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Not an ‘Angel’, not a ‘Whore’: Surrogates as ‘Dirty’ Workers in India

AMRITA PANDE

In this study of surrogate mothers in Gujarat, India, I introduce the concept of ‘sexualised care work’ to describe a new type of care work—commercial surrogacy—that is similar to existing forms of care work but is stigmatised in the public imagination, among other reasons, because of its parallels with sex work. I use the oral histories of the surrogates to examine the accounts they give, justifying their work and resisting stigma. I argue that while the narratives can be seen as a form of resistance, they reinforce the primary identity of these women as dependent mothers rather than independent workers.

In 1776, Adam Smith observed that there are ‘some very agreeable and beautiful talents’, that are admirable so long as no pay is taken for them, ‘but for which the exercise for the sake of gain is considered, whether from reason or prejudice, as a sort of publick prostitution’ (1985: 103). Smith was talking about opera singers. Martha Nussbaum adds her contemporary examples to Smith’s contention,

Professors, factory workers, lawyers, opera singers, prostitutes, doctors, legislators—we all do things with parts of our bodies,

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for which we receive a wage in return. Some people get good wages and some do not; some have a relatively high degree of control over their working conditions and some have little control; some have many employment options and some have very few. And some are socially stigmatized and some are not. (1998: 693)

In this study of surrogate mothers in India, I introduce the concept of **'sexualised care work'** to describe a new type of reproductive labour—commercial surrogacy—that is similar to existing forms of care work but is stigmatised in the public imagination, among other reasons, because of its parallels with sex work. At one level, the significance of this study of commercial surrogates in India is that it is the first attempt to analyse surrogacy in a developing country context. **There are relatively few studies on responses to reproductive technologies in non-Euro-American settings** (Strathern 1992; Sunder Rajan 2000; Unnithan Kumar 2004). This study aims to move beyond this dominant setting and get a broader view of the cultural response to new reproductive technologies like surrogacy.

My aim in this project, however, is not just to extend the study of surrogacy to a new country. By arguing that **surrogacy is another form of labour**, I want to open up conversations on new ways of analysing surrogacy—beyond the Euro-centred and ethics-oriented frame. But as importantly, I want to use commercial surrogacy in a developing country context as a launching pad for discussions on new forms of informal, gendered and stigmatised work. Commercial surrogacy is an unusual kind of work that has characteristics of both **sex work and care work** and, thus, becomes an exciting way to extend the literature on gender and work. How do the curious features of this new kind of work affect the surrogates? Using the case of commercial surrogacy, a new form of women's work lying somewhere at the cusp of care work and dirty work, I explore how the **language of stigma**, especially in conjunction with women's work, suppresses the development of a worker's identity.

What Is Surrogacy?

Surrogacy refers to an arrangement whereby a woman agrees to become pregnant for the purpose of gestating and giving birth to a child for others to raise. She may be the child's genetic mother (traditional surrogacy) or she may be implanted with someone else's fertilised egg (**gestational surrogacy**). All the cases in Anand, the Indian city in which I studied surrogacy, fall under the category of 'gestational surrogacy', where the surrogate has no genetic connection with the baby.

As an alternative means of producing children, surrogacy is an **ancient practice**. Throughout history, in several cultures, women have used other women to bear the children they could not conceive. The surrogate was often a second wife, a concubine, or a maid. Another form of surrogacy was seen in the Middle Ages in Europe, when wealthy women regularly turned their newborn babies over to wet nurses, with the natural mother making only occasional visits—very similar to modern-day commercial surrogacy (Spar 2006).

With **artificial insemination, conception was removed from sex, making it possible for a man to impregnate a surrogate without even meeting her**. But in traditional surrogacy, the surrogate was also the genetic mother of the child she bore. This made surrogacy a legal and ethical nightmare—the surrogate had a greater claim on the child than the intended mother. The next step in assisted reproduction—the development of **in vitro fertilisation** (IVF)—solved this problem.¹ Now the genetic mother (the woman who provided the eggs) could be separated from the surrogate mother. Legally, this split meant that the connection between the surrogate and the baby would be far less powerful than under traditional surrogacy arrangements. Commercially, it increased the supply of both components—the surrogates and the egg donors. Women were more willing to donate eggs if they did not also have to undergo the pregnancy, and **they were more interested in serving as surrogates if the child they were carrying was not genetically theirs** (Ragone 1994; Spar 2006).

The separation of eggs and wombs not only allowed the market to thrive but also changed the market. In traditional surrogacy, the surrogate provides the genetic material as well as the womb. The adoptive parents, therefore, were more likely to emphasise the 'right' genetic make-up (race, physical characteristics, intelligence, and so on). In gestational surrogacy, however, the parents no longer care about the surrogate's genes (Spar 2006). Not surprisingly, gestational surrogacy also allowed the surrogacy market to go global. It was now possible for a South Korean couple sitting in Los Angeles to hire a surrogate from a little village in western India to have a child for them.

Theoretical Framework

In the existing Western literature, surrogacy has primarily been framed as a problem of white middle-class heterosexual women (Roberts 1997; Wajcman 1994). While defenders of surrogacy advocate this service as a manifestation of women's freedom of choice, concerns and debates have revolved around the legalities of pregnancy contracts and the ethics of this practice (Anderson 1990; Andrews 1987; Baker 1996; Markens 2007). Debates around the ethics of surrogacy are rampant in this literature and range from the view that contractual pregnancy is symptomatic of the dissolution of the American family (Ragone 1994) to the charge that it reduces women to a new breeder class (Corea 1985; Raymond 1993; Rothman 1988), one structurally akin to prostitution (Dworkin 1978), or to another form of baby selling (Neuhaus 1988).

These (Eurocentric) portrayals of surrogacy cannot incorporate the reality of a developing-country setting—where commercial surrogacy has become a survival strategy and a temporary occupation for some poor rural women, where women are recruited systematically by a fertility clinic and matched with clients from India and abroad. In such a setting, surrogacy cannot merely be seen through the lenses of ethics or morality but is a structural reality, with real actors and real consequences.

I make a case for commercial surrogacy in India as a new kind of 'sexualised care work' (Pande 2008). By identifying commercial

surrogacy as a new form of labour, it is possible to arrive at a much more nuanced analysis than one based solely on morality. If we are able to understand how surrogates experience and define their act in this new form of labour, it will be possible to move beyond a universalistic moralising position and to develop some knowledge of the complex realities of women's experience of commercial surrogacy.²

Feminist scholarship on reproductive labour and the **care work** of nannies and domestic workers provides a lens to understand commercial surrogacy in India. Reproductive labour typically includes activities such as purchasing household goods, preparing and serving food, laundering and repairing clothing, socialising children and providing care and emotional support (Glenn 1992). Evelyn Nakano Glenn observed that **white privileged women in the United States have historically freed themselves of reproductive labour by purchasing the services of women of colour**. I have previously argued that **with globalisation and ever-expanding reproductive technology, 'gestational services' need to be added to the list of care work (Pande 2008)**. Surrogates in India, who are renting out their wombs on a routine basis for couples from India and abroad, are also involved in care work—they are nurturing someone else's baby in exchange for money. But what makes their work experience atypical is the high degree of **sexualised stigma** attached to it—making surrogacy a special kind of stigmatised and sexualised care work.

Context: Anand, Gujarat, India

Anand is a city of about 100,000 people in the western Indian state of Gujarat. Anand is an unlikely place to have become a centre for transnational and national surrogacy—it is a remote and relatively small town by Indian standards. A curious fact about the demography of the state of Gujarat is that a large percentage of Gujaratis have settled in different parts of the world. Out of the 20 million Indians spread across the globe, 6 million are from the state of Gujarat, that is, nearly 30 per cent of the total non-resident Indian population is from this one state. Non-resident Gujaratis (NRG) coming to India for personal and medical visits are making Gujarat

Indian Journal of Gender Studies, 16:2 (2009): 141–173

one of the most popular sites of **medical tourism in India**—the majority are cardiac patients, but an increasing number are coming for joint replacement, plastic surgery and, now, for IVF (Bhargav 2006).

Currently, there are no laws governing surrogacy in India, and the fertility clinics, like the ones in Anand, are merely 'guided' by the Guidelines for 'Accreditation, Supervision and Regulation of Assisted Reproductive Technology (ART) clinics in India' issued by the Indian Council for Medical Research (ICMR) in 2005.³ The birth certificate is issued in the name of the genetic parent (ICMR Guidelines 2005). However, **in the absence of any formal laws regarding the status of the baby delivered by a surrogate in India, the nationality status of the baby is determined by the laws in the home countries of the intended parents.** For example, in the case of American couples, no adoption procedures are required and the consulate readily adds the child's name to the passport of the intended parents. For couples from the United Kingdom, formal adoption procedures are required.

In November 2007, the Indian Ministry of Women and Child Development declared its **plan to pass a law to regulate the 'business of surrogate motherhood and sperm banks on the lines of similar laws in other countries'** (Singh 2007). But till a law is passed, the clinics that provide ART facilities can follow their own rules.

While infertility clinics from several Indian cities like New Delhi, Mumbai, Bangalore, Ahmedabad and Kolkata have reported cases of surrogacy, **most clinics provide just the technology and require the patients to arrange for their own surrogates.** Anand is the only place where the doctors, nurses and middle women play an active role in the recruitment of women from neighbouring villages. **The clinic has a constant supply of surrogates,** and some of these women are going in for surrogacy for the second time in just two years. As Dr Khanderia, the doctor responsible for bringing the surrogates together in Anand, proudly proclaims, 'There may be surrogacy clinics all over the state, the country and the world, but these people do sporadic surrogacy. No one in the world can match our **numbers—55 surrogates successfully pregnant at the same time'** (personal interviews 2007).

Indian Journal of Gender Studies, 16:2 (2009): 141–173

The surrogates have to sign a consent form that talks about their rights in the surrogacy **contract but the form is in English**, a language almost none of the surrogates can read. Some essential points of the contract, however, are translated for them. So what they do understand is that they have to hand over the baby right after it is born, they have no claims over the baby, the doctor or the couple is not responsible for any death resulting from the process, they will receive payments in instalments and the last payment will be made after the delivery.

Once a woman agrees to become a surrogate, a surrogacy counsellor informs her about the procedures involved. **Gestational surrogacy is a much more complex medical process than traditional surrogacy, since the surrogate is not genetically related to the baby and her body has to be 'prepared' for artificial pregnancy.** The transfer of the embryo itself is not very difficult but the process of getting the surrogate ready for that transfer and the weeks after that require heavy medical intervention. First, birth-control pills and shots of hormones are required to control and suppress the surrogate's own ovulatory cycle and then injections of oestrogen are given to build her uterine lining. After the transfer, daily injections of progesterone are administered until her body understands that it is pregnant and can sustain the pregnancy on its own. **The side effects of these medications** can include hot flashes, mood swings, headaches, bloating, vaginal spotting, uterine cramping, breast fullness, light headedness and vaginal irritation. The surrogates in Anand, however, are aware of only some of the procedures involved. In the words of surrogate Gauri:

The only thing they told me when I came in was that this thing is **not immoral**, I will not have to sleep with anyone and that the seed will be transferred into me with an injection. They also said that I have to keep the child inside me, rest for the whole time, have medicines on time, and give up the child.

We are not really told much about the medicines and injections. In the beginning I used to get ten-ten injections that hurt so much, along with the pills required to make me strong for the pregnancy. We [her husband and she] are not as educated

as you are, you know. I won't really understand much else! And I trust Doctor Madam, so I don't ask.

The clinic is unremarkable looking: one among the many mushrooming sonography centres, ultrasound clinics, medical stores and hospitals lining the crowded market street. There is a big garbage dump right outside the clinic's courtyard but in the courtyard there are two gleaming luxury cars evidently belonging to the doctors. The clinic offers infertility and assisted reproductive technologies like IVF, test tube babies, intrauterine insemination, embryo freezing, endoscopic surgery and sonography. The main clinic consists of a big waiting room, an inner room with one iron bed for women who need to rest after getting their injections and another room hidden behind curtains where women recover from embryo transfers or the effects of anaesthesia given to them when they come to donate eggs.

The two floors above have rooms where the surrogates stay for varying lengths of time—in late stages of pregnancy, recovering from injections or to keep the knowledge of their pregnancies from their neighbours and communities.

The rooms are lined with 8–10 single iron beds with barely enough space to walk in between. One end of each bed is kept raised with a wooden block so that the surrogates have their legs up after the embryo transfer. Most rooms have pictures of happy babies and the infant Lord Krishna, clothes hanging from makeshift clotheslines and a few extra chairs for visitors. **The women have nothing to do the whole day except pace up** and down on the same floor (they are not allowed to climb the stairs and must wait for the nurses to operate the elevator), share their woes and experiences with the other surrogates and wait for the next injection.

Dr Khanderia had her first successful case of surrogacy in 2004, when a woman gave birth to her own grandchildren on behalf of her United Kingdom-based daughter. For this case, the doctor did not supply the surrogate. For her second case, Dr Khanderia persuaded an employee at her clinic to be a surrogate. Since then she has **'matched' seventy surrogates** with couples from India and from as far away as the United States, Taiwan, South Korea, South Africa,

the United Kingdom and Spain. Although the ICMR Guidelines indicate that the ART centre should not be involved in the monetary dealings between the surrogate and the couple or with the recruitment of surrogates (1995: 14), Dr Khanderia not only recruits the surrogates, she checks their medical histories, handles the legal paperwork (signing of the consent forms and the contract regarding payment), monitors the surrogates during pregnancy, delivers the babies and even sets up bank accounts for the surrogates (personal interviews 2006). Dr Khanderia follows some 'informal rules' for selecting surrogates; the woman should not be above the age of 40, she should be medically fit and have a healthy uterus, she should be married and should have borne at least one healthy child and finally she and her husband should be psychologically prepared for this event (personal interviews 2007).

For foreign couples hiring surrogates in Anand, there are substantial cost savings. While those pursuing surrogacy in Canada or the United States can spend between \$30,000 and \$50,000, in Anand the whole process can be accomplished for one-tenth the cost. The added attraction for clients hiring surrogates in Anand is that the clinic runs several hostels where the surrogates can be kept under constant surveillance during their pregnancies.

Data and Method

This study is based on participant observation for nine months at a surrogacy clinic and a surrogacy hostel, and oral histories of 42 surrogates, their husbands and in-laws, eight intending parents, two doctors and two surrogacy brokers. I visited the clinic in Anand in 2006 and collected the oral histories of five surrogate mothers who had already delivered babies and 14 others who were undergoing treatment to be surrogates. In some cases, I travelled to the surrogates' villages and talked to their husbands and in-laws. The oral history interviews of the surrogates were mostly conducted in Hindi and Gujarati, they ranged from one to five hours, and were conducted either in the rooms above the clinic where some of the surrogates lived or at their homes. I revisited Anand in 2007 and collected the oral histories of 23 new surrogates and six surrogates I had interviewed earlier. I conducted more structured

interviews with Dr Khanderia, her nurses and the surrogacy brokers. Additionally, I interviewed several couples from India and abroad who have hired surrogates and are waiting for their children to be delivered in Anand.⁴

I got the consent of all the participants in this study. Most agreed to share their life stories as long as I protected their identities. I recognised the discomfort some participants felt in sharing information, especially since some of them had kept their decision to become surrogates a secret from their communities. To minimise any discomfort, I avoided structured questions, and all the data come from the life stories they shared with me during our conversations or from participant observation at the clinic. Some surrogates refused to give me their real names, some did not want me to use a tape recorder and a few refused to give their consent. I tape recorded interviews when consent was given, but in others, I took extensive handwritten notes that I typed immediately afterwards. I have used pseudonyms except in cases where the surrogates asked me to use their real names.

All the surrogates in my study are married, with children. Their ages range between 20 and 45 years. Except for one, all are from nearby villages. Fourteen of the 42 women said that they were 'housewives', two said they 'worked at home' and another said she worked informally as a tailor for her neighbours. The others worked in schools, clinics, farms and stores. Their education ranged from illiterate to high school, with the average around the beginning of middle school, with just one interviewee having a professional law degree.⁵ The median family income was about Rs 2,500 per month (see Table 1). If we compare that to the official poverty line in India, 34 of my 42 interviewees reported family incomes below or around the poverty line. For most of the surrogates' families, **the money earned through surrogacy was equivalent to almost five years of total family income** especially since many of the surrogates had husbands who were either in informal contract work or unemployed.

Ten of my interviewees were surrogates for couples from the United States, Spain, Britain and Turkey. Twenty were hired by non-resident Indians settled in the United States, United Kingdom,

Table 1
Characteristics of Surrogates and Their Families

Name	Age (Years)	Religion	Work	Husband's work	Income per month (Rs)	Own education	Children	Hiring couple from
Sudha	27	Hindu	Farmer	Truck driver	2,500	Primary school	1	Mumbai
Raveena	30	Hindu	Bank teller	Bank teller	10,000	College	2	South Korea
Meena	26	Hindu	Housewife	Hair salon	3,000	Middle school	3	Mumbai
Pushpa	27	Hindu	Works in a store	Painter	4,000	High school	2	Bangalore and United States (NRI)
Salma	25	Muslim	Housewife	Driver	2,500	Middle school	2	NRI (South Africa)
Dipali	25	Hindu	Insurance agent	Divorced	1,500	High school	2	NRI (South Africa)
Vaneeta	36	Christian	Staff nurse	Tailor	8,000	Primary school	3	NRI (United States)
Vidya	30	Christian	Housewife	Daily labourer	2,000	High school	3	Madras
Daksha	20	Hindu	Housewife	Farmer	1,000	Illiterate	3	Hyderabad
Anjali	25	Christian	Housewife	No fixed job	1,000	Primary school	2	NRI (United Kingdom)
Parvati	36	Hindu	Nurse	Factory worker	4,500	Primary school	1	NRI
Gauri	28	Hindu	Housewife	Salesman	1,500	Illiterate	2	NRI (United States)
Jagruiti	35	Hindu	Works in a school	Barber	2,500	Middle school	3	Delhi

(Table 1 continued)

(Table 1 continued)

Name	Age (Years)	Religion	Work	Husband's work	Income per month (Rs)	Own education	Children	Hiring couple from
Rita	23	Hindu	Housewife	Vendor	2000	Middle school	2	NRI (United States)
Tejal	27	Hindu	Housewife	Painter	1,500	Middle school	2	Mumbai
Sapna	27	Hindu	Housewife	Factory worker	6,000	Primary school	2	NRI (United States)
Savita	45	Hindu	Cleans the clinic	Separated	2,000	Primary school	2	Singapore
Hetal	35	Hindu	Floor Supervisor	Contractor	8,000	High school	2	Jaipur
Jyoti	26	Hindu	Housewife and tailor	Auto rickshaw driver	2,500	High school	3	NRI (United States)
Regina	42	Christian	Maid	Rickshaw puller	1,500	Illiterate	2	NRI (United States)
Varsha	38	Hindu	Waitress	Unemployed	750	Middle school	2	UP
Rita	29	Hindu	Housewife	Plastic collector	3,000	Primary school	2	NRI (United States)
Munni	35	Hindu	Nanny	Unemployed	2,000	Middle school	3	NRI (United States)
Nisha	36	Christian	Nurse	Auto driver	5,000	Middle school	1	United States
Yashoda	38	Christian	Maid at clinic	Widow	1,200	Illiterate	2	Spain
Tejal	30	Hindu	Teacher	Painter	2,000	High school	1	NRI (Dubai)
Tina	26	Christian	Housewife	Auto driver	3,000	Middle school	3	NRI (Dubai)
Rina	26	Hindu	Works in store	Auto driver	4,500	High school	2	United States

Mansi	29	Hindu	Tailor	Tailor	2,500	High school	2	Sri Lanka
Diksha	24	Hindu	Housewife	Factory worker	3,500	High school	2	NRI (United States)
Vaishali	24	Hindu	Cook	Factory worker	3,500	High school	1	United States
Shanta	33	Hindu	Works in a parlour	Auto driver	5,000	Middle school	3	NRI (United States)
Naseem	30	Muslim	Housewife	Daily Labourer	2,000	Middle school	1	UP
Panna	27	Hindu	Housewife	Vendor	3,000	Middle school	3	Turkey
Naina	36	Christian	Nurse	Factory worker	3,000	High school	2	United States
Sharda	38	Christian	Housewife	Mill worker	2,000	Middle school	3	Mumbai
Geeta	35	Hindu	Housewife	Farmer	8,000	Illiterate	2	Does not know
Razia	25	Muslim	Sorts plastic	Unemployed	750	Middle school	2	United States
Ramya	29	Hindu	Bank teller	Factory worker	3,500	High school	1	NRI (United States)
Sangeeta	33	Hindu	Housewife	Watchman	1,500	Illiterate	2	Bangalore
Hasomati	30	Hindu	Housewife	Mill worker	2,000	Middle school	2	NRI (Dubai)
Sarod	30	Hindu	Mill worker	Mill worker	3,500	Middle school	3	NRI (United Kingdom)

Source: Author's own data based on field work in Anand, Gujarat, 2006–2008.

Sri Lanka and South Africa (see Table 1). The remaining had been hired by upper class and middle class professionals and business persons from different states in India.

Surrogacy and Stigma in India

Although surrogacy as a process is an ethical quagmire in almost all countries, surrogates, as 'persons' involved in this process, are usually not stigmatised. In India, however, surrogates face a high amount of stigma. As a consequence, **almost all the surrogates in this study except one decided to keep their surrogacy a secret from their communities**, villages and, very often, from their parents. They usually hid in the clinic or took temporary accommodation away from their communities during the last months of pregnancy. Some decided to tell their neighbours that the babies were their own and later say that they had miscarried.

What explains the **unusually high amount of stigma the surrogates have to face in this country**? A couple of reasons seem possible, related to the **culturally anomalous aspects of surrogacy**.

First, commercial surrogacy is a work that involves the bodies of poor women. Feminist scholars writing about sex work, domestic workers and women factory workers have pointed out that **moral rhetoric and stigma are often evoked whenever the bodies of poor women are in focus**. These scholars point out that the work of domestic workers, nannies, nurses and maids is often associated with a physical and moral taint (see, for example, Sheba George's study [2000] on the stigma attached to the work done by Indian nurses). Additionally, surrogacy involves the stigma of getting pregnant for money, which is associated with the **'immoral' commercialisation of motherhood**.

Commercial surrogacy in India, which entails giving away the baby as soon as it is born, reiterates the disposability of these 'desperate' women and emphasises the 'unnatural' nature of their motherhood. Another possible reason for the huge amount of stigma surrounding surrogacy is that many Indians **equate surrogacy with sex work**. This is partly due to a lack of information—people are not aware of the **reproductive technology which separates pregnancy from sexual intercourse**. The popular media—television and

movies—add to this misconception. Almost all portrayals of commercial surrogacy in the media **equate surrogacy with sex**—an infertile wife agrees to bring a sex worker home who is then impregnated by her husband through normal intercourse. The alternative portrayal is of a sister or friend becoming a surrogate out of pure altruism (and inevitably falling in love with the adoptive father). Thus, all surrogates are portrayed as having some kind of 'relation' (sexual or emotional) with the adoptive father of the child (see **online forums on the television serial 'Mamta' and the movie 'Filhaal', Bollywoodgate 2007**).

Surrogacy as Dirty Work

Everett Hughes (1951) invoked the term **'dirty work'** to refer to tasks and occupations that are likely to be perceived as degrading. This was picked up by several scholars working on deviant occupations. Work can be 'dirty' because it seems to some as 'simply physically disgusting' (like janitorial work and butchering), because it wounds one's dignity by requiring servile behaviour (like domestic work, shoe shining), or because in some way, it offends our moral conceptions (sex work, topless dancing and surrogate mothering). Ashforth and Kreiner (1999) add that although people may applaud certain kinds of dirty work (like taking care of AIDS patients), they generally remain psychologically and behaviourally distanced from that work. Surrogacy seems to fit in well in this sticky area—**surrogates are described as 'true angels' who 'make dreams happen'** (Anleu 1992; Ragone 1994), but surrogacy is also surrounded by controversies around the ethics of 'selling motherhood' and **'renting wombs'**.

The literature on dirty work and stigma indicates that when individuals are engaged in a stigmatised occupation that threatens to 'spoil their identity', it becomes **necessary for them to do 'remedial work' to control, manage and neutralise the stigma associated with their deviant occupations** (Goffman 1963; Sykes and Matza 1957). In the next few sections, I analyse the narratives of women involved in this new kind of 'dirty' and 'sexualised' care work in India.

Surrogacy Narratives

Narratives as Resistance

In his classic study of peasant resistance, *Weapons of the Weak: Everyday Forms of Peasant Resistance*, James Scott (1985: 8) developed the theory of 'prosaic but constant struggle(s)' by the dominated—as a critique of theories on conflict which concentrate solely on acts of 'collective outright defiance' and on 'overt forms of subaltern politics'. Since then, scholarship on social movements and feminist literature on gender and the work done by factory workers, nannies and domestics (among others) have started analysing 'unlikely forms of subversions'; small and local resistances, often remaining at the discursive level and not tied to the overthrow of systems or even to ideologies of emancipation (see, for example, Ngai Pun's [2005] ethnography of women factory workers in China, and Michele Gamburd's [2000] ethnography of Sri Lankan migrant housemaids).

The narratives of the surrogates in this study can also be viewed as 'discursive resistance'. The surrogates give their narratives within a context where the family, community, media and medical professionals attach a variety of meanings to surrogacy and to the position of surrogates as subjects within the process. 'Most of the surrogates' husbands and in-laws view surrogacy as a familial obligation and not as labour performed by the women. The media and community often equate surrogates to sex workers. 'A third kind of meaning attached to the role of surrogates is in the medical narratives where surrogacy is perceived as an impersonal contract and surrogates are disposable women.' Do the surrogates affirm or resist these subject positions? In the following sections, I discuss some patterns in the narratives of the surrogates in this study and argue that while these narratives can be seen as resistances, they are often counter productive to establishing surrogacy as work and surrogates as wage-earning workers.

'We are Not Body Sellers or Baby Sellers': Boundary Work

Scholarship on identity has contended that it is defined **relationally**. For instance, British social historians and Birmingham School sociologists have considered how the working class defines its identity in opposition to those of other classes or what Lamont (2000) calls 'boundary work'—constructing a sense of self-worth by interpreting differences between themselves and others. Holding oneself to high moral standards is also a way of acquiring or affirming one's dignity at work. Often, this means defining the 'others' as 'low moral types' (Lamont 2000; Lamont and Fournier 1992). Literature on dirty work also indicates a similar pattern—members of dirty work occupations draw comparisons with salient occupational groups that they consider to be somewhat similar in prestige but disadvantaged in some way. These groups are sufficiently similar to justify the comparison, but are 'inferior' enough to gratify the need for self-esteem (Ashforth and Kreiner 1999). The surrogates in my study often emphasised the **moral difference between surrogacy and 'prostitution' and between surrogacy and putting a baby up for adoption.**

Meena is a 26-year-old surrogate, having a baby for a couple from Mumbai, India. Her husband, Pragyesh, persuaded her to become a surrogate. He needed the money to pay the mortgage for his street corner barber shop. Meena accepts that she agreed to be a surrogate because her husband needed the money desperately.

I don't think there is anything wrong with surrogacy. **We need the money and they need the child.** The important thing is that I am not doing anything wrong for the money—not stealing or killing anyone. *And I am not sleeping with anyone.*

Dipali is a 24-year old-surrogate, who is confident, speaks English and is one of the few surrogates dressed in 'Western clothes'—a pair of tight-fitting jeans and T-shirt. She is a divorcee with three children, separated from her husband for five years. She is also

the only surrogate who has not kept surrogacy a secret from her neighbours and parents. Dipali admits to being a broker who brings in other women from her community to be egg donors and surrogates at the clinic.

I told my parents that I am doing this. I told them if you can help me, fine: but don't be a hindrance in what I am doing. If I was doing something wrong you could stop me, hit me, anything: but this is not wrong. At least I am not like some other women who have (sexual) relations for money, just because they are so desperate. This is what I told them.

Another kind of moral boundary the surrogates and their family often used was between **surrogacy and adoption**. Surrogate Meena reasons that giving the child away right after birth will not be too difficult:

You have to weigh the pain with the need of the hour. Life won't stop just because one person in the family is not there. We will at most cry for a week or two. But it would have been different if we had to give away our *own* child. No, we would never give away any of our real children. Only we know how we have raised them, taken care of them. I don't understand how people can do that.

Raveena, the only college educated surrogate in the Anand clinic, has similar sentiments about adoption. She is carrying a baby for a South Korean couple residing in California. Raveena and her husband will use the money to pay for their elder son's heart surgery.

I think they (the couple) chose us because of Shalin (their infant son). He was very healthy then. They liked him so much that they wanted to just take him home. Dr Khanderia also chose us because of Shalin. She kept saying someone will definitely want to adopt him instead. But we were sure about one thing, no one and nothing can make us give away our own child. We are not like that. We won't sell our baby.

Apart from morally distancing themselves from other groups of needy people, the surrogates sometimes used traditional standards of morality to affirm their husbands' dignity. They vigorously defended their husbands' moral worth by comparing them to other men and other husbands—perhaps an attempt to balance the moral stigma presumably attached to husbands who are not 'man enough' to feed the family and who allow their wives to be pregnant for other men.

Vidyaben is a 30-year-old surrogate and mother of three children. She was persuaded by her sister-in-law to donate eggs at the clinic and then convinced by the nurses to become a surrogate.

When I came here (the clinic) the first time they didn't really ask too many questions. They didn't have to check much either because he (her husband) is such a good person—doesn't drink, smoke, anything. I am so lucky. Look everywhere, maybe not where you come from, but here husbands are very (laughs), like bulls. But my husband has never raised his hand against me.

Anjali is a skinny woman in her early twenties and has no idea about the money involved in the contract or the exact medical procedures. Her husband seems to be the one in control of the finances. Like Vidyaben, she too was convinced by her sister-in-law that she should donate eggs at the clinic and later was persuaded by the nurses to become a surrogate. Anjali accepts that she is desperate for the money. During the interview she was breastfeeding her baby. She had to convince Dr Khanderia to allow her to be a surrogate even though she was still breast-feeding because there was no money in the house to buy milk for the baby—her husband has no fixed job and she is a housewife.

My husband is unemployed but he is a very good person. He takes care of the children. He stays at home mostly so he knows what to feed them. Most husbands would not agree to let their wives do this (be a surrogate)—but he agreed. I am very lucky. We had no issues (with getting the surrogacy contract) because his history is so clean. He doesn't smoke or drink. We

are Christians. He converted (from Hinduism) and used to work in a Mission earlier.

The surrogates in this study seem to be resisting the stigma of surrogacy by seeing a difference between themselves and others like body-sellers and baby-sellers whom they view as equally needy but 'less moral'. On the one hand, these narratives aim to preserve their sense of self-worth. But on the other hand, the emphasis on the 'high morality' of their husbands and their 'generosity' in giving permission to their wives to be surrogates indicates that the women are overcompensating for their (temporary) role as breadwinners.

'Prestige Won't Fill an Empty Stomach': Downplaying 'Choice'

Another pattern observed in the narratives of the surrogates was the emphasis on surrogacy as *not work* but a compulsion. Surrogate Salma admits that she feels surrogacy is unethical.

Who would choose to do this? I have had a lifetime's worth of injections pumped into me. Some big ones in my hips hurt so much. In the beginning I had about 20–25 pills almost every day. I feel bloated all the time. But I know I have to do it for my children's future.

This is not work, this is *majboori* (a compulsion). Where we are now, it can't possibly get any worse. (She uses a local proverb) In our village we don't have a hut to live in or crops in our farm. This work is not ethical—it's just something we *have* to do to survive. When we heard of this surrogacy business, we didn't have any clothes to wear after the rains—just one pair that used to get wet—and our house had fallen down. What were we to do? Let me tell you something, there are many families like ours who want to do it, but either the husband doesn't approve or the wife doesn't agree to do it. These people are jealous. These are the kind of people who call it immoral. And if everyone in the family agrees, society disapproves. But I say,

if your family is starving what will you do with respect? Prestige won't fill an empty stomach.

Apart from emphasising their *majboori* in deciding to become surrogates, the surrogates also appealed to 'higher loyalties'. The literature on deviant occupations like topless dancing indicates that a 'neutralisation technique' routinely employed by topless dancers was that of appealing to higher loyalties. Most of the dancers had young children and almost all of them cited money for children as their primary motivation for becoming topless dancers (Thompson et al. 2003).

Surrogate Anjali defends her decision to become a surrogate:

I am doing this basically for my daughters. Both will be old enough to be sent to school next year. I want them to be educated, maybe become teachers or air hostesses? I don't want them to grow up and be like me—illiterate and desperate. I don't think there is anything wrong with surrogacy. But of course people talk. They don't understand that we are doing this because we are compelled to do so. People who get enough to eat interpret everything in the wrong way.

Vidyaben, another surrogate, echoes Anjali's sentiment:

I am doing this basically for my children's education and my daughter's marriage. We have lived our life, we have survived it. But they should grow up happier. I want them to grow up and be proud of their parents. I want them to be educated so that in case anything happens to us they can take care of themselves. I am doing everything for them. I am not greedy for the money.

Both Vidyaben and Anjali accept that they need the money, but they underline the selfless use of this money for their children's welfare. A second perspective in the narratives, used by the surrogates to downplay the 'choice' aspect of this 'work', was to differentiate it from other kinds of chosen occupations. Surrogacy, it was argued, was more like a 'calling'. Pragyesh compares his wife's

surrogacy to *tapasya*—the Hindu principle and practice of physical and spir-itual austerity and discipline to achieve a particular aim.

I don't think this is work. When you became a teacher, you just went ahead and took your exams and became a teacher. This is not like that. **It is like God helped her do this for our family.** It is like praying to God—like *tapasya*. This is her prayer to God and ultimately she will get His blessings and her dreams will be fulfilled. Like saints pray under austere conditions, she is living here in the clinic, getting all those injections, going through all this pain. But she will get the fruit of her labour.

In Pragyesh's words, his wife Meena should feel blessed because she is able to fulfil her familial obligations. Ironically, while supporters of surrogacy emphasise the element of 'choice' in surrogacy, that a woman has the right to choose what to do with her body, **most of the surrogates' narratives worked towards downplaying the choice aspect in their decision to become surrogates, as if they are saying, 'It was not in my hands, so I cannot be held responsible, and should not be stigmatised'.** They do this by highlighting their **economic desperation**, by citing higher motivations or by emphasising the role of a higher power (God) in making decisions for them. As a consequence, **these narratives downplay the role of surrogates as independent wage workers and instead reinforce their role as selfless mothers and wives.**

Feminist scholars have argued that motherhood embeds women in families and that their identities are derived from relationships and duties to others (Jeffery 2001; Jeffery and Jeffery 1996). The **'lack of choice' and 'higher loyalties' narratives reinforce the image of women as selfless dutiful mothers whose primary role is to serve the family, their husbands and in-laws.**

'I am Special, They are Special': Denying Disposability

Scholarship on globalisation and factory work has analysed how **Third World women workers are made to feel disposable, and this is an integral part of the working of global capitalism** (Chang 2000; Ehrenreich and Hochschild 2003; Wright 2006). Although in

Indian Journal of Gender Studies, 16:2 (2009): 141–173

economic parlance surrogates are not plentiful in supply, the process of commercial gestational surrogacy in India, in general, and the rules of the clinic, in particular, reiterate the disposability of the surrogates. The surrogates are aware that their role in the entire process is only as vessels, they have no genetic connections with the children and in most cases the children will be taken away from them immediately after birth. The surrogates are not allowed even to breastfeed the babies. For each couple that comes in to hire a surrogate, at least two surrogates are 'prepared' medically and mentally for the procedure. In case one surrogate does not 'match' the adoptive mother biologically, the reserve surrogate is brought in.

Although the experience and institutions surrounding surrogacy stress the disposability of individual surrogates, the surrogates have devised various ways of resisting these discourses of disposability. A variety of narratives were used by surrogates to minimise this feeling of disposability and the stigma attached to being disposable mothers. Some surrogates emphasised the 'special' quality they had which made couples choose them over all the other 'run-of-the-mill' surrogates. Others stressed more the 'special' quality of the adoptive couple and the exceptional bond they shared with the couple.

Pushpa is a 27-year-old surrogate who has already delivered a baby for an Indian couple and was pregnant for the second time in two years—this time for an NRG couple from the United States.

A Gujarati NRI party came from America during the delivery of my first baby. They said that they don't care how long they have to wait—I can rest for 1–2 years, as much as I want but they want only me to carry their baby. Mrs. Shroff—the NRI woman—she is also a Brahman (upper caste). Maybe that's why she liked me, because I am clean. But almost everyone who comes here for a surrogate wants me. Doctor madam says to me, 'Why can't you get me 10–15 more Pushpas?'

The 'I am special' narrative seems exceptionally powerful when invoked by lower class women in India—a country where sex-selective abortions, skewed sex ratios at birth, high female infanticide and mortality and the use of ultrasound and amniocentesis

during pregnancy present compelling evidence of the extensive prevalence of son preference, particularly in the states of Gujarat, Haryana and Punjab (Das Gupta 1987). The feeling of 'being special', albeit transient, affects the surrogates' perception of self-worth.

Pushpa, the surrogate who believes that she is the 'most wanted', adds:

You know, I had always dreamt of being an air hostess. But when I saw the situation at home—with my father earning only 1,500, I knew I couldn't study any more. I just wanted to see America once, so badly. Once I got married I thought it would never happen. But now that I am planning to do this (surrogacy) for the second time, I feel 'Why not'? If I can do this here, maybe I can get some job there as well, no? Will you take me? I'll pay the expenses, you just have to take me with you!

Thus, for some surrogates like Pushpa the narrative of 'being special' did more than just counter the stigma of being 'disposable mothers', it encouraged them to take care of their health, to think of their own needs and it raised their self-esteem. While for Pushpa, surrogacy was a first step towards getting a 'job', the 'I am special' narrative did not produce the same results for everyone.

A complementary narrative used by the surrogates was that **their hiring couples were unique**. Although most Indian couples hiring surrogates tried to build some kind of a relationship with the surrogate, the rules of commercial surrogacy meant that the termination of that relationship was rather abrupt. Dr Khanderia ensured that the baby was taken away right after delivery so that the surrogate had no opportunity to change her mind. Several of the surrogates, however, reiterated how the couple hiring them were different and would not adhere to the clinic's rules.

Parvati is 36 and one of the oldest surrogates at the clinic. Her story reveals that she has undergone a lot of pain and trauma during the surrogacy process. She was rejected the first time because of her age. Then, after months of treatment with hormones, injections and pills, when she finally got accepted by a couple from New Zealand, her husband backed out because his friends told

him that surrogacy involved sex work. He soon realised that they desperately needed the money and gave his consent for Parvati to try once again. This time, however, Parvati was pregnant with her own child. On her husband's insistence she had the child aborted and started the hormone treatment for surrogacy again. Parvati talks wistfully about her relationship with the couple and seems to be confusing what she *hopes* will happen in the future with reality. Although she is yet to deliver the baby she speaks about the important role she plays in the baby's life as if it has already happened:

My 'couple' keep such good relations with me. After delivery, they brought him over to me and let me breastfeed him. They invited me for his birthdays. They called me when he got married. When he gets fever they call and say 'Don't worry, just pray to God. If you want to see him we'll come and show him to you. But don't burn your heart over him.' I am so lucky to have a couple like them taking care of me. I see how the rest of the surrogates in the clinic get treated.

The surrogates seem to be resisting the commercial and contractual nature of their position by establishing some kind of a relationship with the adoptive couple. While this can be seen as a form of resistance to medical narratives and procedures that underscore their disposability, **it downplays the business aspect of surrogacy and consequently their role as 'workers' entitled to a wage.** These 'relationships' between surrogates and adoptive couples make the remuneration structure very informal, often to the detriment of the surrogates' interests.

In the absence of any binding law or contract, individual couples have considerable freedom in deciding the boundaries of remuneration. The surrogacy contract ensured that a payment of Rs 25,000 was made every three months, but beyond that the rates were negotiable. A couple from New Jersey decided to pay the entire amount in kind to their surrogate Salma. Salma explains:

Will (the adoptive father) said 'You make us happy and we'll make you happy'. His wife has become like an elder sister to

me so I do just want to see them happy. They said they would build a house for us wherever we want to build it and however big we want it to be. I am having twins so perhaps they will build us two rooms instead of one. But I don't want to ask.

The 'relationships' formed with the couples often prevented the surrogates from negotiating their wages and further eroded their role as workers. In the next section, I will discuss the last pattern I observed in the narratives of surrogates—making claims on the baby.

'It May be Their Genes, but it's My Blood': Making Claims on the Baby

The literature on care work and emotion work has found that workers reduced the emotional strain of their work by forming familial ties with their clients and wards (Hochschild 1983; Hondagneu-Sotelo and Avila 2003; Parrenas 2001). Faced with the dissonance between their understanding of motherhood (the mother bears, gives birth to and raises the child) and their actions (giving away the child they bear), surrogates often resorted to a similar strategy.

The surrogates are often not told about or do not understand the exact medical procedure involved in surrogacy, but they are constantly told by the nurses and the doctors that they have no genetic connection to the baby. Dr Khanderia narrates how she explains the process of surrogacy to the women:

I had to educate them about everything because, you see, all these women are poor illiterate villagers. I told them, 'You have to do nothing. It's not your baby. You are just providing it a home in your womb for nine months because it doesn't have a house of its own. If some child comes to stay with you for just nine months what will you do? You will take care of it even more because it is someone else's. This is the same thing. You will take care of the baby for nine months and then give it to its mother. And for that you will be paid.' I think finally how you train them, showing the positive experiences of both the parties, is what makes surrogacy work.

The surrogates, however, did not passively accept the doctor's description of their role in the surrogacy process. They did recognise that having no genetic connection makes it simpler to justify the 'giving away' of the baby, but simultaneously they laid some kind of claim on the baby—another possible way of countering their role as 'merely a vessel'.

Surrogate Parvati makes a distinction between genetic and 'blood' ties and stresses her 'blood' ties with the foetus. She explains that she was against foetal reduction surgery in which one foetus has to be surgically eliminated.⁶

Madam told us that the babies won't get enough space to move around and grow, so we should get the surgery. But the couple and I wanted to keep all three. I told Doctor Madam that I'll keep one and they can keep two. We had informally decided on that. After all it's my blood even if it's their genes.

The surrogates also used cultural symbols that parallel different aspects of the surrogacy arrangement to downplay the anomalous aspects of surrogacy and to implicitly reiterate their relationship with the baby. They invoked a tale from Hindu mythology, where the infant Lord Krishna was taken care of by a foster mother, Yashoda. Surrogate Parvati argues that surrogacy is not new to Hindus:

We can't really call it (surrogacy) either work or social service. I personally feel it's nothing strange to us Hindus, it's in our religion. It's something like what Yashoda ma did for Lord Krishna. And Krishna loved his Yashoda ma, didn't he? Do you ever hear stories of Devaki, his real mother?⁷

Other surrogates normalise the process of surrogacy and the act of giving away by finding parallels between giving away the baby on delivery and the act of giving away a daughter at marriage. Surrogate Jyoti reasons that the act of giving away will be painful, but she is ready for it,

Of course I'll feel sad while giving up the baby. But then I'll also have to give up my daughter once she gets married, won't I? She

is *paraya dhan* (someone else's property) and so is this one. My daughter is my responsibility for 18 years, then I have to give her up, but I still remain responsible for anything that goes wrong. At least with this child I won't be responsible once I give her up. Also with this one I'll be happy that she is somewhere where she will be happier. These people will send her to school, college, pamper her much more.

By making claims on the baby/foetus, the surrogates further resist their 'disposability' and the commercial nature of surrogacy. But again, by claiming ties of motherhood with the baby, the surrogates downplay their role as contractual workers. This further diminishes their identity as 'workers'.

Conclusion

My primary motivation in this study has been to move conversations on surrogacy beyond the Euro-American setting and get a broader view of the cultural responses to new reproductive technologies. In this paper, I have situated commercial surrogacy, as it is evolving in western India, as an emerging form of 'sexualised care work' and begun to analyse the effect this kind of 'work' has on the 'workers'.

While the language of morality used by the surrogates affirmed their dignity and sense of self-worth and reduced the stigma attached to surrogacy, they simultaneously reinforced certain gender hierarchies. **Ironically, while the focus of this study has been on surrogacy as labour, most surrogates and their families do not recognise surrogacy as paid labour performed by women.** The in-laws and husbands of the surrogates perceive surrogacy as a familial obligation and a duty. The striking absence of surrogacy as work in the narratives of the surrogates indicates that the surrogates do not resist this image of women as selfless dutiful women whose primary role is to serve the family. Similarly, the vigorous defence of their husbands' moral worth indicates that the women are overcompensating for their (temporary) role as breadwinners.

The second pattern in their narratives, that of emphasising the adoptive couples' 'special quality', is another example of this

tension—discursive resistance both transforming and reproducing power relations. Although the narratives used by surrogates to minimise the feeling of disposability and the stigma attached to being disposable mothers seem powerful when invoked by lower class women in India, the dream of a wealthier or white family coming to rescue them from desperate poverty and a bleak future brings in issues of new forms of subjection based on race and class domination. These narratives reaffirm their role as selfless mothers and desperately poor Third World women waiting to be saved by their richer and/or 'whiter' sisters. Similarly, by forming ties with the baby, the surrogates downplay the business aspect of surrogacy and reiterate their primary identity as mothers rather than workers.

According to Burawoy (1991: 281), the primary architect of the extended case method, 'The importance of the single case lies in what it tells us about society as a whole rather than about the population of similar cases.' My study examines cases of a handful of surrogates in a small clinic, not to formulate generalisations about surrogates elsewhere but instead to explore how the language of stigma, especially in conjunction with women's work, suppresses the development of a worker identity. Scholarship on 'dirty work', like sex work and erotic dance, has analysed how workers neutralise the stigma attached to occupations by citing 'higher loyalties' and 'altruism'.

Simultaneously, scholarship on care work has demonstrated how care workers reduce the emotional strain of the work by forming ties with their wards (Hochschild 1983; Hondagneu-Sotelo and Avila 2003; Parrenas 2001). This case study of commercial surrogacy, a new form of women's work lying somewhere on the cusp of care work and dirty work, can be seen as a way of extending the existing scholarship on gender and work. Instead of stopping the analysis at the narratives and strategies used by women workers to negotiate the peculiarities of their work, I have analysed the consequences of these strategies on the workers themselves. Poignantly, the narratives that increase their feeling of self-worth are also instrumental in eroding recognition of the significant role they play as workers, breadwinners and wage earners for their families.

Notes

1. IVF is the process by which egg and sperm are united *in vitro* (in the laboratory). Subsequently, the embryo grown is transferred into the uterus through the cervix.
2. This article is part of a larger study I am conducting on commercial surrogacy in India. Here, I analyse the narratives of surrogates as a lens through which I seek to understand their complex reality. A more detailed discussion of the structural and economic aspects of this form of labour as well as the multi-layered consequences of surrogacy on surrogates' lives can be found in Pande (2008).
3. The entire document can be accessed at the official ICMR website <http://www.icmr.nic.in>.
4. This study concentrates on the voices of surrogates. My future projects will explore how other actors in the surrogacy process, the doctors, brokers and intending parents, frame surrogacy.
5. This surrogate was an exceptional case, much more educated than the rest, with higher than the average family income. She did not belong to Gujarat and had travelled from eastern India just to be a surrogate.
6. Many European countries limit the number of embryos transferred into a surrogate's womb to three, as multiple births can be dangerous for the surrogate mother and, sometimes, the babies. In the absence of any laws in India, up to five embryos have been transferred. In case more than two develop, the doctor at the clinic recommends a foetal reduction surgery.
7. According to Hindu mythology, Krishna was born as the eighth child of Devaki, sister of the cruel demon King Kamsa. Sage Narada predicts that Kamsa would be killed by his nephew, so Kamsa kills his sister's first six children. The eighth child Krishna is secretly exchanged for a cowherd's daughter. Krishna is brought up by the cowherd's wife Yashoda, and most stories surrounding Lord Krishna in his infant years are about the loving bond between him and his surrogate mother Yashoda.

References

- Anderson, E. 1990. 'Is Women's Labor a Commodity?', *Philosophy and Public Affairs*, 19(1): 71–92.
- Andrews, L.B. 1987. 'The Aftermath of Baby M: Proposed State Laws on Surrogate Motherhood', *Hastings Center Report*, 17(5): 31–40.
- Anleu, S.R. 1992. 'For Love but Not for Money?', *Gender and Society*, 6(1): 30–48.
- Ashforth, B.E. and G.E. Kreiner. 1999. "'How Can You Do It?" Dirty Work and the Challenge of Constructing a Positive Identity', *The Academy of Management Review*, 24(3): 413–34.

Indian Journal of Gender Studies, 16:2 (2009): 141–173

- Baker, B.M. 1996. 'A Case for Permitting Altruistic Surrogacy', *Hypatia*, Spring, pp. 34–48.
- Bhargav, P. 2006. 'Gujarat becomes the Preferred Medical Tourism Destination', *Canada Free Press*, <http://www.canadafreepress.com/2006/india120706.htm>, accessed 6 April 2007.
- Bollywoodgate. <http://www.bollywoodgate.com/indian-tv-serials/mamta.html>, accessed 26 July 2007.
- Burawoy, M. 1991. *Ethnography Unbound*. Berkeley: University of California.
- Chang, G. 2000. *Disposable Domestics: Immigrant Women Workers in the Global Factory*. Cambridge: South End Press.
- Corea, Gene. 1985. *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*. New York: Harper & Row.
- Das Gupta, M. 1987. 'Selective Discrimination against Female Children in Rural Punjab, India', *Population and Development Review*, 13(1): 77–100.
- Dworkin, A. 1978. *Right Wing Women*. New York: Perigree Books.
- Ehrenreich, B. and A. Hochschild (eds). 2003. *Global Women: Nannies, Maids and Sex Workers in the New Economy*. New York: Metropolitan Books.
- Gamburd, M. 2000. *The Kitchen Spoon's Handle*. Ithaca, NY: Cornell University Press.
- George, Sheba. 2000. "'Dirty Nurses" and "Men who Play"', in M. Burawoy, J. Blum, S. George, Z. Gille, M. Thayer, T. Gowan, L. Haney, M. Klawiter, S. Lopez and S. Riain (eds), *Global Ethnography: Forces, Connections and Imaginations in a Postmodern World*, pp. 144–74. Berkeley: University of California Press.
- Glenn, E.N. 1992. 'From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproduction Labor', *Signs*, 18(1): 1–43.
- Goffman, E. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.
- Hochschild, A.R. 1983. *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California Press.
- Hondagneu-Sotelo, P. and E. Avila. 2003. "'I'm Here, but I'm There": The Meanings of Transnational Latina Motherhood', in P. Hondagneu-Sotelo (ed.), *Gender and US Immigration*, pp. 317–40. Berkeley: University of California Press.
- Hughes, E.C. 1951. 'Work and the Self', in J.H. Rohrer and M. Sherif (eds), *Social Psychology at the Crossroads*, pp. 313–23. New York: Harper and Brothers.
- ICMR. 2005. 'National Guidelines for Accreditation, Supervision & Regulation of ART Clinics in India', http://www.icmr.nic.in/art/art_clinics.htm, accessed 13 June 2007.
- Jeffery, P. 2001. 'Agency, Activism and Agendas', in P. Jeffery and A. Basu (eds), *Resisting the Sacred and the Secular: Women's Activism and Political Religion*, pp. 42–57. New Delhi: Kali for Women.
- Jeffery, P. and R. Jeffery. 1996. *Don't Marry Me to a Plowman: Women's Everyday Lives in Rural North India*. Boulder, CO: Westview Press.
- Lamont, M. 2000. *The Dignity of Working Men: Morality and the Boundaries of Race, Class and Immigration*. New York: Russell Sage Foundation.

- Lamont, M. and M. Fournier (eds). 1992. *Cultivating Differences: Symbolic Boundaries and the Making of Inequality*. Chicago: University of Chicago Press.
- Markens, S. 2007. *Surrogate Motherhood and the Politics of Reproduction*. Berkeley: University of California Press.
- Neuhaus, R.J. 1988. 'Renting Women, Buying Babies and Class Struggles', *Society*, 25(3): 8–10.
- Nussbaum, M. 1998. 'Whether from Reason or Prejudice: Taking Money for Bodily Services', *Journal of Legal Studies*, 27(2): 693–724.
- Pande, A. 2008. 'Commercial Surrogate Mothering in India: Nine Months of Labor?' in Kenji Kosaka and Masahiro Ogino (eds), *Quest for Alternative Sociology*, pp. 71–88. Melbourne: Trans Pacific Press.
- Parrenas, R. 2001. *Servants of Globalization: Women, Migration and Domestic Work*. Stanford: Stanford University Press.
- Pun, N. 2005. *Made in China: Women Factory Workers in the Global Workplace*. Chicago: University of Chicago Press.
- Ragone, H. 1994. *Surrogate Motherhood: Conception in the Heart*. Boulder, CO: Westview Press.
- Raymond, J. 1993. *Women as Wombs: Reproductive Technologies and the Battle Over Women's Freedom*. San Francisco: Harper Collins.
- Roberts, E.F. 1997. "'Native" Narratives of Connectedness: Surrogate Motherhood and Technology', in J. Dumit and R. Davis-Floyd (eds), *Cyborg Babies: From Techno-Sex to Techno-Tots*, pp. 193–211. New York: Routledge.
- Rothman, B.K. 1988. 'Reproductive Technology and the Commodification of Life', in E. Hoffman Baruch, A.F. D'Amadeo Jr. and J. Seager (eds), *Embryos, Ethics and Women's Rights: Exploring the New Reproductive Technologies*, pp. 95–100. London: Harrington Park Press.
- Scott, J.C. 1985. *Weapons of the Weak: Everyday Forms of Peasant Resistance*. New Haven: Yale University Press.
- Singh, M.K. 2007. 'New laws to rein in "womb business"', *The Times of India*, 31 October.
- Smith, A. 1985. *Lectures on Rhetoric and Belles Letters*, edited by J.C. Bryce, Vol. IV of the Glasgow Edition of the Works and Correspondence of Adam Smith. Indianapolis: Liberty Fund.
- Spar, D.L. 2006. *The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception*. Harvard, Cambridge, Mass: Business School Publishing Corporations.
- Strathern, M. 1992. *Reproducing the Future: Essays on Anthropology, Kinship and the New Reproductive Technologies*. New York: Routledge.
- Sunder Rajan, R. 2000. 'Introduction: Feminism and the Politics of Resistance', *Indian Journal of Gender Studies*, 7(2): 153–65.
- Sykes, G.M. and Matza, D. 1957. 'Techniques of Neutralization: A Theory of Delinquency', *American Sociological Review*, 22(1957): 664–70.
- Thompson, William, Jack Harred, Barbare E. Burks. 2003. 'Managing the Stigma of Topless Dancing: A Decade Later', *Deviant Behaviour*, 24: 551–70.
- Unnithan Kumar, M. (ed.). 2004. 'Introduction', in *Reproductive Agency, Medicine*

- and the State: Cultural Transformations in Childbearing*, pp. 1–23. New York: Beghahn Books.
- Wajcman, Judy. 1994. 'Delivered into Men's Hands? The Social Construction of Reproductive Technology', in G. Sen and R. Snow (eds), *Power and Decision: The Social Control of Reproduction*, pp. 153–75, Cambridge: Harvard School of Public Health.
- Wright, M. 2006. *Disposable Women and Other Myths of Global Capitalism*. New York: Routledge.