



## Gender and Sexuality in the Workplace

Making India the "mother destination": Outsourcing labor to Indian surrogates

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# MAKING INDIA THE “MOTHER DESTINATION”: OUTSOURCING LABOR TO INDIAN SURROGATES

Sharmila Rudrappa

## ABSTRACT

*This chapter examines the emergence of India as a site for surrogacy, which has led intended parents from all over the world to contract with Indian gestational surrogates to carry “their” babies for them. Through participant observation in a surrogacy workshop, interviews with American intended parents, and interviews with Indian surrogates, I show how ideologies of normative, nuclear families built around genetically similar children, drives American consumers’ desires to seek fertility intervention, and, finally, surrogacy. In India, gender ideologies shape the contours of an inexpensive, compliant labor force of surrogate mothers.*

In October 2007, Oprah Winfrey interviewed a white, middle-class American couple, Jennifer and Kendall West, who had traveled to Anand, India, to hire a surrogate to have a baby for them. Ms. West tells Oprah and her television audience that “the culture shock [at being in India] at first was just so much ... I definitely had a lot of those moments when you just kind of step out of yourself and look at your surroundings and just think, ‘How did I get here?’” In this chapter, I explore exactly this question; how did the Wests,

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like the various intended parents I interviewed from different parts of the United States, both heterosexual and gay, end up halfway across the world, hiring Indian surrogates to have their babies for them? Although the United States is the top destination for surrogacy tourism (Ragone, 1998; Ikemoto, 2009; Lee, 2009), India is emerging as a key site for hiring surrogate mothers. Currently, surrogacy is estimated to be a \$445 million business in India, with the Indian Council for Medical Research projecting profits to reach \$6 billion in the next few years (Sehgal, 2008; Rengachary Smerdon, 2008).

I propose that India has emerged as an important site for transnational surrogacy for three reasons, all of which are deeply gendered: the development of a consumer market in surrogacy; the availability of inexpensive, compliant labor in India; and the coordinated work of independent firms that give consumers in the United States access to this labor. Having a baby through gestational surrogacy in India costs intended parents anywhere from \$20,000 (Lee, 2009) to \$45,000 (interviews, January–March 2010). Indian surrogate mothers earn \$2,800 (Lee, 2009) to \$9,000 (personal communication with interviewees). In comparison, American surrogate mothers can make up to \$25,000 for their labors (Teman, 2010). In addition, labor market conditions in India are such that it is far easier to have a compliant labor force of surrogates. But how do consumers in the United States contract with Indian surrogates? This access is organized through various market intermediaries. In surrogacy, conception and pregnancy are functionally disintegrated, and eventually integrated, with the processes involved in oocyte extraction, sperm donation, conception, and implantation of the fertilized egg, the hiring and surveillance of surrogates, and the eventual movement of newborn babies across the globe.

There is a vast feminist literature on infertility and lesbian/gay parenthood in the social sciences (Becker, 2000; Franklin, 1997; Ginsburg & Rapp, 1995; Inhorn & van Balen, 2002; Inhorn, 2003, 2007; Lewin, 2009; Mamo, 2007; Markens, 2007; Ragone, 1994; Rapp, 1999; Spar, 2006; Teman, 2010). In addition to the recent heightened media attention, surrogacy in India has been examined both in law (Lee, 2009; Rengachary Smerdon, 2008) and sociology (Bharadwaj, 2002; Hochschild, 2009; Pande, 2009). In this chapter, I merge the literature on infertility and surrogacy with a critical examination of consumer and labor markets (Peck, 1996). I pay particular attention to market intermediaries who play a central role in organizing these markets.

Surrogacy deals with a fundamentally different kind of consumer product than most other market products because the end point in the production process is a baby, who is central to fulfilling the desires in both intended

parents and surrogates for a normative, middle-class, nuclear family with two parents. My intention is to provide a transnational feminist analysis of the gendered, global labor markets that shape and are shaped by the seemingly local, individual, idiosyncratic notions of desire for nuclear families based on genetic resemblance.

Surrogacy in general, but especially in cases where individuals from the global North hire women from the global South, raises strong reactions (Dasgupta & Das Dasgupta, forthcoming; Subramaniam & Roy, 2010). Many of the individuals involved – surrogates, intended parents, and market intermediaries – may recognize that these transnational market exchanges are morally ambiguous. This recognition is apparent in the way many interviewees in my research emphasize that surrogacy is a choice that makes a difference in their own and the surrogates' lives, and that transnational surrogacy is useful for all involved. My approach to transnational surrogacy is not to deem these practices "good" or "bad," but to examine how surrogacy markets emerge through a focus on individuals who participate in such markets. How do they get to be a part of these global labor and baby circulations? What feelings and emotions are evoked through their participation, and how do they make sense of their locations in these global circulations? To get to social actors' realities, I built on Foucault's notion of positive ethics, which conceives of ethics as a "set of practical activities that are germane to a certain way of life" (Mahmood, 2005, p. 27). My analysis here is to encourage an examination of transnational surrogacy through perspectives that are "particular, pertaining to a specific set of procedures, techniques, and discourses through which highly specific ethical-moral subjects come to be formed" (Mahmood, 2005, p. 28). Through explaining how emotions drive consumers and how labor markets drive transnational surrogacy, my purpose is to outline the contours of how free will, choice, and agency operate in an already unequal world structured by global labor markets.

I begin by describing the methodology for this study, followed by a discussion of the globalization of infertility intervention and the growth of assisted reproductive technologies (ARTs) in India. Next, I examine the emergence of consumer markets in surrogacy and the organization of a labor market in surrogates. I show that while infertility management and surrogacy are often framed as painful for both intended parents and surrogates, this system provides choice through market transactions in eggs, sperm, medical services, and surrogates. Thus, choice is central in managing the social and emotional pains wrought by childlessness. However, my research shows that parents choosing transnational surrogacy actually have

limited choices. Then why opt for transnational surrogacy? The answer lies in the lower costs of outsourcing pregnancy to India and the ability to work with a compliant workforce. This worker compliance is reinforced through market agents, who provide their international clients access to cheap labor markets in surrogates. Through describing transnational surrogacy, I show how consumer and labor markets are crucially structured around gendered ideologies. The ideal of a nuclear family with genetically similar children drives consumers' desires. On the other side of the world, gender ideologies again are central to making available a compliant labor force of surrogate mothers. It is not just Indian women's sexed bodies, but also their gendered lives that makes them desirable workers in a global surrogacy market.

## METHODOLOGY

This chapter is part of a larger research project that examines the cultural politics of ARTs in India. The study is based on participant observation in an infertility clinic in Bangalore, India, interviews with Indian women and couples utilizing ARTs, interviews with intended parents from the United States who have used Indian surrogates, and interviews with Indian surrogates. The interview sample of intended parents, all in long-term relationships, includes both gay and heterosexual individuals and couples and individuals from different racial, ethnic, and class backgrounds.

As part of this larger project, I have completed two field visits to Bangalore and Hyderabad, India, during the months of June, July, and August in 2008 and 2009. In 2008, I interviewed on the telephone two Indian women wanting to become surrogate mothers. These interviews were preceded by numerous email exchanges. I also conducted telephone as well as face-to-face interviews with seven infertility specialists in Hyderabad and Bangalore. Over summer 2009, I conducted participant observation in two infertility clinics in India. Participant observation consisted of sitting in on doctor-patient consultations for 3.5 to 4 hours per day, six days a week. In addition, I read patient files. Of the numerous cases I observed, only five were for surrogacy, all of which involved Indian citizen intended parents. I interviewed 20 infertile couples or individual women, 2 lawyers drawing up surrogacy contracts, and 8 doctors who worked at this particular clinic, providing fertility assistance.

In addition, I attended a surrogacy "workshop" in Dallas in January 2009. The workshop, organized by a medical tourism company, brought together their in vitro medical specialist from Mumbai, India, to meet with

American intended parents. The workshop was held in the Hyatt Regency at the Dallas Airport because all attendees, including me, flew in for the 2-hour workshop, and flew back to our respective hometowns on the same day. All had learned about the workshop on the web.

And finally, I have conducted seven telephone interviews with straight and gay couples and individuals in the United States. These interviews lasted between 1 and 2.5 hours. I followed up these interviews with email exchanges as well as repeat telephone calls. This part of my research – like the participant observation conducted in Bangalore, India – is ongoing. Many of the interviewees maintain blogs on their experiences with transnational surrogacy to share their knowledge about the process and facilitate the process for others who might be interested in embarking on a similar quest.

I have also depended on the Internet for media articles on surrogacy in India. Through Internet search engines, I identified popular articles and television stories published in the United States, Canada, and the United Kingdom. In addition to the articles, I looked at readers’ comments on these publications/television features. I also used the web to access information on the countless surrogacy agencies that advertise their services to American intended parents. The popular medical tourism companies are PlanetHospital, Surrogacy India, Surrogacy Abroad Inc., and Medical Tourism Corporation. These blogs, media stories, and websites for medical tourism companies are important sources of data because I learned that these are among the first sites that intended parents use in their investigations on transnational surrogacy.

## **MEDICAL DEVELOPMENTS AND THE GLOBALIZATION OF FERTILITY INTERVENTION**

Although earlier technologies of reproduction, namely birth control, decoupled sex from reproduction, the contemporary technologies of reproduction, namely, ARTs, disengage reproduction from sex. That is, the heterosexual act of penetration is no longer necessary for reproduction because intrauterine inseminations (IUIs) and in vitro fertilizations (IVFs) can lead to conception. This has been the case since the first “test tube” baby, Mary Louise Brown, was born in Britain on July 25, 1978, just five years after *Roe v. Wade* legalized abortion in the United States. Within three years of Mary Louise Brown’s birth, the first American IVF baby was born,

and in 1984, the United States saw its first successful egg donor case, when eggs from one sister were fertilized and implanted in another, leading to a successful pregnancy. These experimental, cutting-edge technologies were very quickly converted to commercial use. By 1987, Dr. Richard Paulson in southern California had recruited a group of married women with children to donate their eggs, which would be fertilized with sperm and implanted in infertile women (Mundy, 2007, pp. 48–49). By 1993, Paulson and his group had performed successful donated egg pregnancies in women over 50 years of age (Mundy, 2007, p. 50).

In the 30 years since the first case of IVF, medical technologies have made tremendous advances in conception and childbirth, all of which have moved very quickly into the market and to the consumer. Gay Becker, among the first sociologists to research infertility in the United States, writes that when she began her research in 1984, only 1 of 28 couples she interviewed considered IVF an option. There were no IVF programs in the Bay Area where she was conducting her research. By 1991, there were seven IVF clinics in the Bay Area, and of the 134 couples she interviewed, 31 had attempted one or more cycles of IVF. Interviewees who had not as yet attempted IVF reported they would consider it if all other options failed (Becker, 2000, pp. 9–10).

The growth of ARTs in the United States has been phenomenal. The National Survey of Family Growth calculates that 15 percent of all American women reported use of some kind of fertility service in their lifetime, including medical advice, tests, drugs, surgery, or other treatments (Parham & Hicks, 2005). In 2001, 41,000 children were born as a result of IVF, 6,000 from donated eggs, and 600 from surrogate arrangements in the United States (Spar, 2006). In 2004, 130,000 cycles of IVF were conducted, which resulted in the birth of 50,000 children. This represented a 128 percent increase from 1996 (Mundy, 2007). Fertility assistance is a \$2 billion a year industry in the United States; approximately 1,000 women undergo IVF every week (Markens, 2007, pp. 180–181). Many of these IVFs use donor eggs. In 2003, the Centers for Disease Control and Prevention said that 12 percent of all IVF procedures used donor eggs, which translated to 15,000 rounds of IVF performed on mothers who gave birth to children not related to them genetically (Mundy, 2007, p. 21).

The separation of conception and pregnancy, and the innumerable cycles of IVFs that women have undergone since 1978, have not completely demystified conception, but have contributed to a better understanding of the processes involved, thus leading to more effective fertility intervention. The complex choreography involved in conception has been carefully

studied, broken down to its simplest components, particular procedures subcontracted out, and finally reengineered back together into an embryo that can be grown into a baby nine months down the road. All that is needed for a potentially successful conception is a mature, fertile egg, healthy sperm to fertilize that egg, and a woman willing to have the embryo implanted in her. The process of maturing eggs and preparing the uterus for implantation is made possible by a slew of hormones such as Clomid, Pregnyl, Lupron, and Synarel. Because all of this does not guarantee a pregnancy, gynecologists, andrologists, embryologists, and reproductive endocrinologists mediate the entire procedure, extracting tissue, testing cells, and tracking every stage of embryonic development.

If intended parents are unable to produce their own sperm or eggs, they can purchase them through intermediaries who control market access to these germ cells. If mothers are unable to carry a fetus full term, or if gay men want to father children, then wombs can be "rented," again, organized through market intermediaries. Either the intended mother's eggs or donor's eggs are fertilized with the intended father's sperm, and embryos are implanted into the surrogate who will then nurture the fetus to full term in her body.<sup>1</sup> And finally, at the end of this medically, legally, and commercially mediated process, the intended parents receive a baby.

Until recently, the United States had been an important destination for infertile heterosexual and gay couples from around the world wanting to hire surrogates (Ragone, 1998; Ikemoto, 2009; Lee, 2009). Today, however, surrogacy agencies in Russia and Slovenia tap into European markets, where restrictive domestic laws make such technologies unavailable in countries such as Italy, France, and the Netherlands (Lee, 2009). In addition, countries such as Israel and India have become infertility tourism hotspots.

India's first IVF baby was born just 67 days after Mary Louise Brown, on October 3, 1978, in Calcutta (Bharadwaj, 2002, p. 319). The second and more widely documented IVF birth in India occurred in 1986 in Mumbai, through the joint efforts of Drs. Anand Kumar and Indira Hinduja (Bharadwaj, 2002, p. 323). Ten years after Mary Louise Brown's birth, in 1998, three other doctors in India including Dr. Sulochana Gunasheela in Bangalore had successfully delivered IVF babies (interviews, 2008 and 2009). With the medical expertise in place, the facilitation of global trade in services through the General Agreement in Trade in Services, the availability of cheap drugs, access to cheap labor, India's weak regulatory apparatus, and, finally, the commercialization of surrogacy in 2002, India was set to become the "mother destination." Just over 30 years ago, the birth of

Mary Louise Brown through IVF was viewed as a radically new and ethically disturbing medical development. Today, however, IVF is remarkably commonplace. Although earlier, infertility interventions were all performed within a single nation state, today that is no longer the case. Oocytes from white women in the Republic of Georgia or South Africa, sperm from the United States, and surrogates from India are all brought together to make babies at the lowest costs possible for intended parents anywhere in the world.

### THE CREATION AND MAINTENANCE OF CONSUMER MARKETS

Because surrogacy is about babies, it is also about dreams and desires. For both the surrogate who is the worker, and the straight and queer intended parents who are consumers, transnational surrogacy holds the promise of a normative, middle-class, nuclear family with two parents and their biological child. A website for one infertility clinic advertises, “Come as a couple, leave as a family” (Schulz, 2008), reiterating the common belief that a couple without children cannot possibly be a family unit.

Because of the emotions involved in childbirth and surrogacy, there is often a masking of the reality that there *is* a market transaction in babies. Deborah Spar (2006) notes that “we don’t like to think of children as economic objects. They are products, we insist, of love, not money; of an intimate creation that exists far beyond the reach of any market impulse.” Spar continues that recent innovations in medical technology and business organization have “created a market for babies, a market in which parents choose traits, clinics woo clients, and specialized providers earn millions of dollars a year” (2006, p. xi). To propose that there is a market in babies is *not* to suggest that egg and sperm donors, intended parents, surrogates, and the various market mediators who bring the parties together are immoral because they move ostensibly sacrosanct aspects of life, that is, family, love, and reproduction, into the realm of the market. Instead, the purpose is to explain how such a consumer-driven commodity chain comes to exist, being shaped while simultaneously shaping individuals’ experiences of infertility, feelings of loss, and potential for recovery.

The literature on infertility, including surrogacy (Spar, 2006; Mundy, 2007) is replete with notions of choice; that is, couples and individuals managing their infertility choose from a plethora of treatments from IUIs to surrogacy. Yet surrogacy is not the first option for individuals and couples.

Instead it becomes the last resort for individuals to have a baby genetically similar to them. The intended parents' decision-making process, often described in the literature as the slippery slope of assisted fertility decision making, reflects the increasing medicalization of conception, involving the escalation of infertility management from hormonal injections to stimulate eggs, to failed IUIs, to failed IVFs, and, finally, to surrogacy. Thus, while parents do have a choice, this choice is heavily mediated by the promise of technical fixes, with the promise of fertility and a genetically similar baby just one medical treatment away. As a result, individuals almost always choose greater medical intervention, hoping to acquire the miracle child in the next round of medical interventions. Similarly, choice is seen as central to the operation of surrogacy. That is, intended parents exercise consumer choice in purchasing eggs, sperm, and choosing surrogates.

In the following section, I will explain how this choice works in global surrogacy markets. First, I explain how intended parents choose surrogacy in India as a fertility option. Next, I will show how this choice limits their ability to choose egg donors and surrogates. Thus, transnational surrogacy opens up the possibility of genetic resemblance among parents and offspring for those who might have been priced out of the domestic market; yet, transnational surrogacy is not as amenable to consumer choice as is domestic surrogacy.

## CONSUMER CHOICE IN SURROGACY

Cynthia Travers, a 49-year-old African-American woman in an interracial marriage with a white man for close to 20 years, currently lives in the New York area. She decided she had "enough of traveling around, and it was time to settle in." She and her husband tried to get pregnant, but discovered that she faced infertility. Her doctor suggested fertility assistance, but Cynthia was highly skeptical of the hormonal regimens that form the basis of such treatment and worried about the long-term effects of taking such drugs. Very early upon discovering that she was infertile, Cynthia decided she would hire a surrogate. She worried about the costs of domestic surrogacy, but when she saw the October 2007 Oprah Show featuring the Wests and Dr. Nayna Patel, she felt options open up to her. She picked up the phone and contacted Dr. Patel in Anand, India.

Mark Hoffman, a straight, white man from Boston in his late 30s said that his wife could not have children because, although her eggs were viable, she was born without a uterus. He despaired that his wife had all the ideal

characteristics of being a wonderful mother, but had been denied by biological fate. She felt hurt when she saw pregnant women or women with their own children because she knew she was unable to be a mother herself. Upon reading various blogs of individuals who had used surrogates in India, and through consultations with a gay couple who also lived in the Boston area and had used a Mumbai doctor's services, the Hoffmans decided to go to Mumbai.

Tom Pollock, a mid-30s white man living in the Bay Area, explained that his wife, a first-generation immigrant from Fujian, China, suffered from lupus and was unable to get pregnant for health reasons. She longed to have children. Her parents, living in China, had reconciled themselves to a life without grandchildren because they felt it was an impossible dream. Surrogacy, Tom said, opened up a world of possibilities because they too could now have children who are biologically similar to them. He began to explore surrogacy in the United States, but was overwhelmed by how expensive it was, and also by the seemingly insurmountable difficulties in coordinating the services offered by medical establishments with American surrogates' needs. He explained that he found surrogates, but they did not want to work in the infertility clinics he deemed suitable, and that the clinics he chose were unwilling to work with the surrogates that he had found. Coordinating surrogacy in the United States, according to him, was a nightmare. He said he was glad to have found Dr. Nayna Patel because of the October 2007 Oprah Show. Dr. Patel provided a full slew of services, right from extracting his wife's eggs, fertilizing the egg with his sperm, finding a surrogate, monitoring the surrogate's health throughout the pregnancy, delivering the baby, and preparing all the paper work needed to transport the baby back to the United States. All this, he said, was done under one roof, thus reducing his work.

Both Mark and Tom indicated that, in a large part, their wives were fortunate in knowing that while they had healthy eggs, they could not sustain pregnancies. Such knowledge about their medical conditions precluded them from prolonged cycles of IUIs and failed IVFs, which many couples describe as being physically and emotionally debilitating. The Hoffmans and the Pollocks had used their own eggs and sperm to create embryos, which were implanted in Indian surrogates' bodies. However, not all women have viable eggs. Jennifer Watts and her husband went to Mumbai, India, to have her eggs extracted so that they could initiate the medical process of surrogacy. When she was told that she did not have any viable eggs, Jennifer says she was emotionally devastated because she felt she had done so much and traveled so far only to see failure. However, she

said her husband was very supportive; he urged her to see that the point of this entire process was to have a baby, and they still had a shot at it. The Watts then selected an Indian egg donor whose eggs would be fertilized in vitro with Michael Watt's sperm.

In many cases of infertility among heterosexual infertile couples, the wife initiates conversations on surrogacy. Reading Zara Griswold, author of *Surrogacy was the Way* (2006), is instructive. She says she did not have viable eggs because of ovarian cancer and an hysterectomy in her early 20s. She writes that "as a young woman without any female organs, I felt like a freak. I felt empty physically and mentally. I figured I would never find somebody who was willing to marry me" (2006, p. 21). When she met Mike, whom she eventually married, she notes that she "always carried this guilt ... that Mike couldn't have a genetic child because of [her] defect." When she learned that with an egg donor, Mike would be able to have a biological link to a child, she thought, "that would be so awesome" (2006, p. 25). Mike initially did not want to pursue surrogacy, and would have been happy to adopt a child. Zara, however, insisted. She even had an egg donor who had similar physical characteristics as her, so there would be familial resemblance to both intended parents.

For many heterosexual women, such as Zara Griswold who do not have viable eggs, passing on their genes and having a genetically similar child is not possible. Why, then, do they opt for surrogacy and not adoption? Becker (2000) notes that for many of her women interviewees, the inability to produce eggs was mediated by "mourning the loss of being able to see [their] partner in a child" (2000, p. 72). Women consciously or unconsciously feel that having a child who has a genetic connection to the father strengthens marital bonds. Becker argues that "maintaining the biological lineage through a child that is not only biologically related but that visibly resembles the father may reinforce patriarchy" (2000, p. 72). The men in her study who faced infertility, however, did not talk about the importance of seeing themselves in their children. They hoped that through donor insemination, their wives could experience pregnancy.

Becker (2000) suggests that genetic ties are seen as unmediated and pure, thus leading to strong families. Nelkin and Lindee (1995) note that biological determinism is embraced in a new form, genetic essentialism, which "reduces the self to a molecular identity, equating human beings, in all their social, historical, and moral complexity, with their genes" (cited in Becker, 2000, p. 68). Thus, they say that "a biological entity can determine emotional connections and social bonds—that genetics can link people to each other and preserve a reliable model for a family" (Becker, 2000, p. 68).

Many individuals in the United States view children, but especially children with genetic ties to parents, as the bedrock of family. Genetic ties are seen as primordial ones, more authentic and true, and far surpassing the intensity, and therefore quality, of socially mediated ties. It is not that parenthood is not recognized as socially mediated; instead, genetic ties are perceived as leading to a qualitatively better and deeper social bond between parent and child. Thus, for many individuals, becoming parents to genetically similar children becomes a crucially important life event, and the growth of commercially available infertility interventions now makes it possible for infertile and gay individuals to have genetically similar children.

The persons I interviewed, however, were not all adverse to the idea of adoption. In fact, two of the gay couples had attempted adoption. Brad and Martin, a gay couple in their late 20s living in Atlanta, said that they were ready to start a family. They knew adoption agencies would deem them less than ideal parental candidates because they were young and gay. However, they investigated adoption through a private agency, which scrutinized their lives and their home. The fact that they had steps leading up to their home and that they had a boxer dog as a pet did not bode well for the couple: the agency advised them to buy a different home and get rid of their dog if they wanted to adopt.

Jeff and Geoff, a Chicago couple who were together for 18 years, were initially interested in surrogacy in the United States but were priced out of the market. They spent three or four years trying to build their family through adoption. Jeff told me they did not want to go through state adoption agencies because they worried about the intensive home evaluations, which seemed very invasive. Plus, in spite of laws that protect against discrimination, Geoff had heard that many state agency workers tended to discriminate against gay couples. He felt they would rank low on the priority list for adoption. He also worried that because they would be deemed unworthy parents, the agency would place the more difficult children with them. He had heard stories that state agencies remove children from adoptive homes if birth parents reclaim parental rights. Jeff empathized with birth parents and recognized the right of a parent to be reunited with his/her child, but on the other hand, he did not want to cope with such uncertainties when building his own family.

So Jeff and his partner opted for a private agency that would work with gay parents. He said the discouraging thing about these agencies is that "if you have the money you get a child you want very easily." One of their friends had had success through a private agency. After just a month's wait, they had received approval to adopt a child at the cost of \$60,000. Jeff and

Geoff had been assigned as adoptive parents to twin boys, and they were excited. But the birth mother was nowhere to be found when the babies were due. When she finally reemerged, she "had changed her mind."

By chance, one morning in February 2008, Jeff saw a short segment on surrogacy in India on NBC's Today Show. After having watched the segment, he went to his computer and began his research on surrogacy in India. Jeff said, "In two hours I came out and told my husband, that's it. We're going to India." By March 2008, they were in touch with various surrogacy agencies in India. Finally, after being together for over 18 years, Jeff said that he and Geoff embarked on parenthood. They had two daughters, each fathered by one of them, and separated by a month in age. They had used the same Indian egg donor, but two different Indian surrogates at a Mumbai clinic.

Infertility treatment and surrogacy has historically not been available to all individuals. That is, infertility assistance is stratified. Shellee Colen, who first defined the term "stratified reproduction" in 1986, explains that "physical and social reproductive tasks are accomplished differentially according to the inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status that are structured by social, economic, and political forces" (2006, p. 380). The physical, intellectual, and emotional labors involved in pregnancy, childbirth, childcare, and socializing children is differentially experienced, valued, and rewarded, and stratified by race, sexuality, and class. Likewise, fertility assistance is not universally accessible to all persons in the United States. Infertility rates are 6.4 percent for white women and 10.5 percent for African-American women (Parham & Hicks, 2005), yet in the mid-1990s, 27.2 percent of white women used fertility assistance, compared to 12.8 percent of black women (Roberts, 1997). Although women of color experience infertility at higher rates than white women, the latter resort to ARTs more extensively (Wellons et al., 2008; Roberts, 1997; Mundy, 2007). Those most likely to seek fertility services are college educated non-Hispanic white married women with incomes 300 percent above poverty level, with some form of private health insurance (Parham & Hicks, 2005).

The globalization of surrogacy, on the other hand, opens up the possibilities for those who earlier did not have access to genetically similar babies. Among the participants at the workshop on infertility I attended in Dallas, for example, were a Latino–African-American couple from Atlanta, Georgia, and two couples composed of white women married to Indian men. Likewise, interviewees in my research include older gay couples; younger gay couples with limited financial resources, including one African-American gay

couple; and interracial couples, in addition to heterosexual, white couples. There is similar diversity in the various media stories. As a medical technician from San Antonio who had twins through an Indian surrogate observes, “Doctors, accountants, they can afford it, but the rest of us – the teachers, the nurses, the secretaries – we can’t ... unless we go to India” (Gentleman, 2008). Thus, in contradiction to the commonplace belief that surrogacy is a fertility practice pursued by rich white people, transnational surrogacy in India opens the possibilities for a wider range of individuals and couples to have genetically similar children. As Atlanta interviewee Brad said, he and his partner Martin had not built much equity because they were only in their late 20s. Neither had they reached a point in their careers where they were making good earnings. As they had more or less been shut out of adoption, going to India was the easiest option for having a child. They had used an Indian egg donor, and one of the two men’s sperm.

In summary, the literature on infertility management in general and surrogacy in particular is suffused with language of individual anguish, but also hope expressed through market choice. That is, while the pain of infertility is felt at a deeply personal level, where the discovery of being infertile seems to shatter a coherent sense of self (Becker, 2000), individuals seek to recover coherent, adult selves, and “manage” their infertility through various market options.

As individual consumers, they exercise control at every level in the production of their babies. They make decisions about where they will purchase eggs, where they will buy the technical skills needed to make an embryo, and, finally, who will be their surrogate. Thus, a central aspect to surrogacy markets is consumer choice (Spar, 2006; Mundy, 2007). Yet, my research shows that couples using surrogacy services in India do not seem to have as much choice as do those who can afford such services in the United States. In the following section, I will discuss the operation of choice in surrogacy markets, and how ideal choice might be limited for intended parents pursuing transnational surrogacy.

### *Consumer Choice in Selecting Egg Donors*

The first level at which intended parents exercise their consumer choice is in deciding which eggs to use. Mundy (2007) describes a gay couple’s search for eggs that would be fertilized by both their sperm and implanted in a surrogate. The couple chose an agency called A Perfect Match, which specialized in “good-looking, high SAT-type, blue chip Ivy League or

the equivalent egg donors, whose oocytes run \$10,000 and considerably higher” (Mundy, 2007, p. 138). Like the couples who talked with Liza Mundy (2007), many intended parents using surrogates in the United States purchase eggs through donor companies that depend on mostly college-educated women. Most of these college-educated donors receive information about egg donation through ads in local newspapers, specifically campus newspapers. Businesses such as Options National Fertility Registry advertise regularly in 60 campus newspapers. They have operators standing by, fielding questions from young women who may have the right combination of beauty and brains that potential parents demand (Blackley, 2003). Websites of companies dealing with eggs describe donors as being altruistically motivated because they want to make a difference in families’ lives by making a child possible. Yet, the price women donors demand can vary (Hobbs, 2007). The term egg “donation” is a misnomer. While there is no doubt that many women decide to “donate” their eggs to help individuals who cannot produce their own, there is money exchanged. This money, egg donor companies’ claim, is not for the oocytes but is compensation for the women’s time and effort that goes into harvesting their eggs. Yet, even though the production of eggs is not dependent upon the donor’s skills or intellect, not all women are compensated equally for their “effort” or time. Some get \$2,500 for their efforts, while others can command up to \$50,000 depending on their pulchritude, talents, and intelligence quotas assessed through admissions to Ivy League schools.

American intended parents using transnational surrogacy, if unable to use their own eggs, *seem* to have a plethora of choice in picking out their egg donor. They can ship women over from the United States or other parts of the world to India so that eggs may be extracted, or they can use Indian egg donors. Some agencies send an American egg donor (almost always a white woman) to Mumbai, India, where her eggs are harvested. These procedures cost far less in India than in the United States where higher costs result from doctors’ fees and the price of drugs. An advertisement that appeared in the Duke University campus newspaper in February 2009 is an example of such processes:

Proactive Family Solutions program is unique. In addition to monetary compensation, we give our donors a free trip to India where the egg retrieval takes place... . The medical appointments won’t take much time, which means your two weeks in India will be largely a vacation for you. You will have significant time to explore and absorb a fascinating culture as well as shop, tour and enjoy the nightlife. (cited in Darnovsky, 2009)

PlanetHospital presents yet another business model. Dr. Rudy Rupak, president of the company, says that because of the growing demand for white women's eggs, his company flies donors to India from the Republic of Georgia. PlanetHospital's surrogacy package with an Indian donor costs \$32,500; a package with eggs from a Georgian donor costs an additional \$5,000 (Cohen, 2009).

The most economical option is to use Indian egg donors, the choice of all my interviewees who could not use their own eggs. Jennifer Watts explained that while the costs were part of the reason for using an Indian egg donor, she felt that since they had traveled so far, the child's genetic connection to India was one way that she and her husband could sustain a feeling of association to a country they had never known before. Yet, while choosing an Indian egg donor, intended parents do not have access to the same kinds of information as they might about American egg donors. They operate in a market structured by limited information, and thus, the choice of donor eggs for them is not based on calculations of perfect genes as marked by IQ levels of egg donors, schooling levels, admission to Ivy League schools, or even family health histories. In contrast to American donors, most Indian egg donors, all of whom are anonymous, are not highly educated women. Intended parents look at pictures of the women and read general descriptions of health and occupation to decide on a donor. Brad, the late 20s gay intended parent from Atlanta, said his doctor in Mumbai offered to get eggs for him and his partner from white donors in South Africa. The costs were not prohibitive, but he decided to use an Indian egg donor. He was not too worried about choosing an Indian egg donor because college education, in his rationale, did not necessarily mean a high IQ. "After all," he said, "a large number of our H-1Bs who are skilled workers doing computer stuff are Indians. Overall, they come from a good gene pool, and we know that our child will be fine." Jeff, the gay parent from Chicago, told me sheepishly and with much laughter that "All we cared about was if the egg donor was pretty. She was, and we went with it." Thus, with hardly any information on hand, intended parents may choose eggs based on appearances or stereotypes of Indians being computer savvy. Genetic material from such a population, under reduced information circumstances, is deemed a safe bet.

Cynthia Travers had no choice in her egg donor. As an African-American woman, Cynthia had asked for a dark-skinned egg donor, but since her husband was white, the doctor had simply chosen the lightest skinned egg donor to be fertilized with the husband's sperm. Cynthia was not too happy, but the doctor would not explain to her why she had chosen this particular

egg donor. Cynthia now loves her light-skinned son, and is going to use the same egg donor to have her second child with the same surrogate in India.

### *Consumer Choice in Picking Medical Facilities*

But where to prepare the embryo that will eventually be planted into the surrogate's body? Here too, some companies offer their clientele a choice. Tammuz, an infertility tourism company, describes three plans for its clients on its website:

*The "East" Plan* – In this track the embryo is created in India. The eggs can be from an Indian donor or from a donor that arrives to India for the donation. ... The pregnancy and the delivery also take place in India. In a case where the expecting parents have existing embryos and they wish to transfer them to India, we will assist with that process.

*The "West" Plan* – The entire process is conducted in the United States. IVF is performed with an egg donation in the United States; the embryos are then transplanted to a surrogate in the United States; and the entire course of pregnancy, labor and delivery occur in the United States as well.

*The "East-West" Plan* – This plan combines the "East" and "West" Plans. IVF is performed in the United States with a local egg donor; the embryos are then frozen and transferred to India where they are transplanted into a local surrogate; and the entire course of pregnancy, labor, and delivery occur in India as well.

The price tags on these various reproduction plans vary. The "West" plan is estimated to cost anywhere from \$80,000 to \$115,000. The "East" plan costs \$24,500 not including flight charges and tests such as amniocentesis. And, the "East-West" plan, utilizing an American (presumed white?) egg donor costs approximately \$48,000. The price on the "East-West" plan is higher largely because egg retrieval in the United States, which includes fees for the donor, genetic testing, and medical exams, totals up to \$19,000. Tammuz is able to provide these consumer options because it partners with New England Fertility Center in Connecticut and Jaslok Hospital and Research Center in Mumbai.

### *Consumer Choice in Picking Surrogates*

Thus, while eggs might be extracted from the intended mother, from an American college student, from white women in South Africa, or from a woman who travels from the Republic of Georgia, the body that matures

the carefully assembled embryo belongs to an Indian woman. Her intelligence, beauty, and other such ostensibly inheritable characteristics do not matter. Instead, she is a woman who is deemed to be able to carry pregnancies to term easily, and crucially, is willing to submit to the disciplinary regimens of medicine and law that safeguard the interests of the consumer, the intended families.

Dr. Vicken Sahakian, who specializes in infertility, in Los Angeles, says,

If you're looking at beauty or physical features you're not going to find that in the surrogate pool... It's a fact. Most surrogates I come across are not typical donor caliber as far as looks, physical features, or education. Most egg donors are smart young girls doing it for the money to pay for college. Most surrogates are—you know, they need the money; they're at home, with four kids—of a lower socio-economic class. (quoted in Mundy, 2007, p. 133)

Other infertility specialists (Mundy, 2007) interviewed concurred. Gail Taylor, founder of Growing Generations, which is a surrogacy and egg donor agency in Los Angeles, explains that

In a gestational surrogate you're looking at someone who has healthy, uncomplicated pregnancies; that's compliant, agreeable to all of the circumstances that are unfolding; that's a good communicator, and you're like-minded on all the contractual perspectives: what to do about multiple pregnancies, selective reduction, abortion... And then from the genetic part, the egg-donor route, you can have any number of things: you can look at educational level, physical characteristics, ethnic background and history. It's a lot easier ... to divide those two bodies. (in Mundy, 2007, p. 133)

Couples using transnational surrogacy seem to have less choice in picking their surrogates. They are not choosing women so that they can develop relationships with them (Teman, 2010), but instead, are looking for women who are compliant workers. The doctors and other market intermediaries screen potential surrogates for them; all intended parents need to do is choose between one and another Indian woman who will bear their child. For example, Dr. Rama Devi of Hyderabad who runs the “Dr. Rama’s Institute for Fertility” selects all her surrogates according to criteria that she deems important. The surrogate should be no shorter than 1.60 m and should weigh between 50 and 60 kg. She should be married and have her own children. She should have a regular menstrual cycle and be free of sexually transmitted and hereditary diseases. She should also be clear of ovarian problems, be emotionally stable, and should not have parents or grandparents who died young (excluding accidental death). And finally, the surrogate’s skin color “should not be too dark, and [her] appearance should be pleasant.” In addition, Dr. Rama Devi entertains special requests.

For examples, Hindu couples ask for Hindu surrogates; an Indian couple living outside India requested a vegetarian surrogate; western families often insist that their surrogate not smoke or drink alcohol (Schulz, 2008).

Dr. Nayna Patel, who runs the Anand clinic, says that American intended families use her facilities because her surrogates are "free of vices like alcohol, smoking, and drugs" (Gentleman, 2008). Surrogates who work for her must be between 18 and 45 years of age, have at least one child of their own, and be in good medical shape. Michael Bergen and Michael Aki, a gay American couple from Boston, looked at Panama and the Ukraine, but decided on India because they believed it offered "better infrastructure, more high-tech facilities, and the healthier lifestyle. [Most women] don't smoke, they don't drink, and they don't do drugs" (Cohen, 2009). An Israeli gay couple, featured in *The New York Times*, looked for Indian surrogates with high education levels. From the lists of surrogates provided, they rejected a factory worker in favor of a housewife, who they believed would have a less stressful lifestyle and therefore be the better candidate to carry their baby (Gentleman, 2008).

Mark Hoffman said his wife used her own eggs, but they had a choice in surrogates. He and his wife looked for "someone who is attractive. By that I don't mean someone who has nice features, but we looked for someone who took pride in her appearance. Did her clothes appear clean? Was she meticulous in the way she dressed? Was she of a reasonable body weight? We felt that if someone was careful about the way she looked, then most probably she took care of herself, and our baby too would fare well with her." Jeff and Geoff did not have much option in choosing their surrogate; the hospital in Mumbai found their two surrogates, each of whom would be implanted with two sets of embryos, one set developed with Geoff's sperm and the other with Jeff's sperm. However, Jeff had a "hissy fit" (his words) when one of the two surrogates chosen for them was 5 ft tall, and 72 pounds. He knew Indians were a small people, but this, he said in his interview, "was ridiculous." He doubted she would be able to sustain a healthy pregnancy, both for herself and the baby. Finally, they settled on two surrogates who seemed healthy and who had delivered babies within the past two years. He and Geoff believed that such women had good "track records" of healthy pregnancies and babies, and thus would be good surrogates.

So why then do American intended parents go to India? Price seems to be the main factor. The easy availability of fertility drugs at relatively low prices and the lower remunerations for doctors, medical technicians, and nurses who provide the technical labor make surrogacy a remarkably inexpensive option in comparison to the United States. Second, the price of

surrogates' labor and the structure of labor markets reduce the costs of surrogacy. And finally, in addition to the lower costs offered through transnational surrogacy, there are lower nonfinancial transaction costs when dealing with Indian surrogates. In the following section, I describe the labor market in Indian surrogates, and how the operation of market intermediaries makes them a compliant work force.

### **THE CREATION AND MAINTENANCE OF LABOR MARKETS IN SURROGATE MOTHERS**

Bowles and Gintis (1990) observe that in labor market transactions, the contract only guarantees that labor power is sold, but does not guarantee the quality or quantity of labor. Work activity is distinct from this contractual process; the firm owner has to enlist the worker's consent, or utilize subtle forms of coercion to harvest her labor power. Labor exchanges, like most important exchanges in a capitalist economy, "are contested and ... in these exchanges endogenous enforcement gives rise to a well-defined set of power-relations among voluntarily participating agents even in the absence of collusion or other obstacles to perfect competition" (Bowles & Gintis, 1990, p. 167). Endogenous conditions in the employer-laborer relationship engender greater power to employers because they can threaten workers with demotion, or worse, with being laid off.

However, surrogacy contracts are very different from other labor contracts because the worker cannot separate from the contracted product, the baby, for at least nine months. The central problem for intended parents and the medical intermediaries involved becomes one of controlling the quality of work the surrogate puts into gestating the fetus and eventually birthing the baby. One way by which these controls are maintained in the United States is that surrogates are screened out by agencies if their stated motivations for pursuing surrogacy are solely financial. Instead, the primary reason for their becoming surrogates has to be altruism, that is, helping a childless couple complete their families. Women's altruism, however, does not facilitate complete control over the surrogate once she is pregnant. Zara Griswold (2006), for example, despairs when her surrogate began taking evening classes in the first trimester of her pregnancy (2006). The Griswolds felt their surrogate was taking an unnecessary risk by driving 50 minutes each way twice a week in Michigan winter weather. Eventually, their surrogate complied with their wishes and dropped her classes. When their surrogate was 28 weeks pregnant, the Griswolds decided to take a vacation

in Jamaica to cope with the strain the pregnancy was having on them. On the second day of their vacation, the surrogate's doctor called the couple to say that their surrogate's cervix had dilated and thinned, and she would be put on bed rest for the rest of her pregnancy. Griswold writes, "Something that we admitted to nobody else but to each other was that we were both secretly happy she was stuck at home. Mike used to joke with her [the surrogate] that we wished she was in a bubble—although he was only partially kidding" (2006, p. 40).

One big advantage with outsourcing surrogacy to India is greater control over surrogates' actions. Moreover, there may be fewer emotional demands on intended parents. Interactions between intended parents and surrogate mothers are minimal; geographical distance, cultural divides, language limitations, and class differences create barriers between intended parents and surrogates. This can pose problems, but also has advantages. The possibilities for surrogate mothers to engage in "post-contractual opportunistic behavior" (Galbraith, McLachlan, & Swales, 2005), that is, to make demands on intended parents after the baby is born, is minimal. The surrogate has little ability, for example, to demand parental rights over the child; she can ask to be a part of the child's life, but intended parents need not oblige.

On the other hand, intended parents might want to experience the pregnancy vicariously, and having an Indian surrogate limits this possibility. For intended parents, being present for the surrogate's ultrasounds, medical exams, feeling the fetus move in her, and otherwise accessing the embodiment of pregnancy through the surrogate's descriptions can be very important (Teman, 2010). Mark Hoffman said that this was one of the major drawbacks for his wife when they decided upon India. His wife felt that she could not communicate with the surrogate, and otherwise participate in the pregnancy, as she might have done with an American surrogate. The financial savings in hiring an Indian, however, trumped this concern.

Jeff had a different take on nonfinancial transaction costs. He said, "I never in my life imagined I could get pregnant. As a gay man, and having been one for so long, I have no interest in experiencing a pregnancy. All I wanted to do was be a parent, not experience pregnancy." That, he noted, was something that heterosexual couples – specifically intended mothers – felt and wanted, and not gay couples. Working with Indian surrogates minimized interactions between contracting agents, making the whole process easier for Jeff to deal with emotionally. He felt absolved of being present and having to express appropriate emotions at the appropriate times. Given how emotionally fraught the whole process had been for him,

he found it far easier to deal with the whole exchange as solely contractual, with emotions on his part kept to a bare minimum.

Working with Indian surrogates has other nonfinancial benefits, namely, the ability to hire a compliant workforce. Although commercial surrogacy is legal, there are no laws that govern surrogacy in India, which leads commentators to observe that surrogate mothers there have very few rights (Lee, 2009; Rimm, 2009; Rengachary Smerdon, 2008). Some surrogates, such as the women working with Dr. Nayna Patel in Anand, Gujarat, are housed in dormitories and do not live at home. As a result, every aspect of their lives – including how much they eat, what they eat, how much they exercise – is monitored. Women’s working lives as surrogates are structured by surveillance and medical technologies, and the medical staff in whose care they reside can discipline them easily.

Yet commercial surrogacy in India seems to have arisen precisely because of concerns regarding exploitation. Dr. Sulochana Gunasheela, on the team of experts who drafted the National Guidelines for Accreditation, Supervision & Regulation of ART Clinics in India in 2005, which forms the basis of contemporary surrogacy contracts, says that the push for commercial surrogacy in India came about partially to protect surrogates from exploitation (June 2008 interview). In her experience providing infertility services to couples, she observed that cases of altruistic surrogacy in India are deeply oppressive because working class women can be emotionally blackmailed or coerced into carrying fetuses for their employers and others who have greater power and control over their lives. The move toward commercial surrogacy was intended to protect individuals from being compelled to carry fetuses against their will. In addition, individual surrogates acquired the legally recognized means to demand financial remuneration for their considerable labors.

In face of the innumerable critiques of women being exploited, infertility clinics, hospitals, and doctors involved in providing surrogacy point to the fact that there are any number of women who are willing to work as surrogates. The Indian doctor from Mumbai at the surrogacy workshop I attended in Dallas, Texas, noted, “Any time you decide is right for you, we can work with you. At any given time we have at least two or three women ready to be surrogates. You can choose.”

Why do so many women “opt” to become surrogates? Labor market theorists note that labor markets do not arise out of thin air, but are sociopolitical constructions that involve cultural perceptions of what is or what is not work, and the state’s active involvement in keeping labor markets open. Geographer Jamie Peck (1996, pp. 24–40) says there are four processes

involved in getting individuals to participate in labor markets. These are: (1) incorporation of workers into the labor market; (2) allocation of individuals into particular jobs; (3) the control of workers so that their labor may be harvested efficiently; and (4) the reproduction of the work force.

### *Worker Incorporation into Labor Markets*

Popular articles on transnational surrogacy claim that the women who participate in such labor markets are impoverished individuals. This is certainly the case for many surrogates. Sudha, the 25-year-old mother of two in Chennai, for example, works as a maid earning \$20 per month (Cohen, 2009). Yet, it is apparent that not all of these women are poorest of the poor. Almost all have access to computers and email accounts, indications that they have some education and some economic means. Rubina Mondal is a former bank clerk who worked as a surrogate so that she could earn money for her son's medical treatment (Haworth, 2007). She presently runs a home that houses at least 10 surrogates, all working for Dr. Nayna Patel (Dunbar, 2007). Another surrogate, a mother separated from her husband, tells Gentleman (2008) that her monthly wages of approximately \$69 as a midwife were not enough to raise her nine-year-old son. With the \$13,600 she earned as a first time surrogate, she bought a house, and with the second surrogacy contract she will earn \$8,600, which she will use for her son's education. Rekha, interviewed by Fitterman (2009), says that surrogacy is a business venture, which is more lucrative than her old job in a pharmaceutical lab. With the money she earns, her nuclear family consisting of her husband and two children, can move into a better house. She says the hormonal injections hurt, but she is not scared because her family takes care of her. Her children understand what she is doing, and her husband "actually cooks and cleans. The last time, he made lots of chicken" (Fitterman, 2009).

Cohen (2009) argues that cash-strapped middle-class women choose surrogacy as an employment option. She describes the case of a woman in Bangalore whose husband borrowed more than \$30,000 to start a company that failed. Since the couple could not repay the loan, the wife was looking into surrogacy as a work option. Thus, it becomes apparent that the need for cash inflow into the family's coffers is a strong incentive, whether it is to maintain a tenuous middle-class status or to try to fight into the middle class through buying the necessary accoutrements such as consumer goods, a better house, or an education for one's children.

*Allocation of Labor*

Not all women are suitable surrogate material. Hospitals look for women in their 20s and 30s who are married and have children. Legally, India does not allow a woman who has not given birth to a child to work as a surrogate. The belief is that pregnancy and childbirth cannot be comprehended intellectually or through the imagination; only a woman who has undergone pregnancy and childbirth can be truly ready for the labor experience for which she has contracted. In addition, the belief is that if a woman has a child of her own, she is less prone to get emotionally attached to the contracted child. Ideal candidates, according to doctors who work with these women through their pregnancies, are those who have household help through extended families. In addition, they have husbands who are sympathetic so that there are enough finances in the family to support their children, and there are minimal demands for sexual relations (almost all surrogacy contracts specify that surrogates not have sex when under contract and pregnant). Women are also screened, ostensibly to assess psychological readiness and check for emotional stability. Such screening eliminates individuals who might not be good surrogates, because they might not be able to emotionally separate from the fetus they carry for nine months, or they might exhibit “post-contractual opportunistic behavior” (Galbraith et al., 2005), that is, they might make demands on the contracting parents once pregnant.

*Controlling Labor*

In order to have a good surrogate workforce, the manager (in this case, the medical practice that manages the workers for the contracting family) has to subtly coerce or garner the consent of workers. Much of this worker control in surrogacy can be achieved by housing the pregnant surrogates in dormitories where every aspect of their lives is monitored and controlled. However, contrary to the perception presented in popular media, because so much of this attention is on Dr. Nayna Patel’s Akanksha Clinic, a large number of surrogates are *not* housed in such surrogacy dorms. My research shows that many surrogates in cities such as Mumbai, Bangalore, or Chennai live at home with their own families. Such arrangements lessen the financial overhead for infertility clinics, because real estate costs in a city like Mumbai are prohibitive. However, not having women in dorms drastically reduces the hospitals’ abilities to monitor their worker-mothers.

Thus, pre-pregnancy screening of surrogates becomes vitally important. A suitable surrogate is a woman who has "good" worker attributes such as reliability, deference to authority, adaptability, and compliance to invasive medical procedures. There is no guarantee that all women behave in these gender-disciplined ways. Hiring agents use psychological screening to ascertain surrogates' personality type and family circumstances. A woman might opt for surrogacy because her own child is sick and she needs the funds for the child's treatment. Or she might have a tremendous incentive because she wants to ease her husband's debts, and has the "support" of her extended marital family. Or she may be introduced to surrogacy through kinship networks, and as a result, has greater surveillance than someone not similarly connected.

Other surrogates initiate contact with individual families through the Internet, rather than negotiating these contracts through medical practices. One interviewee expressed that she wanted to live in the intended family's home with her one-year-old daughter while she was pregnant. She was in the middle of negotiations with an Indian couple living in Australia. This couple was most appealing because she could live with them in Australia, and therefore be an international traveler, have someone chauffeur her to medical appointments, as well as take care of her dietary and other needs. The added advantage to all this was that no one in her extended family would know her labor choice. While I did not interview the contracting couple, I could well imagine the advantages that might have accrued to them. The surrogate would have her baby in Australia and sign adoption papers there, thus resolving transnational adoption and immigration complications for the intended couple. In addition, they could have some control over the surrogate's life, from what she ate, when and how much she slept, to how much she exercised. In other words, they could effectively monitor her over the period of the pregnancy.

### *Reproducing Labor*

And finally, surrogacy needs to be legitimated as a form of work so that the labor market in surrogates is replenished with new workers. There are numerous media stories about how Indian women are ashamed to be surrogates because their society judges such contractual arrangements harshly. For example, Dr. Nayna Patel says that she has a dormitory to house surrogates because they cannot tell their kinfolk and neighbors how they earn their money. Surrogate Najima Vohra says she comes from a

village 20 miles outside Anand, where Dr. Patel's clinic is located. The locals there, she says, are very traditional: "They think it's dirty – that immoral acts take place to get pregnant... They'd shun my family if they knew." As a result, Najima Vohra, her husband, 12-year-old daughter, and a 7-year-old son have moved to Anand to hide her labor choice. She noted, "We told our neighbors we were coming here for work, which is not strictly a lie" (quoted in Haworth, 2007). On the other hand, many other infertility clinics expect surrogates to stay in their own homes. The Canadian magazine *Chatelaine* carried a photograph of the contracting parents, the Wiles from Arizona, with their Mumbai surrogate Rekha and her husband Prabhakar. Rekha's husband cooks and cleans so that his wife's pregnancy for the contracting couple goes smoothly (Fitterman, 2009). In larger cities such as Mumbai, Delhi, Bangalore, and Chennai, there may be lesser stigma attached to gestational surrogacy and it is increasingly accepted as a legitimate form of work.

It helps that surrogacy is, in spite of the money exchanged, perceived as an act of altruism on both sides. Dr. Kaushal Kadam of Rotunda Hospital, Mumbai, believes, "I really don't think that this is exploiting the women. I feel it is two people who are helping out each other" (quoted in Gentleman, 2008). The intended parents feel they are assisting another woman to fulfill her dreams of achieving a better house, consumer goods, or education for her children. And the surrogate mother feels gratified that she has fulfilled another woman's ostensibly biological, and therefore natural, urge for procreation. In addition to surrogacy being accepted as a labor choice for women, infertility clinics have to actively seek new surrogates to meet their clientele's needs. Hence, they look at their egg donor lists, all maintained in files, as potential surrogates. Recruiting agents also use surrogates' networks – family members, neighbors, or acquaintances – to find new recruits.

## MARKET INTERMEDIARIES

American intended parents pursuing transnational surrogacy use market intermediaries to reduce the emotional and intellectual costs of doing business. How do they know that the oocytes they have purchased are of "good" quality? Can they be guaranteed that medical personnel are following the proper protocols in labeling and storing their sperm? Given that many individuals are unfamiliar with India, will their stays there be comfortable, or will they be challenged by food, language, and finding

suitable living facilities? Will they receive the proper paper work from the hospitals, and will the Indian state give their new family members birth certificates issued in their names? Will their national consulates give their new babies citizenship and passports so that they may all travel together to their home countries? And finally, how are they to trust the surrogate mother to follow through on the contract? Will she take care of herself, so that the fetus is not harmed?

Surrogacy outsourcing firms have the task of controlling the very large number of nonfinancial transaction costs that arise with transnational surrogacy. Firms that have a market advantage are those that have networks with a large number of agencies that traverse large geographical areas, thus giving their consumers a wide range of services while keeping production costs low. The best example of such a firm is PlanetHospital in California. PlanetHospital is a medical tourism company that arranges services for consumers in the United States and the Middle East, to 14 destinations as disparate as Argentina, Brazil, India, Singapore, South Korea, and Belgium. In each of these destinations, PlanetHospital partners with multiple private hospitals, and each destination specializes in specific medical services. The Rotunda Center for Human Reproduction, Mumbai, specializes in fertility (from PlanetHospital's website).

Most firms do not have such wide networks. A more typical example of a transnational surrogacy firm is Surrogacy Abroad, located in Chicago. Samson Benhur, a native of India and the founder of Surrogacy Abroad, investigated various infertility clinics in India before deciding to partner with Dr. Samit Sarkar of Kiran Infertility Clinic in Hyderabad, India. Since it is illegal for him to directly recruit surrogates, Dr. Sarkar works with another agency to locate women from surrounding areas (Shafrir, 2009). Dr. Nayna Patel, who runs the Akanksha Infertility Clinic, not only works with partnering agencies to find surrogates, but she also locates "a nanny, maid, accommodations, money exchange ... whatever you need or want" (from discussion website on Dr. Nayna Patel's services).

Transnational surrogacy agencies provide legal services so that the baby born in India to an Indian woman has the documents, such as an American passport, to "go back home." Although commercial surrogacy is legal in India, there are no laws that regulate the operation of the various hospitals and clinics. In addition to negotiating multiple nation-state adoption laws and immigration laws to travel with their newborns, intended parents face legal ambiguity regarding their parental rights. Horror stories arise because of the legal imprecision surrounding surrogacy. As a result, surrogacy agencies work closely with law firms. An example of a legal firm is the

Indian Surrogacy Law Center, which advertises its work with Australian, American, and British families. This firm is located in India and can help find surrogates, eggs, and hospital services. It covers all legal aspects, from drawing contracts with all parties concerned to preparing travel documents for babies once they are born (from Indian Surrogacy Law Center website).

In spite of their extensive advertising, my interviews show that surrogacy agencies do not always assuage clients' anxieties. Jeff said that if he had a choice, he would have pursued surrogacy in the United States, but they simply could not afford it. To do something like they'd done in India – where both men had a baby each, borne by a different surrogate, but genetically tied to each of them – would easily cost them \$180,000. Jeff said, “The problem with India was that information was so hard to come by. In the U.S. you can call the doctors, and they're willing to talk with you. Information is thrown at you over here.” On the other hand, in India, he added, “you have to be on it constantly. The logistics of getting everything in order was quite a nightmare, and though successful, the whole process was incredibly stressful.” To pursue surrogacy in India, he said, “it takes a certain leap of faith.”

But these surrogacy agencies do control nonfinancial transactions. Galbraith et al. (2005) argue that the largest transaction costs in surrogacy involve surrogate mothers, including search costs, incomplete contracts, and moral hazards (Galbraith et al., 2005). Search costs refer to the time and effort spent in looking for a suitable surrogate who does not drink or smoke or engage in sex while pregnant and under contract. Incomplete contracts refer to problems that arise if the surrogate were to miscarry, abort the fetus, or insist on keeping the newborn. In such cases, contracts become difficult to enforce and long-drawn court battles can ensue. Moral hazards refer to the “post-contractual opportunistic behavior” (Galbraith et al., 2005, p. 14) exhibited by the surrogate. Once she is pregnant with the intended parents' fetus, she has greater bargaining power. She could make demands on the intended parents, who might feel morally obligated or emotionally blackmailed into meeting the surrogate's demands. Galbraith et al. (2005, pp. 17–18) say that surrogate mothers too face similar sorts of nonfinancial transaction costs. The intended parents could pay her far less than contracted for, once she is pregnant or has delivered the child. They could also renege on the contract, leaving the surrogate with the baby.

Indian surrogates who work for American intended couples find their everyday lives regulated in a variety of ways through various market intermediaries. Recruiting agents, the medical personnel who provide prenatal care, and finally the lawyers who draw up contracts – three

different market intermediaries – structure their working conditions. They may still make demands on intended parents after the baby is born, but these demands can be controlled by intended parents, various interviewees told me, by keeping interactions to the barest minimum as stipulated by contract. And given the wide gulf of differences in privilege, intended parents have far greater control in mediating interactions with Indian surrogates than they might with American surrogates.

## CONCLUSION

In this chapter, I have described the emergence of consumer and labor markets in surrogacy in India. A consumer market in surrogacy is built on idealized notions of family with genetically similar children. Both heterosexual and gay couples seek access to biological children because these kinds of children are seen as legitimizing, solidifying, and otherwise giving meaning to their intimate relationships. While research on stratified reproduction shows that inequalities based on hierarchies of class, race, ethnicity, gender, and sexuality limit couples' abilities to form families with children, surrogacy in India opens new possibilities for couples who were otherwise shut out. Gay men, solidly middle-class heterosexual couples, and individuals with lesser financial means are now able to have genetic children, who stand as markers for authentic family.

Similarly, a labor market in surrogate mothers is structured around gender ideologies that assist with building an inexpensive, compliant labor force in surrogates in India, which is helping that nation emerge as a global site for surrogacy tourism. Women willingly submit to the disciplinary regimes of the surrogacy labor market because of how labor markets in surrogates are structured in India. Labor markets are sociopolitical constructions that involve cultural perceptions of what is or what is not work, and the state's active involvement in creating labor markets and keeping them open. The state creates this labor market by legalizing commercial surrogacy and drawing guidelines and other regulations to facilitate the operation of transnational surrogacy in India. The incorporation of women into the labor market, their allocation into gendered/sexualized jobs, and the control of surrogates so that their labor may be exploited efficiently structure not just the working conditions of surrogate mothers but also foster women's continuous recruitment into the surrogacy workforce.

But how do American consumers, that is, intended parents, access workers in India? I show that market intermediaries mediate such access.

These market intermediaries put consumers in touch with hospitals and infertility specialists, and hire surrogates who will contract with Americans. These market intermediaries are central to controlling and building compliance among surrogate mothers.

Much of the literature on surrogacy describes the wide choice that is available to intended parents who discriminately select among a variety of egg donors, medical facilities, and surrogate mothers. However, my research shows a surprisingly limited choice available to individuals using transnational surrogacy. Then why opt for surrogacy in India? Low financial costs and low interaction costs figure largely in decision-making processes among American intended parents. Surrogacy expenses are lower because of the low wages commanded by Indian doctors and nurses, and also, crucially, because of the lower wages earned by Indian surrogates. But in addition to lower expenses, working with Indian surrogates can potentially mean lower nonfinancial transaction costs for intended parents. Because of how contracts are drawn, these women have far fewer worker rights in comparison to American surrogates. In addition, outside of the contractual agreement, the wide discrepancies in class and privilege accrue interaction benefits to intended parents. Intended parents control when conversations can happen and what topics can be discussed. And finally, market intermediaries, which are surrogate-recruiting agencies, medical facilities, and law firms, are able to control post-contractual opportunistic behavior on the part of surrogates and reduce nonfinancial costs to intended parents.

My work shows that while the language of choice permeates surrogacy on both the part of intended parents and among surrogate mothers, this choice is deeply mediated. While American intended parents no doubt “choose” to hire women to bear and birth “their” children halfway across the world, I show how the structures of feelings – the centrality of children to marking successful relationships, ideologies of genetic resemblance among parents and offspring – shape that choice. Likewise, some Indian women “choose” to be hired as surrogates. This choice, as my work shows, is mediated by notions of ideal motherhood. Women choose to become surrogates so that they may provide their legitimate offspring, borne in legally recognized marriages, the accoutrements of middle-class lives. My work shows that the emergence and maintenance of consumer and labor markets that form the global organization of surrogacy are deeply gendered processes, building from while simultaneously bolstering normative families and gender ideologies.

## NOTE

1. A common practice in surrogacy is to use third person donor eggs, instead of surrogates' eggs. Part of the reasoning is that women who "donate" eggs are seen as a different type than are women who hire out as surrogates (more on that in a subsequent section). But crucially, the surrogate has far fewer legal rights over the newborn if she has no genetic connection to the baby.

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## REFERENCES

- Becker, G. (2000). *The elusive embryo: How women and men approach new reproductive technologies*. Berkeley, CA: University of California Press.
- Bharadwaj, A. (2002). Conception politics: Medical egos, media spotlights, and the context of test-tube and firsts in India. In: M. C. Inhorn & F. van Balen (Eds.), *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies* (pp. 315–334). Berkeley, CA: University of California Press.
- Blackley, M. (2003). Eggs for sale: The latest controversy in reproductive technology. *USA Today, Society for the Advancement of Education*, July 2003, p. 56.
- Bowles, S., & Gintis, H. (1990). Contested exchange: New microfoundations for the political economy of capitalism. *Politics and Society*, 18, 165–222.
- Cohen, M. (2009). A search for a surrogate leads to India. *The Wall Street Journal*, October 9, 2009.
- Colen, S. (2006). Like a mother to them: Stratified reproduction and West Indian childcare workers and employers in New York. In: E. Lewin (Ed.), *Feminist anthropology: A reader* (pp. 380–396). Oxford: Blackwell Publishing.
- Darnovsky, M. (2009). Travel to exotic lands: Sell your eggs. *Biopolitical Times*, June 30, 2009.
- Dasgupta, S., & Das Dasgupta, S. (Forthcoming). Motherhood jeopardized: Reproductive technologies in Indian communities. In: J. Maher & W. Chavkin (Eds.), *Globalization of motherhood: Deconstructions and reconstructions of biology and care* (pp. 131–153). London: Routledge.
- Dunbar, P. (2007). Wombs for rent: Childless British couples pay Indian women to carry their babies. *MailOnline*, December 8, 2007.

- Fitterman, L. (2009). Surrogacy in India. *Chatelaine*, March 30, 2009.
- Franklin, S. (1997). *Embodied progress: A cultural account of assisted conception*. London: Routledge.
- Galbraith, M., McLachlan, H. V., & Swales, J. K. (2005). Commercial agencies and surrogate motherhood: A transaction cost approach. *Health Care Analysis*, 25, 11–31.
- Gentleman, A. (2008). India nurtures business of surrogate motherhood. *The New York Times*, March 10, 2008.
- Ginsburg, F., & Rapp, R. (Eds.). (1995). *Conceiving the new world order: The global politics of reproduction*. Berkeley, CA: University of California Press.
- Griswold, Z. (2006). *Surrogacy was the way: Twenty intended mothers tell their stories*. Gurnee, IL: Nightengale Press.
- Haworth, A. (2007). Surrogate mothers: Wombs for rent. *Marie Claire*.
- Hobbs, P. (2007). Miracles of love: The use of metaphor in egg donor ads. *Journal of Sociolinguistics*, 11, 24–52.
- Hochschild, A. (2009). Childbirth at the global crossroads. *The American Prospect*, October 2009.
- Ikemoto, L. (2009). Eggs as capital: Human egg procurement in the fertility industry and the stem cell research enterprise. *Signs*, 34, 763–781.
- Inhorn, M. (2003). *Local babies, global science: Gender, religion, and in-vitro fertilization in Egypt*. New York: Routledge.
- Inhorn, M. (Ed.) (2007). *Reproductive disruptions: Gender technology, and biopolitics in the new millennium*. New York: Berghahn Books.
- Inhorn, M., & van Balen, F. (Eds.). (2002). *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies*. Berkeley, CA: University of California Press.
- Lee, R. (2009). New trends in global outsourcing of commercial surrogacy: A call for regulation. *Hastings Women's Law Journal*, Summer, 275–300.
- Lewin, E. (2009). *Gay fatherhood: Narratives of family and citizenship in America*. Chicago, IL: University of Chicago Press.
- Mahmood, S. (2005). *Politics of piety: The Islamic revival and the feminist subject*. Princeton, NJ: Princeton University Press.
- Mamo, L. (2007). *Queering reproduction: Achieving pregnancy in the age of technoscience*. Durham, NC: Duke University Press.
- Markens, S. (2007). *Surrogate motherhood and the politics of reproduction*. Berkeley, CA: University of California Press.
- Mundy, L. (2007). *Everything conceivable: How assisted reproduction is changing men, women, and the world*. New York: Alfred A. Knopf.
- Nelkin, D., & Lindee, S. (1995). *The DNA mystique: The gene as a cultural icon*. New York: Freeman Press.
- Pande, A. (2009). It may be her eggs, but it's my blood: Surrogates and everyday forms of kinship in India. *Qualitative Sociology*, 32, 379–397.
- Parham, G. P., & Hicks, M. L. (2005). Racial disparities affecting the reproductive health of African American women. *The Medical Clinics of North America*, 89, 935–943.
- Peck, J. (1996). *Work-place: The social regulation of labor markets*. New York: Guilford Press.
- Ragone, H. (1994). *Surrogate motherhood: Conception in the heart*. Boulder, CO: Westview Press.

- Ragone, H. (1998). Incontestable motivations. In: S. Franklin & H. Ragone (Eds), *Reproducing reproduction: Kinship, power, and technological innovation* (pp. 118–131). Philadelphia: University of Pennsylvania Press.
- Rapp, R. (1999). *Testing women, testing the fetus: The social impact of amniocentesis in America*. New York: Routledge.
- Rengachary Smerdon, U. (2008). Crossing bodies, crossing borders: International surrogacy between the United States and India. *Cumberland Law Review*, 30, 15–85.
- Rimm, J. (2009). Booming baby business: Regulating commercial surrogacy in India. *University of Pennsylvania Journal of International Law*, 30, 1429–1462.
- Roberts, D. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty*. New York: Vintage Books.
- Schulz, S. (2008). The life factory: In India, surrogacy has become a global business. *Spiegel Online International*, September 25, 2008.
- Sehgal, P. (2008). Reproductive tourism in India: Adoption and surrogacy laws have yet to catch up, October 7. Available at [http://thewip.net/contributors/2008/10/reproductive\\_tourism\\_soars\\_in.html](http://thewip.net/contributors/2008/10/reproductive_tourism_soars_in.html). Accessed on July 27, 2010.
- Shafir, D. (2009). Outsourcing pregnancy. *The Daily Beast*, October 11, 2009.
- Spar, D. (2006). *The baby business: How science, money, and politics drive the commerce of conception*. Boston, MA: Harvard Business School Press.
- Subramaniam, B., & Roy, D. (2010). New materialism and the practices of colonialism: Technologies of surrogacy in India. Paper presented at the STS South Asia Conference, May 14, 2010.
- Teman, E. (2010). *Birthing a mother: The surrogate body and the pregnant self*. Berkeley, CA: University of California Press.
- Wellons, M. F., Lewis, C. E., Schwartz, S. M., Gunderson, E. P., Schreiner, P. J., Sternfeld, B., et al. (2008). Racial differences in self-reported infertility and risk factors for infertility in a cohort of black and white women: The CARDIA Women's Study. *Fertility and Sterility*, 90, 1640–1648.

### WEBSITES ACCESSED:

- Indian Surrogacy Law Center. Available at <http://indiansurrogacylaw.com/>. Accessed on November 20, 2009.
- PlanetHospital. Available at <http://www.planethospital.com>. Last accessed on November 17, 2009.
- Dr. Nayna Patel's services. Available at <http://www.phpbbplanet.com/surrogacyindiaf/view-topic.php?t=9&sid=39eb6161799fd4bbb6ab5260868de304&mforum=surrogacyindiaf>. Accessed on November 17, 2009.
- Tammuz International Surrogacy. Available at <http://www.tammuz.com/main.php?lang=eng>. Last accessed on November 15, 2009.

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4. Susan Markens. 2012. The global reproductive health market: U.S. media framings and public discourses about transnational surrogacy. *Social Science & Medicine* 74, 1745-1753. [[CrossRef](#)]
5. Marcia C. Inhorn, Zeynep B. Gürtin. 2011. Cross-border reproductive care: a future research agenda. *Reproductive BioMedicine Online* 23, 665-676. [[CrossRef](#)]