Indian Transnational Surrogacy and the Disaggregation of Mothering Work

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Transnational commercial surrogacy in India is a small but growing phenomenon that is attracting media attention as part of a larger popular interest in surrogacy in the United States and elsewhere. The technologies and medical knowledge that allow for surrogacy have been in use since the 1970s, but only recently has there been any talk of a "surrogacy industry." The number of assisted reproduction technology (ART) clinics in India is growing but is still relatively small. The doctors at the Akanksha clinic in Anand, Gujarat, where I did fieldwork in early 2008, were aware of a handful of other clinics in Chennai, Mumbai and nearby Ahmedabad. Though the first known successful surrogacy for foreign clients did not occur until 2004, the path for this industry was prepared by already-existing infrastructures of transportation and communication networks, neoliberal economic discourse promoting outsourcing (and highlighting the cheapness of Indian labor), and epistemologies of the body and kinship as they have been influenced by Western science and medicine. The enabling conditions for transnational surrogacy occur in a context of contested cultural domains, where competing claims about the meaning of parenthood, the value of mothering and of the child, and the moral and ethical implications of reproductive technologies have to vie for traction.

The case of Indian transnational surrogacy is quite different from surrogacy within the US for reasons of culture, government regulations and legal structures. Since it caters to clients from wealthier nations, transnational Indian surrogacy requires us to attend to the political-economics of the global division of reproductive labor. When a person from the US hires an Indian woman to carry a child by in vitro fertilization (IVF) commercially, on one level it is an exchange of services for payment. On another, the surrogate mother is doing work that enhances and actually reproduces the life of that person or family, and as such she is contributing to the enrichment and longevity of the US economy and society. For the women working as surrogates that I interviewed at the Akanksha clinic, surrogacy also requires the reconceptualization of their bodies and their relationship to childbirth.

The Surrogacy Process

The Akanksha clinic started out as an obstetrics and gynecology clinic that offered IVF, where embryos created outside of the body are transferred to a woman's womb for gestation. After the clinic's first successful surrogacy case in 2004 and the resultant media coverage, demand led the clinic to first hire recruited surrogates, and then later self-referred surrogates. Naina Patel, director of the clinic, matches international clients with surrogate mothers based on a variety of factors including the age of gestational and biological mothers. When the client herself does not have viable eggs, eggs from Indian donors are used, and this particular clinic stipulates that the surrogate and the donor must be separate individuals. This policy is meant to insure that the surrogate mother has no genetic claim to the child and to discourage emotional attachment to the child after it is born.

After an initial interview, there is usually little contact between surrogate mothers and intended parents. The relationship between the intended parents and surrogate mother is almost always completely mediated by the clinic staff. US clients with whom I spoke about this practice noted that the doctors explained to them that this arrangement was in their best interest, as the surrogates almost never speak English, and the clients rarely speak Hindi or Gujarati. When the clients do speak one of these Indian languages, such as with non-resident Indian clients, there can be long-distance phone communication. For the most part, however, such communication is limited, leaving little opportunity for emotional bonding.

Surrogate mothers are highly encouraged to live in designated hostels near the clinic where they can rest instead of working and providing care to their families. This also allows for unimpeded surveillance by clinic staff. Their families visit them in the hostels from homes outside the town of Anand. The two hostels offer computer, English language and sewing courses, and have a cook who prepares food for the women. Counseling is available from the hostel manager, who is a former surrogate herself, as well as from other clinic staff who have been surrogates. Surrogates receive a fee of roughly six thousand dollars, which can be the equivalent of up to nine years of their regular family income from their own or their husbands' manual labor. The overall surrogacy process at this clinic costs clients about twenty thousand dollars, in comparison to the roughly one hundred thousand it costs in the US.

Most of the clients who come to India to hire surrogates, and all of the clients at the Akansksha clinic, are heterosexual couples where the intended mother cannot carry a fetus to term herself. In this sense the clients require a surrogate mother in order to create a child based on their own (complete or partial) genetic material. Some of the clients' home countries do not allow surrogacy or only allow it under limited circumstances, such as in non-commercial arrangements. Others come to India because they cannot or do not wish to pay the substantially higher cost for surrogacy in their home countries. In this way, ARTs simultaneously create the possibility of a biological child for couples who do not have the ability to produce one on their own, and demand for surrogate mothers.

COMMENTARY

The Uterus as a Spare Room

When working as a surrogate becomes an option in a specific area of India, women from that region who see surrogacy as an opportunity to establish economic security approach reproductive clinics. Women interested in working as surrogates—most often day-laborers from rural communities with a middle school- or high school-equivalent education—arrive for an interview with clinic staff who give them a basic understanding of IVF. This is meant to help them both to understand that surrogacy does not involve their bodies sexually, and also to encourage them to emotionally distance themselves from the fetus and the child they will deliver. Through counseling and conversation, medical personnel encourage surrogates to see themselves as gestation-providers whose only link to the fetus is the renting of a womb imagined as an empty and otherwise unproductive space. This formulation of surrogacy and pregnancy makes possible the commodification of the womb and the disaggregation of the work of mothering into distinct affective and biological components—necessary conditions for the transnational distribution of this work.

The analogy most surrogates use to explain what they are doing is that the womb is like a spare room in a home, where someone else's baby will stay and grow. The baby is a guest—separable from rather than part of the woman's whole body, and thus distinct from the surrogate as a subject. The relationship each woman develops with her womb and the fetus it supports is thus (at least partially) constructed from conceptions of the body and self promoted by medical staff, and linked to the ways in which Western medical culture makes sense of kinship through ART. Notions of kinship deriving from these technologies are actively taught to the surrogates at the clinic to a degree that surrogate mothers eventually seem to accept these notions, at

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Subject Categories as They Impact Care

Care at HMB is structured such that both women in labor and those suffering from pregnancy loss are admitted and looked after side by side. HMB users are not addressed by name but rather as *Mãe* (Mother)—a term even used by health professionals to address women treated for incomplete miscarriage or abortion, whom they also refer to as "*curetas*" (literally, the surgical instrument used for performing a curettage). The management of care obeys temporal and spatial criteria and serves to mark each category. Unless a woman's life is at risk, priority is given to those in labor, so doctors wait until late afternoon before carrying out curettages "as if they [the women seeking treatment] were *restos*" (the organic material scraped from the womb during the procedure), as one nurse commented to us. Afterward, when not sent to one of the wards where mothers and babies recover and await discharge, these patients are sent to a ward referred to as the *infectados* (infected ones)—a label inherited from pre-misoprostol days, when insecure abortions led to high rates of infection. Thus, in this context ostensibly dedicated to fostering motherhood, successful reproductive subjects are constantly juxtaposed with women who have lost a pregnancy.

Differences between the categories of successful and failed reproductive subjects are repeatedly highlighted, often to the latter's detriment and discomfort. For example, visitors to new mothers look curiously at neighboring beds. We sometimes heard them innocently ask such women "Where is your baby?" Women categorized as failed reproductive subjects are often further labeled to distinguish those seen as *suffering* from miscarriage from those seen as *perpetrating* abortion. Co-internees branded one young woman, who had just suffered a dramatic miscarriage, as a practitioner of abortion. "You took something," they said, "You are too young, you provoked it." Moreover, such an inferior status is reinforced not just by such questions or accusations, but also in the standard day-to-day language used by hospital staff, or in the internal dialogues of the women themselves. "I thought it natural they care for the mothers first," one interviewee told us, after she had awaited admission all day, though bleeding and feverish. In short, the net effect of care—in its structural, practical, linguistic and psychological aspects—is to place all such women in a category of "anti-mother," in contrast to the legitimate "mother" status afforded to the majority of the maternity hospital's users.

These symbolic processes reflect the wider political sphere. Most Brazilians support the continued criminalization of abortion, despite its widespread prevalence. Today, six years after the research reported here, attitudes have hardened and the public debate over abortion has become more acrimonious and visible. On one side the feminist movement supports the right to abortion; on the other, religious groups oppose that right. The latter exert powerful influence in Congress, obstructing initiatives to change the law. Although during the past five years the Ministry of Health has taken a number of actions, such as recognizing that current

> [H]ealth professionals at HMB tend to treat most admissions for pregnancy loss as suspicious... Some make condemnatory comments or even directly accuse the women of "doing this to your baby."

abortion policies and practices in Brazil generate a serious public health problem and publishing a "Norm for the Humanized Care of *Abortamento*," directed at health professionals, care in such facilities as HMB has not improved in any significant way. On the contrary, in a number of Brazilian cities, among them Salvador, there are reports that some health professionals have begun to report women who seek help at a public facility with suspected incomplete abortion to the police. In this way, such health professionals render even more traumatic these women's experiences of public healthcare, worsen the risk of an increase in already unacceptably high maternal mortality rates, and reinforce the gender stereotypes that structure their practice.

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told me that bearing a child for another person or couple was the single most important thing they had ever done with their lives—their pinnacle achievement, their life's "best work." This is remarkable considering that each surrogate I interviewed had previously given birth to her own children. Although the monetary compensation they received was valued, they described it as paling in comparison to the awesome sense of importance they felt in carrying and delivering another person's child into the world. Ultimately, not having a genetic link to the babies they carry to term is the factor that enables surrogates to emotionally distance themselves from them, with genetic continuity and an original intent to parent overriding nine months of intimate contact.

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Surrogacy

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least as far as they allow them to go through with surrogacy.

ARTs have made it possible to disaggregate the work of motherhood into (1) the provision of an ovum and gestation a fetus, and (2) the work and care of child-rearing and what Charis Thomson calls "procreative intent," and then to differentially-value these kinds of labor and distribute them across class and national lines. At the same time, however, a number of surrogates describe expectations of future responsibility on the part of the client to the surrogate and her family that lie outside the surrogate's fees and correspond to local notions of familial duty, implying that their acceptance of the logic put forward by medical staff is far from complete, and their understanding of mothering work as disaggregated may not be absolute.

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