specific protections. Their information is limited to the narratives of friends or relatives who have also been surrogates or what the doctor or recruiter tells them. As Kapila, a surrogate from Akanksha Clinic explained,

They read [the agreement] out loud to us in Gujarati because we cannot read.

The doctor makes agreement.

The filtering of information through a party like the doctor managing the surrogacy for international patients creates potential for a specific framing that reduces participation from the surrogate. This removes some of their individual agency by relying on hierarchical deference. The structural, class, and educational differences create a patriarchal relationship between the surrogate and the doctor (or in the case of Surrogacy India, the managing director). The surrogates are put in the position of subordinates who must rely on information given to them by more powerful individuals instead of having stronger representation for themselves.

This relationship of dependence creates an environment ripe with the possibility of exploitation. While there are many doctors who do care about the well-being of the surrogates there are certainly opportunities for others to take advantage of the situation. The position of the educated and literate is one of postcolonial dominance. Globalization causes power lines to shift (Shome & Hegde, 2002), creating planes of disempowerment where these women are concerned. As borders are crossed with increased frequency there is a blurring of power relations with the body caught at the center. The surrogates are potentially vulnerable to abuses that may arise out of this relationship. It is vital to continue to consider their bodily health as well as their emotional and spiritual well being.

Dr. Desai described his concerns about the surrogates' health as well as the information they receive. He explained,

The process has to be regulated because I am interested to know what happens to these surrogate mothers. I expect there to be complications in 15% of pregnancies. Out of 100 deliveries according to international guidelines, 15% will be complicated according to public health standards. So I'm interested to know how many complications took place, how many had abortions. Successful pregnancies we all see, but how many were aborted. How many times has she been exposed to surrogacy. For every pregnancy exposure the surrogate has to go through a lot of medical process and does she even know what she is going to. Two lakhs may be a very big amount for this woman so she is ready to expose herself. She has to be informed of all the good things that come with it and also all the bad things that come with it.



Figure 6.4. Dr. Desai at Civil Hospital in Ahmedabad. (source: Stephen Littlejohn)

Dr. Desai added,

The ICMR guidelines are very clear, but it does not talk about compensation to be given to the surrogate mother in case of complications or the type of health care given to those surrogate mothers. The surrogates don't have any health insurance. Whether the surrogates are volunteering their services or are they being forced. Forcing will come from society—it will come from the family or from other social issues that would make her come forward for surrogacy. ...It is a matter of great concern for the state, but people are not focusing on this because there are no complications taking place yet. There is no complaint coming from those people paying for the services. But what are the health services being offered [surrogates], what is the rate of the C-section, what are the rights of these women, the insurance available? We have to make sure there is no exploitation of these women.

While the potential for surrogate exploitation is often acknowledged there is a surprising amount of concern for the intended parents. These parents are not only privileged by the doctors, but also the policy that should be protecting the Indian surrogates with the same enthusiasm.

Commissioning Parents

The intended parents, often a foreign couple, seem to have a great deal of autonomy under the bill's current guidelines. There is extensive information about the screening of a surrogate and her suitability, while not including information on the screening for suitability of the commissioning parents. There is no apparent differentiation between local and foreign parents. The one distinguishing factor is the requirement of a local guardian responsible for caring for the surrogate when the parents

reside outside of India (Clause 34.19). This clause essentially requires that the surrogate herself is in need of parenting, but no mention of care for the baby that is being born. Dr. Desai commented,

Those foreign couples who are coming and those of the higher class, who know what they are going for, who are the beneficiaries of this—they are not worried for the women who are opting for these services, but the state should be involved in studying why these women are coming forward.

The commissioning parents, referred to as “patients” by the fertility doctors are given significant leeway in terms of what they can request. At time this even goes against Indian law in a disturbing manor. While it is difficult to confirm these occurrences, one surrogate at Akanksha Clinic gave surprising information at the end of the interview. I asked, “you don’t know what sex [the babies] are right?” as gender identification is illegal under any circumstance in India. One surrogate responded,

No, I don’t know because the couple wanted a surprise. If the party forces they can be told.

She added,

Whether it is a girl or a boy, it will be theirs so it does not matter, nobody regrets as long as there’s a baby at the end.

Allowing, the foreign couple to skirt the local laws, puts them in a position of unnecessary power that implies they are above the rules. The doctors are very sympathetic to the circumstances of the infertile couple and focus on their need for reproductive choices. Dr. Banker of Pulse Hospital, Dr. Patel of Akanksha Clinic and Dr.

Malpani of Malpani Infertility Clinic all referred to fertility treatments as reproductive rights of the infertile patients. Dr. Palshetkar, who has a private practice in Mumbai said,

I think you need to see the perception from all the sides. The women [intended parents] are shattered. They are traumatized by the fact that someone is going to carry their child. They are worried—is she going to take care properly, is she eating properly? Imagine the stress on the other side. It's not easy decision at all.

These inconsistencies and lack of clarity in the roles of all the participants in commercial surrogacy cause concern from some. Dr. Malpani describes his hesitations,

We get a lot of interest, but we do not do any commercial surrogacy. It is very easy to do, but my only concern is that the rules, the laws are not well defined. Everything is done on an ad hoc basis. Anyone can set up a guideline—it's not binding and that's what I'm not comfortable with. Everyone's rights and responsibilities should be well defined. I just worry something will go sour one of these days, you know, like the baby M case and then everyone will talk about how terrible the doctors are and how they exploit these Indian women. 99% of patients won't have problems, but the 1% that have a problem—that's not good for anyone.

The doctors providing fertility treatments are personally and professionally invested in the success of surrogacy in India. The commercial surrogacy practice is vitalizing several industries in India as well as the United States and while concerns are expressed the dominant discourse is one of support for surrogacy to not only continue but to grow. Dr. Patel's final words to me about surrogacy were,

I would say that surrogacy in India I would consider as India's gift to the world. The world should not look down on India. In fact, like you know the Indians are very helpful people all over the world and if by doing surrogacy the Indians are trying to help infertile couples inside the country and outside the country it should be recognized as such.

At the center of the surrogacy process is the creation of a baby. This is often not a part of the discourse until it comes time to take the baby home from India. In the two major cases of baby Manji and Nicolas and Leonard many voice that the best interest of the baby should be considered. This is complicated by a lack of international agreement on how to handle such processes.

The Baby

Finally, the bill does not fully address the problem of documentation and citizenship that became so controversial in its first two national cases. As Dr. N.B. Dholakia of the Gujarat Ministry of Health stated in our interview, "The biggest complication is that sometimes we don't know who the baby belongs to or whose name goes on the birth certificate." Clause 35.7 states, "The birth certificate of a child born through the use of assisted reproductive technology shall contain the name or names of the parent or parents, as the case may be, who sought such use." It is still ambiguous enough that in the case of baby Manji where there was an egg donor, intended mother and surrogate it may still be unclear. Understandably, the authors of the bill could never foresee every potential problem given the complex nature of arrangement. However, given that medical tourism is not a new phenomenon in India, some of the complications with regard to the identity of the baby can be addressed.

The baby is not a prominent part of the specifics in the ICMR guidelines. There remains some ambiguity as to who is ultimately responsible for securing documentation for the child or how care for the child should be handled once it is delivered. Again, a lot of control is placed in the hands of the doctors who are benefiting the most financially from the agreement. Dr. Desai provides an important public health perspective to the well being of the baby.

On the other side we have to make sure the couple is going to be a good party for the baby. Are they really going to take care of the child? Is there any record of how they are going to raise this child or are they simply paying the surrogate and leaving.

The positioning of each stakeholder in the proposed bill reveals their privileges and limitations. There is a lack of equity in responsibility and sacrifice. The surrogates take on much more of risk and sacrifice the most autonomy under the current provisions. While the ICMR guidelines have provided a useful framework for regulating the surrogacy industry, there are important changes that can provide a more equitable agreement. The protection of the rights of the surrogates is critical to any future surrogacy work in India.

The Future of the Bill

Surrogacy has only been recognized in India since 2002, but it has already ignited international debate and controversy. The process requires complex medical procedures and good-faith agreement from very different participants and the business is moving faster than the law. There is no uniformity when it comes to regulating surrogacy. In the United States the federal government has not produced any law, leaving the states to

determine their own policy in local courts. This has resulted in largely disparate treatment of surrogacy around the country. While India is attempting to create a unified regulation of the reproductive industry the current bill is inadequate to fully address the needs of each participant—namely the surrogate and the child.

In an interview with Dr. A.N. Desai, Associate Professor of Obstetrics and Gynecology at Civil Hospital in Gujarat, he argued that a women's health perspective should be taken in order to address the best interest of the surrogate and the baby. He stated,

Surrogacy is a public health issue. We must make sure the rights of the women are protected.

This perspective will be very useful in adjusting the current guidelines appropriately. The medical professionals involved in constructing the regulation of the ART industry in India are frequently private fertility experts. They and their colleagues have a lot to gain by promoting practices that bring business to India. The inclusion of public health orientations will expand the consideration given to surrogates. Pregnancy, and particularly IVF pregnancies can pose risks to a woman's body. Though the surrogates are compensated, safety and well being should be of the utmost concern, not only for the sake of the baby, but for the future of the surrogate.

The guidelines should also be precise about the consequences for not adhering to the high ethical standards. The registration and regulation of ART clinics is much clearer than any regulation for additional agencies. While Surrogacy India may implement the ICMR guidelines stringently as the first and only third-party surrogacy agency, it is not required of them. As the industry gains momentum there will only be more agencies

finding their way into the business. The guidelines in the bill, as it stands today, address only ART clinics. There are public hospitals and other medical professionals offering a wide variety of fertility treatments as well as law firms and travel agencies beginning to specialize in fertility tourism. These organizations and professionals should be held to the same ethical standards as the official ART clinics. The government will need to recognize the increasing number of players in the world of ART and adjust the regulation accordingly.

Additionally, the current draft of the bill limits who can recruit and advertise for a surrogate. Clause 34.7 states that commissioning couples may advertise as long as they do not include “details relating to the caste, ethnic identity or descent of any of the parties.” It also prohibits ART clinics from doing the recruiting of the surrogates for the couple. However, it does not define parameters for advertisement or recruitment from other agencies or the surrogates themselves. Neither is there mention of regulation or consequence with regards to the advertisements if they do not meet the standards they have included.

The information collected about the surrogates also reveals a problematic tendency towards eugenics in reproductive medicine. On Form M-2, Information about the Surrogate (See Appendix C) contains the requisite medical history and health information, but goes one step beyond critical physical characteristics. After height and weight there are questions about skin color, eye color, and hair color. A surrogate living at the Pulse Hospital revealed a similar trend when she was selected by her commissioning parents,

They asked me if I had a light child.

These considerations have no bearing on the child's traits as the surrogate does not provide any genetic material. While there are debates regarding the necessity of selecting traits from sperm and egg donors, there is no medical reason to privilege certain traits in a surrogate. The characteristics would only have social meaning and would promote discrimination against certain castes or ethnic identifications. The bill should do the important work of limiting these considerations to only medical reasons (e.g. if a couple wants a child to resemble them genetically).

Finally, the guidelines should include more protections for the surrogate from the agreement process to the delivery. They should also have clear recourses if the commissioning parents do not hold up their end of the deal or if they are mistreated by doctors. Including representatives or advocates as part of the process would help lessen the power differences between the parties. Information needs to be disseminated to the surrogates by someone who does not have an emotional or financial interest in them taking the job.

The Positioning of Rights in Policy

By examining the policy in its early stages I have identified gaps and contradictions that can be remediated for the interest of all parties. The future of surrogacy is dependent on the following general considerations: (a) implementation of clear guidelines and requirements for additional agencies, not only the ART clinics, (b) clearly defined legal consequences when those requirements are not met, (c) consistency in managing documentation and immigration of the children, and (d) advocacy available for surrogates and for the babies who are at the heart of the industry.

In this chapter I have explored how the policy deliberations in India have emerged in the media discourse about precedent setting cases. I have also examined *The Assisted Reproductive Technology (Regulation) Bill, 2008* in order to uncover the privileges and rights of the various stakeholders in the surrogacy process. Winston and Bane (1993) write,

Certain thematic contrasts pervade public policy deliberations. These contrasts include those between justice and compassion, autonomy and responsibility, equality and difference, competitions and cooperation, public and private, self-interest and the common good. (p. xi)

The construction of the bill and the debates surrounding the recent controversies reveal a privileging of individual choice, the private experience, and self-interest. The commissioning parents and the doctors remain the most powerful figures in the surrogacy process. The policies reinforce a structure that ensures the success of the commercial industry and a future of more patients seeking treatment in India. While the general direction of the Bill points to potential protection for surrogates and the babies, there needs to be more work done in this area.

In the final chapter I outline the overall findings and conclusions of this study. Additionally, I describe the theoretical and conceptual contributions to the communication field and opportunities for further investigation. I will also explicate inherent strengths and limitations of the study. Finally, I close with reflections from the process and implications for work on the body, identity, and policy.

Chapter 7: Conclusions and Implications

In this dissertation, I examined the role of the body, identity and policy in the discourses surrounding surrogacy in India. Employing a feminist framework and a critical discourse analysis methodology I investigated how individual and structural framings of the roles of participants in surrogacy reveal their positionalities and identities. Specifically, this study centered on the process of surrogacy in India and the perspectives of stakeholders including healthcare professionals, government officials, surrogates, and community organizers. By examining the impact of the significant technological and cultural shifts in family production, this study moves inquiry forward to better understand some of the complexities of contemporary fertility treatments.

The scientific advancements that have led to increased choice for some, have also led to confusion and concern. Surrogacy has not been a common part of fertility medicine in India for long. However, by beginning to study the various implications at this stage, the ground will be set to seriously consider the consequences and impact of the growth of the industry. I argue that the lived experiences of the surrogates and the direct communication from other parties provide valuable insight into how surrogacy is being enacted in one location. This study revealed a number of contradictions or paradoxes in the discourse about surrogacy in India.

Qualitative data was collected through face-to-face interviews in Anand, Ahmedabad, and Mumbai, in India. Additional information was gathered experientially in New Delhi and Jaipur to inform the socio-cultural understanding of the context. Four research questions were posed in order to increase understanding of the surrogacy process and raise consciousness about the experiences of the participants. It was important to

enter the field and speak to people first hand in order to move beyond the information available through mediated sources (e.g. websites, news articles, and talk shows). This information is often incomplete and lacks significant detail or contextualization for a nuanced description of the process.

This chapter includes the summary of the findings for each research questions and the theoretical contributions. The findings are applied to the current literature on individual identity, embodied experience, and policy as they are related to communication. I then write about theoretical contributions and explore the strengths and limitations of the study as well as potential for future research in this realm. Finally, I offer some reflections based on my experience of the research process which provides directions for future studies.

Findings

Surrogacy as a Process

The first research question asked: How is the process of surrogacy communicated and enacted in India? The interviews with doctors, health officials, surrogates and community organizers revealed a complex reasoning for the practice. The dominant message is that surrogacy is good for everyone involved as well as good for India as an economical unit. The various fragments that contribute to this discursive construction emerged in three significant areas. These categories include surrogacy as a medical intervention, surrogacy as a commercial enterprise, and surrogacy as an altruistic exchange.

The medical discourse about surrogacy is focused on a reproductive choice for infertile couples. The doctors and the ICMR guidelines all reiterated the importance of

surrogacy being acceptable only when medically necessary. The benefits of surrogacy are focused toward the infertile couple who wants additional reproductive choices. The doctors refer to the reproductive rights of the couple. Surrogacy is a treatment option for these couples who desire a child of their own with some genetic link. The medical aspects of the pregnancy for the surrogate, however, were absent from the discourses.

Fertility treatments are expensive and can take years. It is not a service that is available to all women and couples attempting to conceive. The cost is particularly high in countries like the United States where medical insurance has limited coverage for fertility interventions. This financial motivation is prominent in decision to travel thousands of miles to a country like India for treatment. This border crossing creates an entire industry of tourism infusing local economies during the weeks foreigners must reside in India during the process. Surrogacy may be considered a medical treatment, but it is big business for those who choose to engage in the process. It is also highly privatized in countries like India where basic medical care is provided by the government. The private sector is able to carve a specialized niche providing care for wealthier segments of society.

While the private commercialization of surrogacy is a large motivation for it to continue in India, on an individual level, the participants explained the need for its use more altruistically. Surrogacy was described as a positive alternative for those involved for many reasons. One of the prominent descriptions was “win-win.” Doctors and surrogates alike spoke of how surrogacy helps a couple have a baby and also helps a surrogate provide for her family. Surrogacy is discussed as a “helping” profession and a gift.

The surrogacy industry has a continuum of approaches. There is no one way to address the medical, business, or altruistic aspects of the work. Through the interviews and casual observation surrogacy as a practice is revealed to be as complex as the individuals involved. Dr. Patel at Akanksha Clinic managed her practice through interpersonal means. She highlighted the personal relationships she has with the surrogates and the patients at her clinic. She paired patients with surrogates and was a continual part of the communication process between them. The surrogates themselves as well as the one intended parent I spoke with displayed a great deal of trust and gratitude toward Dr. Patel. Dr. Banker of Pulse Women's Hospital preferred a hands-off approach, limiting his interaction with parties to strictly medical concerns. He left the selection of surrogate's up to the intended parents and did not participate in the relationship. Finally, Surrogacy India developed detailed procedures and documentation for careful management of the entire surrogacy process. They are involved in the most minor aspects of the surrogates and the intended parents participation. Whether a relational method or a process management approach the medical community is the driving force for the continuation of surrogacy in India.

Being a Surrogate

The next two research questions are focused on the surrogates' experiences, both as they narrate them as well as how they embody them. Research question number two asks: How is the position of the female body constructed in surrogacy discourses? The embodied experience of the surrogates is central to their position in the process. They refer to their pregnant bodies frequently in the interviews and the physical aspects are privileged in other areas of discourse.

Examining the various framings, I applied Balsamo's (1996) descriptions of four types of post-modern bodies in contemporary culture. The surrogates enact a laboring body through the work of pregnancy. From the various discomforts that arise with the changes in her body, to the delivery itself the pregnant body is always at work. The surrogates also live in a marked body during their pregnancy. As the months pass, their appearance changes dramatically leading them to remove themselves from interactions with family and friends. They cannot hide the fact they are pregnant and the pregnancy changes their body in significant, sometimes irreversible ways. The surrogates also experience the repressed body. Modern technology moves toward control of the body through science with increasing regulation and discipline. The IVF fertility treatment that surrogates undergo represses their natural state in order to impose a new use of that body temporarily. Finally, the surrogates also represent the disappearing body as their reproductive capability is compartmentalized and commodified. The corporeal experience becomes less significant as scientific advancement finds ways around natural courses in an effort to mimic bodily processes that take too much time on their own. The body is manipulated and monitored continually throughout the surrogacy process. This study adds to Balsamo's theory by examining these body categories in a corporeal setting. While her initial list of four post modern bodies comes from close examination of literature and technology, the key aspects of each body are seen in the experiences of the surrogates interviewed for this study.

The embodied experience is transferred from the intended mother to the surrogate mother for a significant portion of early motherhood experience. While the intended mother must relinquish the pregnancy to another, the surrogate takes on the physical risks

associated with IVF pregnancies in place of another woman. This bodily transference affects the identity construction of the surrogate during and after the surrogacy process.

Research question number three asks: How do the surrogates enact and communicate their identities? I approached this question cautiously with the intention of respecting and honoring what the surrogates offered as it is. The approach to this chapter was much more interpretive than other areas of inquiry in the dissertation. I wanted to avoid the problem of “speaking for others” (Alcoff, 1996), while at the same time recognizing my own positionality and impact on the interview process. The eight surrogates I met and spoke with were each unique. Some were more vocal, others quiet in their reflections.

All the surrogates privileged their identities as mothers by focusing on their own children as motivation for participation in surrogacy. They all referenced the importance of helping another woman become a mother regardless of the fact that they are being paid. They also spoke of their connection to the baby they are carrying during the pregnancy. While their opinions differed with regard to how much information they want about the child after birth, they all struggled with the emotional moment of handing the baby over.

The surrogates also strongly identified with the work of surrogacy and the legitimacy of it as a job. They were clear about their considerations of other possible jobs and how they still chose surrogacy because of the economic opportunity. Their role as earners for their families was often the most salient in their motivations. They become increasingly savvy through the process by talking to women who have worked as surrogates before as well as making plans for their income.

Finally, the surrogates see themselves as helpers. They spoke of the act of giving another woman a baby as noble and important. They feel responsible for the life of the child and appear to have spiritual beliefs associated with doing what is right for the child. These identities intersect in complex ways as the women move through their individual journeys as surrogates.

The surrogate's description of their experiences revealed several contradictions that are present in other areas of the discourse as well. These contradictions include helplessness vs. hopefulness, boldness vs. tradition, and receiving a gift vs. giving a gift. Several of the women agreed that they chose surrogacy because of their "helplessness." They felt they had few resources to offer their children and were unhappy with their current circumstances. Yet, they also revealed a hopeful attitude in how their lives would change due to their work as a surrogate. They looked to the future and the life they would be providing their children now. In order to make that change the women acted boldly, taking a somewhat controversial job away from their home and their family. They sometimes even lobbied their husbands for support in their choice. This enactment of agency was often in tension with the traditional role they served in their community. They frequently chose to hide the pregnancy from relatives and neighbors because it would not be accepted. Finally, while they received compensation for the pregnancy in the form of money and gifts, they also focused on the act of giving the baby. The women were participating as surrogates to achieve a goal and to gain a substantial income, but they were also proud of the fact that they would be positively affecting others by providing them a family. The tensions between the sacrifice and the opportunity are seen in their reflections on their experience.

Policy

The identities and bodily experiences that are constructed for the surrogates during the process are heavily influenced by the policies in place, or lack thereof. With the presence of the ICMR guidelines and probability of a law regulating the industry these issues are in flux in India. Currently, the lack of official regulation leaves an opening for problematic practices in the area of surrogacy. It is up to the doctors and agencies to maintain an ethical approach to the process. Even if the guidelines are passed into law, there are gaps and contradictions that lead to a lack of protection for the surrogates. There are unclear consequences for anyone who does not follow the designated rules. There is also a serious lack of information regarding compensation and representation of the surrogates. As the bill stands it protects the interests of the intended parents and the clinics above all else. The policy can be hegemonic in its privileging of those with resources and its lack of strategic action to protect the most vulnerable participants. As surrogacy continues to grow in popularity so too will the bill have to address the potential complications in the future.

Analysis of the bill also revealed a continuum of policy issues and contradictions. While the bill clearly makes the case that the rights of the surrogates should be protected, it is not very specific in how that should be accomplished. It also recognized the importance of the baby in the surrogacy process without going so far as to address the issue of who should be parents through surrogacy (outside of the requirement of a medical need). The bill ultimately puts the health and safety of the participants in the hands of its authors—the medical professionals in the field of Assisted Reproductive Technologies. If the bill is passed, the information will have to be disseminated in a way

that makes clear the implications of participation. A disparity often existed between my own understanding of what was in place, the reality of what was in place, and the possibility of what may come due to the current cases pending in India.

Theoretical Contributions

The major contribution to communication theory includes expanding the use of discourse analysis to look closely at the implications of a policy on the lived reality of the people it affects. There is very little communication research that specifically addresses the impact of policy rhetoric and the positions of people affected. By looking at the ways in which the policy structure privileges certain participants the tensions between structure and agency, societies and individuals can emerge in new ways. The policies have implications for the other research questions posited in this study. The positioning of the surrogates in the guidelines and potential policy has direct effect on the experience of the surrogates and thus how they construct their identities in the process. The policy also has significant practical implications, not only for surrogates, but the various participants in surrogacy across the globe. The position of the surrogates in the proposed policy confirm the challenges of constructing agency in a more social domain, rather than as purely individual. Policy and law are the constructions of groups of people in power. Communication theory has a lot to offer in terms of recognizing hegemonic tendencies as well as identifies opportunity for equity and justice. Policy makers must expand their perspective to consider the importance of the language used to define the rights and responsibilities of all those involved.

This study also confirmed previous theories about embodiment and identity. In an effort to understand the surrogates' experiences I looked to feminist theory on the

female body and reproduction. According to Riley (1988) the body is a subjective site of reality in the social world. Historically, the female body was seen as weak and unstable. Science within a patriarchal system has worked to control the female body and its “flaws” (Grosz, 1994). The modern fertility treatments continue to contribute to defining the female body and what its “natural” functions are. When a woman cannot conceive on her own, there are more and more options available to her. A woman who can easily have children is not considered vulnerable to potential complications or dangers in her pregnancy.

The process of surrogacy and specifically transnational surrogacy also contributes to post-colonial theory. It is an important site of investigation where historical abuses are concerned. Women of color and women in developing nations have often been considered, “too fertile” (Ikemoto, 1996). By encouraging the hiring of Indian women to be surrogates for western women, there is a troubling reification of women of color having bodies made for reproduction and the work that wealthier women cannot do. Additionally, surrogacy continues to create new ways in which the female body can be useful to others, rather than just to herself. Women of color have often been subjected to medicalization of their bodies in pursuit of more reproductive options for white women (Mies, 1993; Smith, 2005). The work of surrogacy further contributes to these feminist critiques of contemporary commercial technologies imposition on less privileged groups of women. This study points to an additional area that should continue to be researched and questioned for the benefits for the women involved, rather than blindly accepted as progress for all women.

This study also complicates the assumption that technology, science, and increased use of the body is automatically exploitive of poorer women. As Dr. Malpani of the Malpani Infertility Clinic explained,

The whole attitude is oh she is a poor woman, that doesn't make her stupid.

His point is useful to remember in investigations that question positionality and agency within certain contexts. There is sometimes an assumption that in order for something to be the right answer to oppressive structures it cannot just be in the interest of the individual. While societal change is important, this study points to the additional value of change on a smaller scale. The surrogates were very aware of their options and their decision making process. They enacted individual agency within a system that had failed to educate them or provide comparable options.

Identity and agency are concepts that often are tied together in various ways. The opportunities and constraints that individuals experience based on their specific locations become part of identity negotiation processes (Mendoza, Halualani & Drzewiecka, 2002). This study confirmed the fluidity of identity and the complex intersections that emerge for women as their experiences expand. The surrogates' all confronted their own feelings about the pregnancy and their futures with their families. This experience, this moment in their lives that I was able to observe, seemed to change the direction of how they viewed themselves. They bonded with other surrogates and made plans for the income they were earning. They asserted their individuality and negotiated a space for their choices as mothers, as professionals, and as women.

This study also contributes to methodological questions of how to do responsible critical work while still being true to the participants' own thoughts and feelings. The

body and reproduction are difficult issues to address fully in any one study. The questions surrounding issues like surrogacy are important, but there are many challenges associated with taking on these topics. It is compelling to talk directly to the people involved daily in the business of surrogacy. But how does a researcher do justice to what people have said, while applying theory to the human condition? The questions should be asked, but an intellectual crisis can emerge.

A study like this one cannot make enormous contributions to work on surrogacy, but it can do the important work of raising consciousness about the lived experiences of women in one location. As hooks (2000) has said, “Everything we do in life is rooted in theory. Whether we consciously explore the reasons we have a particular perspective or take a particular action there is also an underlying system shaping thought and practice” (p. 19). This study attempted to unearth pieces of that underlying system that has shaped the way surrogacy is framed. Feminist frameworks caution against the re-creation of stereotypes of “third world” women as universal victims dependent on the colonial structures they have been left with (Hegde, 1996; Mohanty, 1988;). Research cannot give women voice, but it can provide an outlet for under represented narratives. In order to represent these perspectives accurately without compromising the participants or one’s own commitments reflexive practices must be engaged. This dissertation provides a useful example of the intricacies associated with going into a culture that is not your own and approaching a sensitive topic that is open to criticism and discomfort.

As a study situated in a feminist perspective, a central goal was to create a space for the stories of a particular group of women that have not been previously heard. As Grosz (1987) said,

Feminist theory is neither subjective nor objective, neither absolutist nor relativist: it occupies the middle ground excluded by these oppositional categories. Theory is relational—based on a position (that of the sexed subject) and is connected to other practices—which is neither neutral nor indifferent to individual particularities (as the objectivist or absolutist maintains), nor purely free-floating, and able to be occupied by any subject at will (as the subjectivist or relativist maintains). (p. 479)

This study did not necessarily produce concrete theory or framework, but rather expanded the grey that exists between perspectives. By relying largely on the words of the participants themselves this study attempts to closely represent the heartfelt opinions of the participants without doing harm to their perspectives. A critical framework looks for the potential for power imbalances, exploitation, or domination, but it should not then enforce its own frame in a similarly domineering manner. Within this framework data does not speak for itself. There is recognition of the noteworthy influence the interpretation and framing the researcher imposes. It is a process of hardship—one that should not be taken lightly. Responsible research cannot be required to eliminate this hardship, but rather grapple with it, with transparency.

Strengths and Limitations

The major strength of this study is the direct contact with a variety of participants in the surrogacy process on location in India. The interviews shed new light on the information I had previously analyzed. The qualitative method combined with a critical discourse analysis perspective allowed for the privileging of certain narratives as well as the important work of examining the structure of the industry. I was able to gather data

that led to a more nuanced understanding of how surrogacy works, as well as its legal status in India. Interviewing health care providers, health officials, surrogates, and feminist community leaders contributed to a broad range of positions. Though the overall discourse was similar it was important to locate the opinions across the landscape of surrogacy. Additionally, the time spent in India allowed this researcher to gain first hand cultural and social experiences that contextualized the location of the study.

While the fieldwork was invaluable to accessing important perspectives and information, there were several limitations of this approach. The time spent in India was relatively brief. A longer period of time in the field could have contributed to more opportunity for observation at clinics and contact with more individuals who may have different opinions about surrogacy in India. The number of interviewees created a small sample of highly invested individuals in the surrogacy process. Additionally, a majority of the access was to the private sector of fertility medicine and thus the data represents a limited point of view. Though there is breadth in the range of interviewees, there could be more depth in the numbers of people representing each perspective areas. There are several voices still missing from the surrogacy discourses. One such voice is that of the surrogates' husbands. The surrogates gave some insight into how their families react to their work and how their relationships operate while they are pregnant. However, it would be useful to have the viewpoints of these men directly represented. Additionally, most information presented in the data and in this dissertation is framed from a heterosexual perspective. While never my intention to ignore the possibility of heteronormative and/or heterosexist aspects of surrogacy or my analysis, I was unable to

address these issues in the scope of this one study. The study was also limited to some of the more well-known sites of surrogacy.

The position of the researcher in this study is both a strength and a limitation. As a cultural outsider I cannot claim intimate knowledge of the location or a native understanding of how the process of surrogacy might be seen. I cannot argue that I know what it is like to work as a surrogate or be a mother physically, emotionally, or otherwise. While this in some ways limits my understanding of the various positions it is also useful in several ways. The topic of motherhood and pregnancy is very personal. In the time I have been investigating this topic I have learned that many individuals feel the need to defend their choices because of the contradicting discourses. Being removed from this experience does not necessarily make me an objective outsider, but it does provide some distance and a willingness to take people at their word. It was critical to this study to embrace the experiences of others as they explain it. By listening with an open mind and an open heart many new directions materialized that will only lead to further the knowledge about the intricate world of surrogacy.

Future Research

This study focused on the process of surrogacy in a limited area in India. The surrogates lived experiences are central to this investigation and their narratives reveal important areas for further inquiry. The surrogates commented on how the time away from their family impacts their marriage and their own individual emotional experience. It will be critical to talk to these members of surrogates' families to more closely capture the full impact of their work as surrogates. The women I spoke with were either at the very beginning of the surrogacy process or about to give birth. Spending time with

surrogates after they have returned home would help complete the picture of the impact this has on their relationships and their individual identities.

While interviewing the surrogates at Pulse Hospital I met a “field worker” named Urmila ben. Her primary duty is to go to the villages outside of Ahmedabad and talk to women there about surrogacy. She is essentially a recruiter. She is compensated for each qualified woman she brings to a clinic. This piece of the process is critical to understanding how surrogacy is framed in areas that have less access to education and information about new medical technology like IVF. Recruiters like Urmila ben also have critical influence on how the families of surrogates understand the process and their support of the surrogate during her pregnancy. By talking to these recruiters and visiting the villages where they find surrogates more information can be unearthed about the social and cultural contexts of the surrogates. Additionally, the recruitment process can reveal areas of exploitation as well as empowerment where the surrogates are concerned.

In this study only one intended parent was interviewed. There are many online resources for parents seeking surrogacy outside of their home country, including support groups and blogs. However, continued contact with the various stakeholders in this process should include direct interviews with these couples. The decision making process that they engage in is important to understanding the complexities of contemporary family production. Their experiences and perspectives are critical to completing the picture of surrogacy and its globalized future.

Reflections

Surrogacy is a complex process driven by unique motivations of the participants. There is nothing simple about the decision to hire a surrogate when you cannot conceive

or to be a surrogate and carry another's child. It is not necessarily an equal exchange and it is difficult to quantify the value of the child produced or the service a surrogate provides. Each participant takes on risks unique to their role in the process. However, it remains apparent that the surrogate embodies the most physical and emotional risk in order to claim economic opportunity. This does not erase social injustice or gender discrimination in their lives, but it does provide them with an individual sense of agency to change their own course and contribute to a different way of life for their families.

At the heart of this exchange are two individuals, both desperate to change their circumstances. One to have a baby of her own, the other to create a better life for the children she already has. These women are driven by a sense of helplessness. One living in a body that has not allowed her to fulfill her dream of motherhood, the other limited by social injustice and a community that has not allowed her to have the opportunity she deserves. Both women profit in some way through this unlikely alliance, but it is a compromise that requires personal sacrifice. The commissioning mother must give up her own individual control of the pregnancy she cannot carry. The surrogate mother releases individual control of her own body as she becomes the vessel for another family. The process is certainly not empowering for every woman who decides on surrogacy. It is ultimately a means to an end for each woman. Sawicki (1991) has said, "'motherhood' is both a place of empowerment and enslavement for women" (p.197). Surrogacy exemplifies this tension. Both the commissioning mother and the surrogate privilege their identities as mothers and take extraordinary measures to fulfill this role.

APPENDIX A

Interview Guides

Doctors/Clinic Staff

1. How long have you been working in this specialty?
2. Why did you decide to work with reproductive technology?
3. How does the surrogacy process work in your clinic?
4. What international clientele seem to come here the most?
5. Why do you think they choose India? Your clinic?
6. How do you select surrogates?
7. What is the national conversation about surrogacy in India?
8. What are your opinions on the regulation or lack thereof with regards to
commercial surrogacy?

Surrogates

1. Introductory questions:
2. Name you prefer to use?
3. Permission to record?
4. First time as surrogate? How long have been doing this?
5. Do you live here (at clinic? In this city?)
6. How did you decide to become a surrogate?
7. Tell me about your experience so far...
8. How do you explain to others what you do?
9. How does your family/community feel about you being a surrogate?
10. How do you see yourself in the process of surrogacy? What is your relationship to the intended parents?
11. What are some of the good/enjoyable things about being a surrogate?
12. What are some of the difficult/challenging things about being a surrogate?

13. Do you want to do it again? Why/why not?

14. What do you think about people from the United States coming to India for surrogacy? Why do you think they come here?

Intended Parents/Clients

1. Introductory questions:

2. Name comfortable using

3. Permission to record

4. Where from?

5. Why currently in India?

6. Where are you in the surrogacy process?

7. How did you decide to go this route?

8. Why India? Why this clinic?

9. What was your role in the selection of a surrogate? (If able to choose, how did you decide?)

10. What kind of interaction/relationship do you have with your surrogate?

Government officials:

1. Introductory/background
 - a. Position/title
 - b. Permission to record
2. What is the government's role in surrogacy agreements or practices? Does it differ when international clients are involved?
3. I understand there is a bill in parliament about regulation of surrogacy and Assisted Reproductive Technology (ART) clinics. What is that status of that bill? Do you support it? Why, why not
4. Why do you think India is such a popular choice for fertility tourism?
5. There are several cases in the news right now about legal complications with surrogacy cases. The couple from Japan and now the parents from Germany.

Can you tell me more about those cases? How might these situations impact how the industry works?

6. How do you see the future of this industry?
7. Is there anything else you think is important for me to know?

APPENDIX B

THE ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) BILL, 2008

FORM - J
Agreement for Surrogacy
(See Rule 15.1)

I, _____ (the woman), with the consent of my husband (name), of _____ (address) have agreed to act as a host mother for _____

_____ who are / is unable (or do not wish to) have a child by any other means.

I had a full discussion with _____ of the clinic on _____ in regard to the matter of my acting as a surrogate mother for the child of the above couple.

I understand that the methods of treatment may include:

1. Stimulation of the genetic mother for follicular recruitment
2. The recovery of one or more oocytes from the genetic mother by ultrasound guided oocyte recovery or by laparoscopy.
3. The fertilization of the oocytes from the genetic mother with the sperm of her husband or an anonymous donor.
4. The fertilization of a donor oocyte by the sperm of the husband.
5. The maintenance and storage by cryopreservation of the embryo resulting from such fertilization until, in the view of the medical and scientific staff, it is ready for transfer.
6. Implantation of the embryo obtained through any of the above possibilities into my uterus, after the necessary treatment if any.

I have been assured that the genetic mother and the genetic father have been screened for HIV and hepatitis B and C before oocyte recovery and found to be seronegative for all these diseases. I have, however, been also informed that there is a small risk of the mother or / and the father becoming seropositive for HIV during the window period.

I consent to the above procedures and the administration of such drugs that may be necessary to assist in preparing my uterus for embryos transfer, and for support in the luteal phase.

I understand and accept that there is no certainty that a pregnancy will result from these procedures.

I understand and accept that the medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal and living child.

I am unrelated / related (relation) _____

to the couple (the would-be genetic parents).

I have worked out the financial terms and conditions of the surrogacy with the couple in writing and an appropriately authenticated copy of the agreement has been filed with the clinic, which the clinic will keep confidential.

I agree to hand over the child to _____, or _____ and _____ in case of a couple, or to _____ in case of their separation during my pregnancy, or to the survivor in case of the death of one of them during pregnancy, as soon as I am permitted to do so by the hospital / clinic / nursing home where the child is delivered.

I undertake to inform the ART Clinic, _____, of the result of the pregnancy.

I take no responsibility that the child delivered by me will be normal in all respects. I understand that the biological parent(s) of the child has / have a legal obligation to accept the child that I deliver and that the child would have all the inheritance rights of a child of the biological parent(s) as per the prevailing law. I will not be asked to go through sex determination tests for the child during the pregnancy and that I have the full right to refuse such tests. I will, however, agree to foetal reduction if asked by the party seeking surrogacy, in case I happen to be carrying more than one foetus.

I understand that I would have the right to terminate the pregnancy at my will; I will then refund all certified and documented expenses incurred on the pregnancy by the biological parents or their representative. If, however, the pregnancy has to be terminated on expert medical advice, these expenses will not be refunded.

I have been tested for HIV, hepatitis B and C and shown to be seronegative for these viruses just before embryo transfer.

I certify that (a) I have not had any drug intravenously administered into me through a shared syringe; (b) I have not undergone blood transfusion; and (c) I and my husband have had no extramarital relationship in the last six months.

I also declare that I will not use drugs intravenously, undergo blood transfusion excepting of blood obtained through a certified blood bank, and avoid sexual intercourse during the pregnancy.

I undertake not to disclose the identify of the party seeking the surrogacy.

In the case of the death or unavailability of any of the party seeking my help as the surrogate mother, I will deliver the child to _____ or _____ in this order; I will be provided, before the embryo transfer into me, a written agreement of the above persons that they will be legally bound to accept the child in the case of the above-mentioned eventuality. (If applicable) My husband has approved my acting as a surrogate. (Strike off if not applicable.)

Endorsement by the ART Clinic

I/we have personally explained to _____ and _____ the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he / she / they understand these details and implications.

Signed:
(Surrogate Mother)

Name, address and signature
of the Witness from the clinic

Name and signature of the Doctor

Name and address of the ART clinic

Dated

APPENDIX C

THE ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) BILL, 2008

FORM – M (2)

Information on Surrogate
(See Rule 15.1)

Date of filling the form (except items 20-31)

Date of filling items 20-31

BASIC INFORMATION:

1. Identification number

2. Name

3. Age / Date of birth

4. Address

5. Photograph

6. Tel no.

7. Marital status

8. Education :

a. Surrogate

b. Spouse

9. Occupation :

a. Surrogate

b. Spouse

10. Monthly Income

11. Religion

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)

FEATURES:

32. Height
33. Weight
34. Colour of skin
35. Colour of hair
36. Colour of eyes

DETAILED PHYSICAL EXAMINATION:

37. Pulse
38. Blood pressure
39. Temperature
40. Respiratory system
41. Cardiovascular system
42. Per abdominal examination
43. Per speculum examination
44. Per vaginal examination
45. Trans-vaginal sonography

46. Other systems

Footnotes

(1) To be carried out within 15 days prior to embryo transfer. Test no.30 to be done only if Test 28 is negative.

(2) Any additional test carried out on the basis of the history and examination of the surrogate OR any test requested by the recipient who shall pay for the additional requested test

To the patient, a copy of this form without items 20-31 filled in, may be provided when asked for. The investigations in items 20-31 may be done when the patient has chosen the surrogate provisionally, subject to the results of tests in items 20-31 being satisfactory.

Name(s) and signature(s) with date(s) of person(s) filling the form:

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