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Critical Conceptions: Technology, Justice, and the Global Reproductive Market

Medicine, Markets and the Pregnant Body: Indian Commercial Surrogacy and Reproductive Labor in a Transnational Frame

Kalindi Vora

Transnational commercial surrogacy in India is a small but growing industry attracting media attention as part of a larger popular interest in surrogacy in the U.S. and elsewhere. The doctors at the clinic in northern India where I did fieldwork in early 2008 were aware of a handful of other clinics in the Indian cities of Chennai, Mumbai, Hyderabad, and Ahmedabad. The path for this industry was paved by already-existing infrastructures of transportation and communication, discourses about outsourcing and the cheapness of Indian labor, and epistemologies of the body and kinship as they have been influenced by Western science and medicine. These conditions of possibility are interwoven with the continued development of biotechnologies of human reproduction in ways that increase the choices of those with access to these technologies. For women implicated in new technologies through the biological materials or labor they provide, for example through the roles of egg donor or gestational surrogate, advances in reproductive technologies can increase the range of income options while simultaneously compromising the desirability of these options. The enabling conditions for transnational surrogacy occur in a context of contested cultural domains, where multiple understandings of the significance and social meaning of reproductive technologies have to vie for traction. By tracing some of these understandings, this article considers how transnational Indian surrogacy reflects aspects of the privatization and commodification of reproduction and reproductive labor. This article also addresses how commercial surrogacy, in the eyes of some participants, operates within economies of altruism that re-signify the meaning of the act of surrogacy and the social relations it entails.

Scholarship on assisted reproduction in India suggests that for the middle class elites who can afford them, assisted reproductive technologies can reduce the social stigma for otherwise childless married women and help provide old-age security for couples who have been unable to have children in other ways.[1] There is evidence that the reach of these technologies is expanding,[2] but the economic constraints on women who become surrogate mothers means that women in their own social and economic strata are not candidates for the potential benefit of these technologies themselves,[3] and it therefore serves as another example of "stratified reproduction."[5]

In early 2008, I observed and interviewed doctors, lab technicians, clinic staff, commissioning parents who were in the process of having a child through a surrogate, and women working as

surrogates at the Manushi fertility clinic in northern India.[5] In the tradition of medical anthropology, I approached the clinic as a contact zone where unique interactions and relationships occur, and these constitute the center of my study. In the tradition of both subaltern historiographies and feminist methodologies, I aim to point to possibilities in the subject positions of those from whom I learned during fieldwork without representing this knowledge as anything but a particular reading produced from my context as a scholar based in the U.S..

After outlining the surrogacy process at the Manushi clinic, I will look at how commercial surrogacy in India relies on a Western medical understanding of the body that constructs the uterus as surplus, and a genetics-based model of parentage that creates a connection between the intended parents and fetus, and a distance between the surrogate and the guest-fetus. I then look at discourses of altruism in the clinic that contain understandings of the act of surrogacy and the clinic's surrogacy practice that exceed or supplant this medical discourse and the associated alienation and commodification of gestation. I look specifically at how the clinic portrays surrogacy as a form of social work, emphasizing the ways that fees paid to surrogates through the clinic materially improve their lives rather than serving only as wages and profit to the clinic, and the ways that the understanding of the divine nature of the act of surrogacy provides another narrative of the meaning and value of commercial surrogacy outside of market logic. I will conclude by briefly addressing what the co-existence of these different ways of making meaning about surrogacy suggest about the roles played by transnational Indian surrogacy and the fertility clinic in decolonizing and neoliberalizing contemporary India.

II. Biogenetic Parenthood and the Work of Surrogacy

Hanging on the wall of the director's office in the small but growing Manushi clinic is a multi-media work commissioned by the clinic's director. A line of soft abstract shapes representing the salwar chemise-clad pregnant bodies and covered heads of six women arcs around a central and taller abstracted female figure dressed in white. A group of staff explained to me that the central figure in white represents the director, Dr. Bhakta, herself. Her arms are outstretched to draw in the group of women, whose most distinguishing features are their exaggerated wombs, marked as embossed circles with a centered fetal-imprint pressed into the plastic material of their bodily forms. According to one staff member, the piece is meant to portray the director's vision of the clinic's surrogacy practice as a form of altruism and care for the women who become commercial surrogates, and the image is a way to signpost this vision to commissioning parents who visit the clinic. The image also represents the pregnant body as imagined through the discourse of the medicalized body, where the uterus is an empty and un-utilized space. The artistic representation draws attention to the central importance of the once-empty uterus. Now filled, the womb marks the service being performed by the surrogates and reflects the primary way that the clinic encourages both potential and active surrogates to approach gestational surrogacy as a service.

Reproductive technologies and associated medical discourse were developed primarily in advanced capitalist countries and have since traveled to India, and with them come the co-constituting Euro-American notions of kinship as biogenetically based.[6] One of the outcomes of the way that medical discourse about reproductive technologies, through this linking of kinship and biogenetics, distances actual individualized bodies from the biology of reproduction, is that it creates a framework for commissioning parents, doctors, and surrogates to imagine the act of gestating a child as a paid occupation in which a service (gestation and childbirth) is exchanged for a fee. The exchange is not limited to these terms, but the way that medical discourse isolates the reproductive body and gametes from the social context in which they originated allows for gestational surrogacy to be conceived of as a form of paid work or service

by participants.

Most of the women who come to the Manushi clinic come from at least an hour's bus ride away, and generally find out about the opportunity through friends or family. According to the clinic's guidelines, a potential surrogate must be married with at least one child and have permission from her husband to be eligible. Once pregnant, surrogates are highly encouraged to live in designated housing near the clinic where they can rest instead of working and providing care to their families. This arrangement also allows for surveillance by clinic staff. Their husbands, sometimes accompanied by children, come to visit them in these hostels during the weekends. Most surrogates hide their participation from extended family and sometimes even their own children because of the associated stigma.

The overall surrogacy process at this clinic costs clients roughly twenty thousand dollars, depending on whether or not they use donor eggs and how many *in vitro* fertilization cycles are necessary to accomplish a pregnancy. The clinic mandates that embryos be created using either the intended mother's ova or those of a donor, but never those of the gestational surrogate. Egg donors and surrogates are selected by the director rather than by the commissioning parents. After an initial interview, there is usually little contact between surrogate mothers and intended parents. The relationship between the intended parents and their surrogate is almost always completely mediated by the clinic staff. Clients who come to this clinic from abroad to hire surrogates cite a number of reasons for their decision, including the desire for a child who shares genetic material with one or both parents, the comparatively high cost and administrative complexity of domestic and international adoption, and because, in some cases, the clients' home countries do not allow surrogacy or only allow it under limited circumstances such as in non-commercial arrangements. The Manushi clinic only accepts client couples for surrogacy when they are heterosexual, and when the woman cannot physically support a pregnancy herself. The clinic has suspended this first rule in the case of a small number of male single-parent clients, and it is conceivable that these individuals might be part of non-heterosexual family formations. The latter rule is meant to insure that the clinic is only arranging surrogacy when it is 'medically necessary' and to prevent clients from using surrogates to avoid pregnancy.

Many non-Indian commissioning parents expressed a feeling of obligation to their surrogates beyond the portion of their fee that was intended for the surrogate, usually between five and seven thousand dollars. By giving gifts during pregnancy or additional gift monies after delivery, these parents both assuage the uncertainty and sometimes guilt they may feel about potentially exploiting the surrogates, and allow themselves to feel that they are improving the lives of the surrogates. While some intended parents write to their surrogates and send email correspondence and photos of the infant in the first year, most of the surrogates said they do not hear from their former clients very frequently. The clients I spoke to tended to express a feeling of connection to "India" rather than to individual women, some mentioning that they would inform their children of the circumstances of their birth or that they hoped to bring the child to India someday to see where it was born, but not necessarily to visit the clinic or surrogate. The sense of duty described by clients operates both with and against the commodity nature of their exchange. While gifts to their surrogates are not required, they are sometimes described as compensating for the relatively low fees paid to surrogates. To an extent, commissioning parents may thus feel a personal obligation to pay their surrogate something more than the market rate, but for those to whom I spoke who were still in the middle of the surrogacy process, they imagined that the stronger association would ultimately be with the homeland of the surrogate, not the woman herself.

Through counseling and conversations with doctors, a surrogate is encouraged to think of her womb as a space she can rent out; the analogy many surrogates spoke of is that the womb is like a spare room in a home, where someone else's baby will stay and grow. One of the doctors at the clinic described the approach of clinic staff this way:

> "[We] try to explain to them that what you are doing, you are doing for someone else, whatever money or gifts they give you. The emotional attachment is going to be there, but they understand one thing, even if they are not educated that much, which is that we have to give the child back to the parents. That's one of the most important things, and we haven't had any case otherwise."

In discussing the anticipation of parting with the infant upon its birth, a number of the women working as surrogates explained independently that since the baby wouldn't look like her, she wouldn't feel a bond with it. This explanation is used by doctors to guide surrogates in thinking of the child as not their own. Despite this coaching and the understanding that the babies are not theirs, women who had already delivered did say they missed the infants after they left India and hoped to hear about their development, receive pictures of the children, and maintain a connection to these families.

The prominent narrative of the distance between a gestational surrogate and the eventual infant she will deliver as an inevitable result of the genetic distance between the two is a product of a Western medical discourse of the body and biogenetics of parenthood. Emily Martin has observed the ways that the medical gaze, particularly as administered through visual technologies like ultrasonography, enforces the Cartesian mind/body dualism and alienates pregnant women from the process of being pregnant. She has elaborated this as the obstetrician becoming a "mechanic" and the pregnant woman a "laborer."[7] The relationship to and understanding of the womb as a separable body part from the woman's whole body and from herself as a subject, and hence of the baby as a guest that is not part of her body, is a product of an understanding of the body and self which must be naturalized for the women acting as surrogates, and allows participants to understand gestation as a form of paid work. At the same time, this does not exhaust the meaning of how surrogates understand their social relations and even kinship relations with commissioning parents and the infant they bear, as Amrita Pande's recent study of surrogates and kinship at a fertility clinic in Gujarat reveals.[8]

Women who were currently working as surrogates explained the need for secrecy that many felt resulted from the fact that people in their communities would not understand that they had not had sexual relations in order to conceive, and therefore surrogacy would not be accepted as an altruistic act or as valid employment. At the same time, everyone I spoke to expressed conviction that carrying another person's child as a surrogate was not compromising any moral standards around sexuality, a trend which is supported by Amrita Pande's observations of commercial surrogacy in India.[9] This conviction is at least partially the result of coaching in the process and meaning of conception and childbirth received through the clinic's explanations of how surrogacy makes a guest fetus but not a mother. These explanations are based on the Western medical understanding of the genetic basis of parenthood, though whether or not the surrogate mothers themselves fully accept their role within these terms is not clear in their versions of the clinic's narrative of how surrogacy works, and is challenged by the way that surrogates explain their role in terms of the divine, discussed below.

In addition to the intervention of Western medical discourses of the body and biogenetic parenthood, it is the availability of women in India as surrogates, through both economic necessity and the lack of formal regulation, that makes transnational Indian surrogacy possible.

Barbara Katz Rothman has argued that in the U.S., discourse about surrogacy figures the surrogate's womb as property to use as she sees fit, and the fetus as property belonging to the intended parent.[10] This discourse has traveled with the technologies involved in surrogacy, so that the understanding of procreation and parenthood that surrogate mothers are taught includes the figuring of the womb as a place to rent out for use by someone else's infant. The technologies that define and separate the roles of egg donor, intended mother, and gestational mother, in combination with the patriarchal discourse of infant-as-property, work with the commodifying logics of capitalist culture to objectify the work of gestation and the fetus so that they can participate as commodities in the transnational surrogacy industry. Even so, it is essential to note that this is not the primary economy to which women working as surrogates describe their labor as contributing. While women readily acknowledge that it is the demands of material circumstances that impel them to take up this otherwise undesirable work, many women also described their role of a surrogate in terms of an altruistic, or even divine, economy.

Altruism and the Divine

In the discussion and description of what it is like to be a part of transnational surrogacy arrangements in this clinic, doctors, surrogates, and commissioning parents all described their interest and actions as at least partially if not primarily motivated by altruism. In the context of clinic staff, this discourse took the form of a general narrative of the clinic's project of social work: rehabilitating women who take on surrogacy into more disciplined, self-sufficient and professionalized workers, and helping childless couples from around the world build their families. Intended parents also described the opportunity to help needy women working as surrogates as part of the benefit of hiring a surrogate in India rather than in their home countries. In the context of how surrogates describe their participation, carrying a child for a couple without children is described in empathetic and spiritual terms as an opportunity to provide something that is usually the domain of a godly gift.

Many of the surrogate mothers I spoke to, all of whom were Hindu or Christian, emphasized a feeling that they were doing something great, often in the religious language of being like a god, or being able to give a gift to an infertile couple that is a gift usually given only by god.[11] Most were usually quick to then include the doctors as part of this ability to provide, but the emphasis was on their own power to give. Those who spoke to this topic emphasized that this exalted aspect of their actions was much more important than the money aspect, and in fact was their primary motivation. At the same time, when I asked one former surrogate mother how she would feel if one of her daughters wanted to be a surrogate when she was older, her reply was immediate and negative: she explained that the whole reason she herself undertook a surrogacy was so that her children could become educated and wouldn't have to do such things, and that she would not want her daughters to experience that pain. I have to assume that she meant a certain experience of pain, both physical and emotional, that exists in surrogacy but not in carrying and birthing one's own child. Her comments also suggest that despite the narrative of the gift, which mediates the economic transactions within surrogacy by putting them in the realm of voluntary exchange and altruism, surrogacy is a type of work that is not desirable except when economically necessary.

The turn to the divine within these narratives can offer an alternative explanation of the meaning of surrogacy in a frame that is not limited to the medical discourse of the body and biogenetic parenthood. In the context of the clinic, it marks both a woman's powerful role as a surrogate, and signifies the value of the outcome of producing a child for a childless couple in non-monetary terms. For the reader and scholar who does not originate from within the communities where the women working as surrogates reside, this mode of understanding and relating

surrogacy could suggest a way to approach the significance of this act in terms beyond those of labor and economics. It could also provide a way to bridge potential gaps in women's understanding of the clinical explanation of surrogacy as a reproductive technology, which the doctors describe again and again to surrogates in a very basic way as a mode of recruitment. This includes the explanation of how *in vitro* fertilization works, where an infant is conceived without sexual relations, ultimately leading to the birth of a child who "does not look like you." The discourse of the divine aspects of surrogacy suggests alternate ways that surrogacy might be imagined and have value that don't translate to the genetic definition of a biological parent, and don't necessarily circulate within the economic logic of surrogacy as technologically-mediated 'women's work' in the global economy.

Medicine, the Body and Power in Decolonial India

Is the process of becoming biological workers for women who participate in commercial surrogacy a process of neoliberal subject-making that echoes processes in the colonial period, when Western medical discourse functioned as part of European experiments with modernity in their colonies?[12] The precise answer cannot be determined without extensive research over time, and in fact might need to be written and theorized in part by the surrogates themselves. At the least, the context of commercial surrogacy in India raises fascinating questions that continue observations about the role of medical discourse, the body, and power made since the time of British colonial rule.

Putting Indian commercial surrogacy in the context of the scholarship on the role of Western medicine in the colonial period suggests that the body has been and remains an independent signifier and site of subaltern modes of being even in the clinic, and even when surrogates themselves at least partially reproduce and utilize the rhetoric of the Western medicalized body. The work of David Arnold and Gyan Prakash tracks the entanglements of empire, economics, science, power, and the formations of culture and subjectivity during British colonial rule. In his work on epidemic disease in 19th century India, David Arnold has demonstrated how the body, and particularly the Indian colonial body, has historically been a site of colonization and conquest.[13] This observation points to the corporeality of the British colonial project in India, but also yields the body and discourse about the body as sites for contestations of power in Indian history. Indian transnational surrogacy provides an important lens to view ways that specific technologies, instruments of measure and examination, and materializations of the body continue to manifest contested power and subjectivities within medicine as an institution and a global market. For example, the re-formulation of the surrogates' bodies as empty spaces that can be cultivated to re-produce Western society and Western lives recapitulates the colonial epistemology of land as property, where resources, including native labor, were used to sustain the metropole. This contemporary racialized and gendered political economic relationship rests upon a biopolitical order undergirded by access to technology, in this case reproductive technology.

As political and economic structures in India have been re-organized through independence and later neoliberalization, these precedents have been recast in interesting ways that share continuity with what Arnold observed in 19th century colonial structures of power and governance. We can see evidence of the effort to create neoliberal subjects in the coaching of surrogates into a particular relationship to their body and its abstraction through the medical gaze into parts with specific utility to the market. Similarly, the process of imagining surrogates as workers through the alienation of pregnant women from the process of pregnancy is encouraged by medical discourse and technology. In pointing to the dimensions of transnational Indian commercial surrogacy that operate as a neoliberalized form of reproductive labor, and

specifically as a form of biological labor, I aim to contribute to a feminist analysis of the bioeconomy called for by Catherine Waldby and Melinda Cooper in their discussion of human oöcyte vending. They describe such labor as unrecognized as such, due to the fact that it is comprised of giving clinics access to the productivity of women's bodies, rather than consisting of specific tasks.[14] They also note a larger dynamic in the global economy for this "clinical labor," which, when taken together with scholarship on the trade in human organs[15] and clinical trial subjects,[16] points to the outsourcing of the clinical labor with the highest risk and undesirability to populations in the Global South. Masao Miyoshi[17] has pointed out how transnational corporations, central global neoliberalizing forces, have extended and rearticulated colonialism, and by looking at the global market for biological labor[18] and clinical labor,[19] it would seem that neoliberal logics organizing labor markets similarly rearticulate colonial logics.

The meaning of surrogacy to different participants is complicated by their different understandings of the process itself, as well as different understandings, experiences, and expectations of the social relations involved and generated in the clinic. Gestational surrogates at the Manushi clinic are subjected to the medical gaze in a way that they have not been in prior pregnancies, and are encouraged by clinic staff to see their own bodies and pregnancies through the medical gaze in order to work towards separating surrogacy from non-commercial gestation, and to see surrogacy as a way to improve their lives materially through the financial opportunity it provides. Yet surrogates maintain that the divine aspects of their participation outweigh material considerations. The Manushi clinic's surrogacy practice proves to be a valuable lens for examining the intersection of reproductive technologies, the worldviews and self-understandings of various participants, as well as the general neoliberal disciplining of biological reproduction as a form of labor.

Endnotes

1. Marcia C. Inhorn and Aditya Bharadwaj, "Reproductively Disabled Lives: Infertility, Stigma, and Suffering in Egypt and India," in *Disability in Local and Global Worlds*, B. Ingstad and S.R. Whyte, eds. (Berkeley: University of California Press, 2007): 78-106. [Return to text]

2. A. Bharadwaj, "How Some Indian Baby Makers are Made: Media Narratives and Assisted Conception in India," *Anthropology & Medicine* (2000) 7: 63-78. [Return to text]

3. Marcia C. Inhorn, R.Ceballa, and R. Nachtigall, "Marginalized, Invisible, and Unwanted: American Minority Struggles with Infertility and Assisted Conception," in *Marginalised Reproduction: Ethnicity, Infertility and Assisted Conception*, N. Culley, N. Hudson, F. Van Rooij, eds. (London: Earthscan, 2008); Debora Spar, *The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception* (Boston: Harvard Business School Press, 2006). [Return to text]

4. S. Colen, "'Like a Mother to Them:' Stratified Reproduction and West Indian Childcare Workers and Employers in New York," in *Conceiving the New World Order: The Global Politics of Reproduction* Faye Ginsburg, Rayna Rapp, eds. (Berkeley: University of California Press, 1995): 78-102. [Return to text]

5. All identifying details of names and locations have been altered. [Return to text]

6. Marcia C. Inhorn and Daphna Birenbaum-Carmeli, "Assisted Reproductive Technologies and Culture Change," *Annual Review of Anthropology* (2008) 37: 177-196. [Return to text]

7. Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction* (Boston: Beacon Press, 2001): 57. [Return to text]

8. Amrita Pande, "It May be Her Eggs but it is my Blood: Surrogates and Everyday Forms of Kinship in India," *Qualitative Sociology* 32.4 (2009): 379-397. [Return to text]

9. Amrita Pande, "Not an Angel, Not a Whore: Surrogates as Dirty Workers in India," *Indian Journal of Gender Studies* 16.2 (2009): 141-173. [Return to text]

10. B. Katz Rothman, *Recreating Motherhood* (New Brunswick, NJ: Rutgers University Press, 2000): 29. [Return to text]

11. The vast majority of surrogates describe themselves as Hindu, and though there have been some Christian surrogates, the clinic directors report that they have only had one or two Muslim women who inquired about the process of becoming a surrogate, and explained this by saying that they don't often have Muslim women who are interested for reasons of spiritual beliefs about the integrity of the body. This can also be attributed to the fact that the clinic is located in an area with rather high Hindu-Muslim communal tensions, and the clinic directors are Hindu; their word of mouth recruiting strategy only reaches people who are already connected with the clinic or with past surrogates and as such would tend to be Hindu or Christian as well. [Return to text]

12. Kalindi Vora,"Indian Transnational Surrogacy and the Commodification of Vital Energy," *Subjectivities* 28.1 (2009): 266-278; Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton, NJ: Princeton University Press, 1999): 13. [Return to text]

13. David Arnold, *Colonizing the Body* (Berkeley and Los Angeles: University of California Press, 1993): 15; "Touching the Body: Perspectives on the Indian Plague," in *Selected Subaltern Studies*, Ranajit Guha and Gayatri Chakravorty Spivak, eds. (New York: Oxford University Press, 1988): 391-426; Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton, NJ: Princeton University Press, 1999). [Return to text]

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