Critical Sociology

Article

Reproducing Dystopia: The Politics of Transnational Surrogacy in India, 2002–2015

Critical Sociology
2018, Vol. 44(7-8) 1087–1101

DOI: 10.1177/0896920517740616
journals.sagepub.com/home/crs
SAGE

Sharmila Rudrappa
University of Texas at Austin, USA

Abstract
In the decade following legalization of commercial surrogacy in 2002, India became the largest provider of surrogacy services. Then, in December 2015 commercial surrogacy was banned. In this article I show that commercial surrogacy was no panacea for working-class women, but the ban can potentially be far worse because the Indian state now allows only altruistic surrogacy between citizen couples and their women kinfolk who will provide gestation services for no monetary compensation. By positing altruistic surrogacy as a superior alternative, the Indian state has effectively deregulated surrogacy, potentially allowing deeper exploitation of women. I conclude that if the state wants to halt exploitation of working-class women, which is the expressed reason for banning commercial surrogacy, then policies need to be directed at strengthening labor laws to protect women as productive individuals, rather than wives or mothers.

Keywords
India, intimate labor, population control, stratified reproduction, surrogacy

Introduction

In 2015 Ms. Jayashree Wad filed a public interest litigation case in the New Delhi Supreme Court to prohibit international clients from coming to India for surrogacy.[1] In her petition Ms. Wad worried that her country had become a baby factory for a large number of foreign couples wanting surrogate mothers who were illiterate, impoverished, and exploited for commercial gain. Surrogacy, she maintained, was a violation of women's right to life and liberty (Balaji, 2015). Following the public interest litigation, India's Supreme Court directed the central government to respond to whether commercial surrogacy amounted to exploitation, and whether the practice was an affront to the dignity of womanhood. The government responded with seemingly no equivocation. In a letter dated October 27, 2015, Dr. R.S. Sharma, head scientist of the Indian Council of

Corresponding author:
Sharmila Rudrappa, Department of Sociology, CLA, A1700 One University Station, University of Texas at Austin, Austin, TX 78712, USA.
Email: rudrappa@austin.utexas.edu

Medical Research addressing 100 infertility clinics in various parts of India, stated: "as per the stand of the Department of Health Research, Ministry of Health and Family Welfare, Govt. of India, surrogacy will be limited to Indian married couples only and not foreigners. Therefore you are requested not to entertain any foreigners availing surrogacy services in India." In August 2016 the Indian government went further, and cleared the path to a ban on commercial surrogacy. Altruistic surrogacy, however, is allowed.[2]

As the world's "mother destination" (Rudrappa, 2010), since 2002, when commercial surrogacy was legalized, India has accumulated significant foreign earnings. Since then, because of the lack of legislation, the industry was governed by a set of non-enforceable guidelines based on a series of Assisted Reproductive Bills, which clearly favored businesses and clients to the detriment of surrogate mothers (Qadeer, 2010; Rudrappa, 2012a; Sarojini and Sharma, 2009; Shah, 2009). The current Surrogacy Bill 2016, which is set to become law, bans commercial surrogacy and permits only altruistic surrogacy where surrogate mothers, or "mother workers" as Pande (2010) calls them, will receive no remuneration for their labor.

In this article I ask three questions:

1. Does altruistic surrogacy—that is, providing no monetary compensation for biological reproductive labor—protect working-class women?
2. What does this ban on commercial surrogacy inform us about how the Indian state perceives working-class women's bodies and reproductive labor?
3. If altruism *deepens* exploitation of surrogate mothers, what will it take to provide greater rights to those who provide gestational services that will be exchanged either for money or for other kinds of trade?

By locating commercial surrogacy, and its eventual ban in India's longer history of reproductive interventions, starting with mid-20th century population control programs, I reveal that working-class Indian women are not treated as embodied persons, but as *res extensa* or inert material whose reproductive organs are meant to be manipulated for population management purposes, profit making in fertility tourism, and finally, through altruistic surrogacy, harnessed for the reproduction of upper-middle-class heterosexual, nuclear families. I conclude that if the state genuinely wanted to protect working-class women, it would recognize the concreteness of working-class women's existence as conscious beings who, on their own volition, engage in the intimate labors involved in gestation and parturition. Such a development would mean that rather than prohibition, the state would acknowledge *surrogacy as labor*.

This article is organized in the following manner: I briefly summarize India's population policies that have targeted working-class women, followed by a synopsis of the surrogacy industry, and its eventual ban in 2016. Next, I describe how infertility doctors, surrogacy brokerage firms, and client parents claim that surrogacy is a utopic gift exchange, where surrogate mothers are described as renting out, or even "donating" their wombs to grow embryos that a priori belong to clients. I show how the ban on commercial surrogacy and the concomitant legal authorization of altruistic surrogacy can deepen exploitation of working-class women. I argue that reproductive interventions—population control, commercial surrogacy, and state enforced altruistic surrogacy—are dystopian developments that deepen working-class women's vulnerabilities. These are markets in life where the privileged receive vitality in exchange for necrosis among working-class families in India. If the Indian state wanted to protect working-class Indian women, it would recognize reproductive processes as sentient labor, and extend fuller rights to women who engage in it.

Reproductive Interventions: Population Control, Commercial Surrogacy, and Altruistic Surrogacy in India[3]

Population Control, 1960s–1980s

That the histories of reproductive interventions in India are intimately intertwined with Cold War politics should come as no surprise. Over the 1950s and 1960s, food production in developing countries slumped significantly. Simultaneously, declines in mortality rates contributed to population growth. Fearing the rise of communism among resource-poor nations, the U.S. intervened both in agriculture and population planning, through the Green Revolution (Patel, 2013) and an unprecedented focus on global population control (Connelly, 2009). "Something like a war" was unleashed on working-class Indian women's bodies, setting the context for how working-class women's reproductive abilities would be perceived by the Indian nation-state.[4]

With pressure from USAID, the World Bank, the United Nations, and the Ford Foundation, which together provided most of India's foreign aid, India implemented the world's biggest state sponsored population control program at the time (Ledbetter, 1984). The first large-scale intervention, during 1965–1967, was an internationally coordinated campaign by the Population Council to induce 29 million Indian women to accept intra-uterine devices (IUDs). Because of inadequate training, lack of equipment, and directives to reach target numbers, problems arose almost immediately. In spite of incentives, women were unwilling to take on the risks associated with a badly run IUD program that included women getting prolonged pelvic infections, ectopic pregnancies, and, eventually, infertility (Rudrappa, 2015). The IUD program proved to be a failure, only attracting under 5 million women acceptors. In a more concerted effort, India received $435 million in loans and credits from the U.S. (Ledbetter, 1984: 742), this time to diversify reproductive interventions: permanent sterilizations in the form of vasectomies and tubal ligations were introduced, and prioritized in state sponsored programs. Abortions too were legalized in 1971 through the Medical Termination of Pregnancy Act in an effort to curb population growth.

All of these interventions paled in comparison with developments in the mid-1970s. Faced with the highest rate of inflation since Indian independence in 1947, and with charges of violating election laws, then Prime Minister Indira Gandhi suspended a range of civil rights and declared a national Emergency. In the two years between June 1975 and July 1977, political repression reached unprecedented levels: opposition leaders were arrested, activists were disappeared, the press was censored, and, crucially, men from impoverished minority communities, especially Muslim communities, were rounded up and forcibly sterilized (Rudrappa, 2015). Between 1975 and 1977 10.93 million people were sterilized; 75% of these were men (Singh et al., 2012).

When Emergency measures were lifted and civil rights restored in mid-1977, sterilizations dropped to a mere 948,769 sterilizations. Of these, 80% were tubal ligations on women, leading to the observation that one of the unanticipated outcomes of the Emergency was the acceleration of female sterilization and steep declines in vasectomies (Basu, 1985). Because of sterilization abuse of men, vasectomies had become highly unpopular in India. Always women-centered, except for the brief period in the mid-1970s, population control programs now targeted women more so than before, with permanent sterilization of working-class women as the dominant method to achieve population control from the 1980s onwards. The legacy of these population interventions can still be seen today. Male sterilization or vasectomies are negligible in comparison to tubal ligations conducted on women.[5] Rural women are still recruited, bussed in, and sterilized in temporary medical camps set up in villages (Rudrappa, 2015).

The Globalization of Assisted Reproductive Technologies and Surrogacy

As in India, sterilization abuse of women of color was rampant in the U.S.[6] Yet, white U.S. women had no access to fertility control, until in 1965 when the U.S. Supreme Court awarded married women the right to use birth control as a constitutional right to privacy. Five years later President Nixon passed Title X of the Public Health Service Act, which made contraceptives available to all American women. Very quietly, however, along the heels of minimally invasive contraception, came another kind of reproductive intervention—fertility assistance. Just five years after the legalization of abortion in the U.S., the world's first in-vitro fertilized (IVF) baby, Louise Brown, was born in Britain on July 25, 1978. The first American IVF baby was born in 1981, and India's first officially documented IVF birth occurred in Mumbai in 1986 (Bharadwaj, 2002: 323). IVF births are not newsworthy anymore; a total of 5.4 million IVF babies have been born worldwide from 1978 to 2016 (ESHRE, 2016). Unlike the large-scale implementation of fertility desistance of an earlier era where hundreds of thousands of women of color and Third World women were sterilized, these fertility assistance markets, including surrogacy, are almost exclusively available to the wealthy in the northern hemisphere.

The successful separation of conception and pregnancy entailed in IVF, right from freezing sperm, ova extraction, in-vitro conception, the transfer of embryo from petri-dish to human womb, to finally the delivery of babies, has resulted in a variety of fertility markets. If individuals are unable to produce sex cells, they can purchase sperm and eggs through sperm/egg banks. And, surrogate mothers can be recruited to carry fetuses to term. Charis Thompson (2005: 8) describes the "dynamic coordination of technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics" as the ontological choreography central to making new families. Loan officers who facilitate second mortgages on homes; sex cell donors; medical personnel who collect sperm and eggs; sperm and egg banks; lawyers; social workers; administrators in consular offices who give visas and passports; agencies that recruit surrogate mothers; and surrogate mothers, all collectively synchronize their varied labors to make possible hyper-ovulation, ova extraction, sperm collection, in-vitro fertilization, and implantation of embryos into medically rendered hyper-fertile surrogate mothers who birth babies who are ultimately legally transferred to intended parents (Rudrappa, 2015: 35).

When surrogacy was initially commercialized, mainly in the U.S., all interventions existed within a single nation state. However, by the time India legalized commercial surrogacy in 2002, that was no longer the case. Frozen sperm, and women as potential egg donors, could be shipped across the world in order to prepare embryos to be gestated in women who resided in countries that were surrogacy-friendly, and where women's labor was extraordinarily cheap. The U.S. was reputed to be the largest supplier of surrogacy services in the world,[7] but new market entrants such as Thailand and India challenged U.S. prominence in the industry. Surrogacy in the U.S. can cost anywhere from $80,000 to $100,000 for a singleton baby, in comparison to $35,000 to $40,000 in India.

By 2011 India had 200 infertility clinics registered with the National Association for Assisted Reproduction in India, though estimates claim a higher number closer to 500 infertility clinics, to an even more preposterous figure of 3000 infertility clinics.[8] In 2011 infertility assistance was estimated to be a $2 billion industry. Through decades of state subsidized medical education, and working with women's bodies in providing "birth control" (as described above) and childbirth services, India had skilled medical expertise in place. As a GATS signee (the General Agreement on Trade in Services), India boosted global trade in health by providing financial incentives to private hospitals, reduced import tariffs for medical equipment, and expedited medical visas and joint insurance collaborations in order to facilitate medical, and infertility travel (Unnithan, 2010). In addition to the availability of cheap drugs, weak regulatory apparatus and the commercialization

of surrogacy in 2002, India emerged as the world's "mother destination" (Rudrappa, 2010). The biggest factor that facilitated its global prominence in providing surrogacy services, though, was the availability of compliant women recruited from working-class communities in rural and urban India. Those very communities targeted for female sterilization in population control programs were the ones targeted for surrogate mothers.

It is crucial to outline the kinds of medical interventions women underwent in order to prepare them for gestational surrogacy. The first noteworthy fact is that in-vitro fertilizations that characterize commercial surrogacy are *not* foolproof. Though there are no studies in India, the U.S. Center for Disease Control reports that only 22.4% of all IVF cycles (which includes surrogacy) resulted in live births. Failure rates are very high. The same is arguably true in India, and therefore infertility specialists increase the odds of IVF success by using younger women's eggs, healthy sperm, and choosing surrogate mothers who are at ideal fertility age. Yet, even these measures do not guarantee a pregnancy, let alone a successful birth. In order to increase the chance of live births, infertility specialists in India routinely hired two surrogate mothers for each client they worked with. Each woman, upon being hormonally stimulated for pregnancy, was implanted with four embryos each. The women then underwent what doctors and clients euphemistically referred to as "fetal reduction" procedures to achieve an "optimal birth outcome," which was one to two viable fetuses per surrogate mother. Infertility doctors and clients, and *not* the surrogate mothers, decided on optimal birth outcomes.

My interviews with surrogate mothers in Bangalore revealed that informed consent was absent; none of the surrogate mothers had received information regarding the kinds of medical interventions they would eventually undergo. Even though almost all of them had delivered their own children vaginally, a majority of the surrogate mother interviewees underwent cesarean surgeries. Many women were unaware they would deliver through cesarean surgery at weeks 36 to 38 of gestation. And finally, none of the surrogate mother interviewees had received post-natal care from the agencies that hired them (Rudrappa, 2015).

In 2012 nearly 10,000 foreign clients visited India for reproductive services; nearly 30% of these were either single or queer identified (Krishnan, 2013). Ten years into the existence of commercial surrogacy India finally flexed its regulatory muscle; in 2012 the Indian Ministry of Home Affairs prohibited single individuals, gay couples (most of whom were men), and unmarried heterosexual couples from receiving medical visas for the purposes of surrogacy in India (Ahmad, 2015). Some government officials contended that this ban was because homosexuality was antithetical to Indian culture. They also maintained that surrogated children had the right to be raised in heterosexual nuclear families. This anti-gay discrimination brought industry wide condemnation either because infertility agencies were genuinely concerned about homophobia, or because a segment of their clientele was cut out of the market. Feminist organizations too protested; the Delhi based SAMA Resource Group for Women and Health said this development was "discriminatory, baseless, and a violation of rights to equality, freedom, and reproduction" (cited in Dhar, 2013).

SAMA was right, but had not anticipated the turn the industry would take when they commented on the Indian government's homophobia. The ban on gay couples *deepened* the vulnerabilities of Indian surrogate mothers. Some businesses decided that if clients could not come to India, then Indian surrogate mothers could be moved to neighboring Nepal to facilitate the trade. Gay couples wanting to pursue inexpensive surrogacy in India shipped their frozen sperm to some Delhi agencies, which was used to fertilize eggs from Indian donors. These embryos, legally belonging to the men, were implanted into Indian surrogate mothers who then crossed international borders into Nepal where they would give birth in Kathmandu, from where clients could pick up their children.

This newly established reproductive trade route between Delhi and Katmandu came to a screeching halt when an earthquake hit Nepal on April 25, 2015 that left 8000 people dead and

injured more than 21,000 people. Israel airlifted 26 newborn babies and left their Indian surrogate mothers behind. Nepal was racked with aftershocks, and Israel once again airlifted four babies (Pileggi, 2015). After facing much criticism the Attorney General of Israel announced that the Indian surrogate mothers living in Nepal at different stages of their pregnancies and under contract with Israeli gay men citizens would be permitted to complete the birth process in Israel. The hundred or so surrogate mothers were flown to Israel where they resided for the duration of their pregnancies. What subsequently happened to the mothers after childbirth is unclear (Robertson, 2015). Nepal was not the only node on these international circuits. Informal conversations with a Mumbai infertility specialist during my September 2015 trip to India revealed that a few surrogate mothers were brought in from Kenya, implanted with embryos belonging to gay men, and after an observation period of 24 weeks, were flown back to Nairobi where they birthed babies who would be picked up by gay fathers.

The Ban on Commercial Surrogacy, and the Turn to Altruistic Surrogacy

While these developments were no doubt appalling to observers of surrogacy in India, what came next was even more so. On August 24, 2016 the Union Cabinet voted for the Surrogacy Bill 2016, which bans commercial surrogacy altogether because it violated women's right to life and liberty. Altruistic surrogacy, however, would be permitted.[9]

Before examining the new legislation in greater detail I want to note that this ban on commercial surrogacy could, prima facie, protect surrogated babies. Commercial surrogacy brought in significant numbers of international clientele into India. Many of these individuals came to India because of the lower costs, *and* because of various legal restrictions against surrogacy in their own countries. Countries such as Finland, Germany, Spain, Italy, Portugal, Bulgaria, and Pakistan ban all forms of surrogacy. Others, such as the United Kingdom, Ireland, Denmark and Belgium permit the coverage of reasonable expenses incurred by the surrogate mothers, making surrogacy akin to an altruistic arrangement. Still other countries, such as Israel or Australia, allow only heterosexual couples to enter into surrogacy agreements.

As a result, when their babies were born in India, some foreign clients have gotten entangled in a legal quagmire when returning home with "their child." The first such case was the case of Baby Manji, born on July 25, 2008 to a surrogate mother in Dr. Nayana Patel's clinic, commissioned by a Japanese couple, the Yamadas. The infant had been IVF conceived using Mr. Yamada's sperm and an anonymous Indian donor. The couple, however, divorced a month before the birth of Baby Manji, and Yuki Yamada did not want her anymore. Ikufumi Yamada, the sperm donor and father, did. The situation presented a legal crisis because Baby Manji's parentage and nationality were impossible to determine under the existing definitions of family and citizenship in Indian and Japanese law. The case reached a resolution when the Indian government issued a transit permit for the baby to travel out of India but only to Japan; and, Japan granted the three-month-old baby a one-year visa on humanitarian grounds, which expired in October 2009, leaving Baby Manji essentially stateless (Points, 2009).

Another case involved a single Norwegian mother, Kari Ann Volden, who had used donor eggs and sperm, and an Indian surrogate mother who gave birth to twin boys in 2010. Norway refused to issue passports to the babies saying the Indian birth mother was the legal parent. India too refused legal recognition of the babies because, according to surrogacy regulations in the country, Volden was the legal parent. The stateless babies and their intended mother lived in India for two years before she legally adopted them and returned to Norway (Ladegaard, 2013).

Similar situations have arisen when British couples, Australians, and Germans have gotten stranded in India because these countries have initially refused citizenship to babies either because

the intended parents were gay, or were of different nationalities from each other, or were single parents. Indian citizens and their surrogated children, on the other hand, do not face the same challenges because they operate under a single national juridical-legal regime. By banning gay couples, diasporic Indians, and other foreigners, the new ban on transnational surrogacy protects the child from potential statelessness.

However, the current ban on commercial surrogacy does nothing to protect surrogate mothers. In fact, it could *deepen* surrogate mothers' vulnerabilities, just as when gay couples were banned from pursuing surrogacy in India in 2012, and Indian surrogate mothers were sent to Nepal, and Kenyan surrogate mothers were brought to India (discussed above). With this current ban, if the past offers any lessons, surrogacy brokers will in all probability map out global routes to continue their brisk trade in reproduction, moving working-class pregnant women from one country to the other to take advantage of the uneven juridical-legal terrain of country-specific laws that govern surrogacy. Sending Indian women to Nepal and bringing Kenyan women to India: in these sorts of developments surrogate mothers become analogous to shipping containers. Working-class women of the global South become cargo carriers of life—life that *a priori* belong to clients—across borders to facilitate family-making in the global North.

Yet, it is not just the ban on commercial surrogacy alone that can deepen exploitation; the far more worrisome development is that the government will permit only altruistic surrogacy where women shall receive no monetary compensation for their biological reproductive labor. The proposed law allows altruistic surrogacy for Indian citizen heterosexual couples who have been married for more than five years and have medical reasons for their childlessness. A married couple is ineligible if the husband has children through a prior marriage or relationship; the wife's childlessness or infertility does not count. The surrogate mother must be a "close relative" of the couple, married, and must have given birth to a healthy child prior to surrogacy. She can be a surrogate mother only once in her lifetime and must not receive monetary compensation because she provides gestational services out of selflessness. Gay couples, unmarried couples, single women and men, foreigners, and married couples with children—biologically achieved or through adoption—are specifically named as ineligible for surrogacy.

The proposed law mandates setting up a national surrogacy board and committees to implement its provisions, much like the authorization committees that were created by the Transplantation of Human Organs (THO) Act, 1994 for monitoring the donation of kidneys. Meant to curb the *legal* for-profit organ trade in India, where kidneys were harvested from live indigent donors for wealthy patients, the THO Act and its authorization committees now limit organ donation between family members (Shroff, 2009). However, authorization committees can approve of transplant cases between unrelated individuals if the donor expresses genuine affection and interest in giving her organ to the recipient; the committees must be convinced that no money will be exchanged for these kidneys. In the southern state of Karnataka, between January 1996 and March 2002, 1012 patients were officially cleared to receive kidneys from unrelated live donors. In an investigative journalistic account, Vidya Ram (2002) examined 274 cases of these unrelated live donors cases; a fourth of these involved donors who were in economically-dependent relationships with the recipients or their families, as employees.

Similarly, there is nothing to stop indigent women from providing surrogacy services to wealthy intended parents. National Boards and authorization committees of the sort meant to monitor altruistic surrogacy, as in the case of kidney donation, tend toward loose interpretations of who constitutes a "close" relative. "Altruistic" surrogate mothers might be in deeply dependent, long-standing relationships with intended parents and unable to refuse when asked to provide their biological reproductive services for free.

The Meanings of Commercial Surrogacy for Surrogate Mothers and Intended Parents

A significant part of my recently published book, *Discounted Life* (2015), is an account of how the various actors involved in surrogacy negotiate exchanging money for babies in India.[10] Given that surrogate mothers and clients have no experience with monetizing pregnancy and childbirth they are uncertain whether their involvement in surrogacy is a gift or a commodity exchange. To summarize briefly, gifts and commodities are simply objects that circulate in social spaces, but *how* they circulate is an important distinction. While the literatures on gifting and commodities are extensive, suffice it to say for our purposes here, gift exchanges signify ongoing social relationships between individuals or groups of individuals. Contrary to any idealistic notion of egalitarianism, gift exchanges are marked by deep inequalities based on social hierarchies determined by age, gender, (dis)abilities, sexuality, religion, race, and caste. Commodity exchange, on the other hand, is an atomized relationship where producers and consumers typically are strangers to each other. In exchange for money, consumers receive a commodity from producers, who are almost always at a disadvantage because of the structures of capitalism. Thus, gifts or commodities reflect social relations; i.e., the gift or the commodity economy is bound up with the forms of the person, who is diversely constituted, and in turn, is constituted herself by the gift or commodity exchange.

In *Discounted Life* I show that through contesting whether pregnancy and the resulting baby is a gift or commodity, the client parents and surrogate mothers negotiated the terms of their relationship with each other. The clients were unequivocal: though they use the language of gift in describing their transactions, they were committed to the practices of commodity production. That is, they spoke extensively about how, by birthing a child for them, the surrogate mother had given them a gift far greater than life itself; yet they had no interest in maintaining an on-going relationship with these working-class Third World women who had made this "gift greater than life" possible. In spite of using the rubric of gifting, they acted like consumers in capitalist society: they went their separate ways once the transaction was completed.

The surrogate mothers, on the other hand, were ambivalent. They thickly described the labor that went into gestational surrogacy, and why they should be paid more than the $4000 they received for their labors. While the parties involved did not recognize the surrogate mothers' labor, the women themselves documented the effort that went into being subjected to invasive medical procedures that surround surrogacy. They explained that they had to give up their regular jobs[11] just so that they could be at the clinic for daily appointments to receive their hormonal injections in order to prepare them for pregnancies. Some mothers said the injections were painful; others said they felt nausea and weak when they received the hormonal infusions that thickened their uterine walls in preparation for embryo transplantation. The doctors monitored the thickening of their uterine linings through trans-vaginal ultrasounds, which many mothers found extremely humiliating because condom-covered probes were inserted into their vaginas in order to image and map the changes in their reproductive organs. Some mothers likened these trans-vaginal examinations to sexual assault.

Upon implantation, a whole new set of worries began for the surrogate mothers. Would the embryos take, or would implantation fail? A failed IVF procedure resulted in all sorts of shortfalls; they lost wages because they had quit their regular jobs, but also, in anticipation of pregnancy and knowing they would be residing in surrogacy dormitories for close to nine months, they had made arrangements to take care of their children. They relied on their social networks, hoping neighbors, friends, and female relatives would take care of their children. Such childcare required them to make financial arrangements, some even taking loans to pay upfront for childcare. Thus, getting ready for surrogacy took up a considerable amount of coordination and effort, and cost them

substantially if implantation failed. Though legally entitled to some compensation, various agencies did not pay them in order to maximize their own earnings or accrue savings for clients

If surrogate mothers were successful in getting pregnant, they had to leave home and stay for close to nine months in surrogacy dormitories. The mothers spoke of the pain of separation from their own families, especially their young children.[12] And finally, they described the emotional labor they performed in disengaging their feelings from the fetus so that they could fulfill the terms of the contract and give up that baby.

As I discuss in *Discounted Life* (2015), the surrogate mothers I met during fieldwork in Bangalore, India were not the poorest of the poor, but were a part of the growing citizenry whose economic and social lives were eviscerated by the loss of secure and well-paying jobs, safe housing, clean drinking water, and good schooling for their children. They were the urban precariat. Many mothers told me that when they first signed up as surrogate mothers, they believed that the $4000 they earned would alter their class status because they would save a part of their earnings, and invest the rest in order to generate more income. But there were many demands on their surrogacy earnings. They had to pay off usurious money-lenders, find better schooling for their children for a few years, and better housing. Moreover, their kinfolk, coming from the same socio-economic backgrounds as the mothers, requested loans or asked for money to build wells on village farms, to pay for medical treatments, or to assist with paying off debts. There were numerous demands on the surrogate mothers' earnings, and many women's $4000 disappeared within the year. Thus, instead of being a life-changing proposition, surrogacy became a stopgap measure by which these urban working-class women attempted to bring in a lump sum of cash into their precarious economic lives.

The women eventually recognized that the one strategy to manage their precarity was to widen their social networks to include elites. Through their reproductive labor the surrogate mothers met doctors, surrogacy brokers, and clients who all had access to resources, and came from upper-middle-class backgrounds. These individuals could potentially help with children's schooling, act as gateways to better health care, and provide access to better employment either for themselves or their husbands. Thus, even though the women said they pursued surrogacy only for the money, they hoped the entire reproductive arrangement was more like a gift exchange. If the clients maintained that the babies were priceless gifts, then the meanings of surrogacy surely transcended mere market exchange, and the tenets of gift-exchange would be maintained. That would mean enduring social relationships between the gift-giver, in our case the surrogate mother, and receiver who is the client couple. Thus, some surrogate mothers hoped that they would be able to maintain social relationships with doctors and clients. In most cases, however, that was not the case. Intended parents walked away with "their child" once the terms of the contract were met. By contract, they had been fair and impartial participants by paying up, and keeping their end of the bargain. They were not legally or socially obliged to give any more.

Why Altruistic Surrogacy is Bad for Women

Such a market reproductive exchange is profoundly unfair. While at face value the Indian government's ban on commercial surrogacy, because the state essentially believes that reproductive exchanges must not be corrupted by money, may seem like a good idea, its replacement with altruistic surrogacy is dangerous for women. To understand why, an examination of the press conference given by Mrs. Sushma Swaraj is instructive.[13] Mrs. Swaraj is India's external affairs minister and stalwart of the right-wing Bharatiya Janata Party. She headed the Group of Ministers who studied surrogacy, and gave recommendations to the Union Cabinet, which subsequently decided to ban commercial surrogacy. In her press conference Mrs. Swaraj said the new

surrogacy legislation was a "revolutionary step" toward women's welfare. She believed that commercial surrogacy was "against nature," and only enhanced clinics' earnings. Altruistic surrogacy practiced between extended family members, on the other hand, removed the taint of money, which protected women from commercial brokers and safeguarded their bodies and reproductive labor within extended kin networks.

To summarize, there are two key highlights to Mrs. Swaraj's and the current government's perspective. These are:

a) Commercial surrogacy is "against nature" because women receive money for gestational work they have always done for free. Thus, women should not receive money for giving birth to babies. This only leads to their exploitation.

b) Altruistic surrogacy, with no money exchanged, is a revolutionary step toward women's welfare because exploitation happens only in commercial agencies and infertility specialists; on the other hand, families are safe havens for women.

The reality, however, is that for a large number of women around the world and not just India, the family is the site for the materialization of substantial inequalities and domestic violence. Families are never quite safe havens from the corrupting forces of the market; instead, they are sites that engender gender subordination.

By posing altruistic surrogacy *within* kin networks as the path to "women's welfare," the state re-inscribes an idealized concept of the traditional, heterosexual family that prescribes strict gender norms of what is expected of men, and what is expected of women where gender norms are perceived as innate biological manifestations. Thus, gestation, childbirth, and child rearing are not labor processes; instead, these activities arise naturally because of the taken-for-granted, unproblematized sexual, material body embedded within a patriarchal family. Women are caring, compliant, and selfless simply because they are naturally so; they are born that way. The state endorsement of altruistic surrogacy is premised on the notion that women are expected to provide free biological and social reproductive labor, but only within kin networks. But by moving gestation back into the folds of the family the state has effectively deregulated surrogacy. It does not need to pass any legislation or offer protective measures for women any more because they will now ostensibly be sheltered from exploitation within kin networks, where all exchanges are idealized as being based on love, mutual respect, and reverence for motherly efforts.

The Indian State's Approach to Working-class Indian Women's Reproductive Labor

What does the ban on commercial surrogacy and the authorization of only altruistic surrogacy inform us about how the Indian state perceives working-class women's bodies, and reproductive labor? It is instructive to consider India's long history in reproductive interventions ranging from population control (1960s to the present), commercial surrogacy (2002–2015), to altruistic surrogacy (2016 onwards). All three interventions are shaped by an enduring state logic that women themselves are least competent in managing their bodies and their reproductive capacities. Therefore, their bodies must be regulated by the state, as evinced by population control programs; by medical personnel, as in the case of commercial surrogacy; and finally, by extended families, in the case of altruistic surrogacy.

In population control programs working-class women are not treated as embodied human beings, but instead as overly fecund objects whose unruly and ultimately profligate wombs must be reined in for the nation's overall economic wellbeing. This focus on population control conflicts

with maternal health outcomes in India, with deeply negative implications for reproductive justice. For example, neonatal mortality rates in India remain very high, at 39 babies per 1000 live births in 2004. In comparison, global neonatal mortality rates were 28; 35 in the Southeast Asian region; and, 40 deaths per thousand live births in low-income countries. Nearly 1.2 million deaths occurred in India in the first four weeks of life; neonatal death accounted for nearly half of the total infant mortality, pointing to the severe lack of prenatal and postnatal health care for women (Jeejamon and Stephen, 2009). Thus, what working-class women in India need is not population control, but a concerted effort at better maternal and neonatal health outcomes so that working-class women's reproductive desires might be met.

If population control programs implicitly posit that working-class women's bodies must be regulated for the good of the nation-state, then commercial surrogacy grew exponentially through economic speculation on women's biological reproductive labor power in order to create surplus. The same profligate fecundity that was viewed with suspicion under population control was now harnessed for engendering upper-middle-class families replete with paternal lineage intact, generating revenue for various infertility agencies, hospitals, surrogacy agencies, and, finally, foreign exchange for the nation. When commercial surrogacy was first legalized in India in 2002, infant mortality was still inordinately high (as the figures above show); yet, the very populations that had low maternal-infant health outcomes were now meant to reproduce for elites, and for the nation. By the time commercial surrogacy was halted in December 2015, it had become a global industry that generated $2 billion annually. But in order to generate these revenues, by law and in the actual business practice of surrogacy, women had to be imagined as having no volition in gestation and parturition. As I have described above, every detail of their pregnancy right from how many embryos were implanted, to how many would be aborted, to when and how women would give birth, was all driven by client needs and medical expertise.

The third instance of reproductive interventions—that is, banning of commercial surrogacy, which de-commodifies reproductive labor—should for all intents and purposes be a positive development. As various critics of neoliberalism, including Arlie Hochschild (2003) have argued, developments such as surrogacy have led to the "commercialization of intimate life," and accelerated the marketization of social relationships. But the altruistic forms of reproductive exchange the state endorses is far more harmful to women because it places women's reproductive capacities firmly back within kin networks where they shall receive no remuneration for gestation. The Indian state has withdrawn completely from arbitrating on the commerce of gestation and instead relegated reproductive matters to the private sphere of the family, where women are treated as gendered subjects of family, caste, and community. But this is not a surprising development. In the light of the history of reproductive interventions it is hard to imagine the state stepping in to safeguard its women citizens as *qua* citizens.

Conclusion: Surrogacy as Intimate Labor

Whether the Indian state endorses commercial surrogacy or bans surrogacy altogether is another question, but I argue the starting premise of any legislation is that women's reproductive labor must be recognized as embodied, mindful activity rather than as a natural activity women engage in, in the progression from their social identities from daughter, to wife, to mother. In order to extend the greatest possible guarantees of freedom for women the state must treat them as citizen subjects rather than women who are members of nuclear families, extended kin networks, castes, and religious communities. At the current moment, this is exactly what altruistic surrogacy does in India.

Speaking of the specific case of commercial surrogate mothers, Amrita Pande (2010) uses the term "mother workers" to highlight the fact that biological motherhood is deeply entangled with

the market, and that women receive money for pregnancy and childbirth. However, what sorts of labor do surrogate mothers perform under market conditions? Cooper and Waldby (2014) accurately describe such surrogacy as clinical labor. They define clinical labor as "the process of *material abstraction* by which the abstract, temporal imperatives of accumulation are put to work at the level of the body" (Cooper and Waldby, 2014: 12). Though gestation is not recognized as labor per se because the surrogate mothers do not perform codified, quantifiable tasks, "they offer themselves up as subjects, giving clinics access to the productivity of their in-vivo biology, the biological labor of living tissues and reproductive processes" (Waldby and Cooper, 2008: 59). Surrogate mothers are workers in a Marxian sense because in-vivo processes of oogenesis and gestation create surplus value. I take my cue from other feminist scholars, notably on Mary O'Brien (1981) and Nancy Hartsock (1998) in calling for the recognition of women's reproduction as forms of labor, by which I mean that it is a conscious, life-giving, meaningful social activity. But gestation is more than just labor as Marx may have described; pregnancy and childbirth involve "a unity of mind and body more profound than is possible in the worker's instrumental activity" (Hartsock, 1998: 167).

In that sense then, surrogate mothers may be clinical laborers, as Cooper and Waldby (2014) call them in what Parreñas et al. (2016) call intimate industries. Intimate labor refers to the paid employment involved in forging, maintaining, and managing interpersonal ties through tending to the bodily needs and wants of care recipients. Such intimate needs/wants include "sexual gratification, bodily upkeep, care for loved ones, creating and sustaining social and emotional ties, and health and hygiene maintenance" (Boris and Parreñas, 2010: 5). Intimate industries, stated briefly, are the institutionalization of intimate labor and the unequal relationships between various actors engaged in intimate exchanges.

Other forms of intimate labor, namely sex work, nursing, elder care, and childcare have been devalued, but have at least been accorded social, political, and, critically, legal recognition. Sex workers in Calcutta and Mumbai, for example, have set up successful cooperative banks for community members to deposit their earnings. The state-owned Life Insurance Corporation of India provides life insurance for sex workers in Calcutta through a policy specially designed for sex workers.[14] If the Indian state is genuinely interested in protecting surrogate mothers' rights, then it has to recognize surrogacy as a legitimate form of work and extend the kinds of protections democratic societies extend to their working citizens. This would mean health insurance schemes, the right to unionize and form collectives and cooperatives, and protecting the mothers' collective bargaining rights on wages and work conditions. It is these conditions, I conclude, rather than pushing for altruistic, free reproductive exchanges within kin networks, that commercial surrogacy in India can come much closer to achieving the reproductive rights of clients and workers in this particular globalized reproductive industry.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Notes

1. Commercial surrogacy is a market arrangement where a surrogate mother gestates and births a baby for the intended couple for wages. She and the intended parents are virtual strangers to each other. The surrogate mother generally has no genetic relation to the infant, and the embryo that is implanted in her legally belongs to the couple. The embryo, fertilized in-vitro, emerges from a variety of market arrangements, including the procurement of human ova or sperm through sex cell banks.

2. The Indian parliament is currently debating on lifting the ban on commercial surrogacy for Indian citizens and the Indian diaspora.
3. Parts of this section are from Chapter 1 of my monograph (see Rudrappa, 2015).
4. I borrow this phrase from Deepa Dhanraj's 1991 documentary film titled *Something Like a War* on the history of population control programs, euphemistically called "family planning programs."
5. Thirty-seven percent of married Indian women opted for tubal ligation in 2005–2006. Female sterilization is more common in south India. The median age at sterilization is 23.3 years in Andhra Pradesh; 23.9 years in Karnataka; and 24.9 years in Tamil Nadu. See *National Family Health Survey (NFHS-3)*, 2005–06: India, Vol. 1, Mumbai: IIPS. By comparison in the U.S., of the women younger than 50 years, 20% had been sterilized, with another 15% married to men who had vasectomies (Watkins, 2012: 1463).
6. For example, the U.S. General Accounting Office found that four of the 12 Indian Health Service regions sterilized 3406 American Indian women without consent between 1973 and 1976. From https://www.nlm.nih.gov/nativevoices/timeline/543.html accessed on June 8, 2016. And, the District Court of Columbia found that an estimated 150,000 poor people were sterilized without proper consent under federally funded programs in 1974 (Hansen and King, 2013). Dorothy Roberts (1997) writes that in the 1970s sterilization became the most rapidly growing form of birth control, rising from 200,000 cases in 1970 to over 700,000 in 1980.
7. The U.S. is still a popular site for transnational surrogacy. Of the 2,071,984 assisted reproductive technology cycles performed during 1999–2013, 30,927 (1.9%) used a surrogate mother; this is an increase from 727 (1.0%) in 1999 to 3432 (2.5%) in 2013. The proportion of non-U.S. clients for surrogacy declined during 1999–2005 from 9.5% to 3.0% but increased during 2006–2013 from 6.3% to 18.5% (Perkins et al., 2016).
8. An article in the *Outlook Business* magazine, dated October 15, 2011, gives the lower figure. See http://business.outlookindia.com/printarticle.aspx?278530 (accessed March 24, 2014). The U.K.-based *Daily Mail* reports the exaggerated statistic: http://www.dailymail.co.uk/news/article-2439297/How-IVF-treatment-Indias-latest-booming-industry.html (accessed March 24, 2014).
9. At face value, altruistic surrogacy can make surrogacy available to a larger number of Indian couples because surrogate mothers do not get paid. However, the costs of assisted reproductive technologies entailed in any sort of surrogacy are exorbitantly high. Thus, altruistic surrogacy will remain inaccessible to a large number of Indian couples who cannot afford infertility assistance.
10. Over the course of four years (2008–2011) I conducted participant observation in infertility clinics and a surrogacy agency in Bangalore, southern India; interviews with 70 surrogate mothers in Bangalore; interviews with 31 egg donors and focus groups with 25 garment workers also in Bangalore; and, interviews with 20 gay and straight couples in the U.S. and Australia.
11. Most of the surrogate mothers I interviewed in Bangalore were garment workers.
12. Some mothers, however, found the mandatory dormitory stays quite liberating. As one mother explained to me, she never remembered a time where she could sleep in, and not attend to housework, get children to school, and go to the factory to work. At the dormitory she got to relax and hang out with other women who had similar backgrounds to her. She missed her children and family, but, over time, came to appreciate dorm life (Rudrappa, 2012b).
13. https://www.youtube.com/watch?v=wtI4Mskjpnk (accessed August 26, 2016).
14. From http://economictimes.indiatimes.com/wealth/personal-finance-news/indian-sex-workers-get-life-insurance/articleshow/3054023.cms (accessed June 11, 2016).

References

Ahmad T (2015) India: Draft regulating assisted reproductive technology published. *Global Legal Monitor*, U.S. Library of Congress. Available (accessed 9 June 2016) at: http://www.loc.gov/law/foreign-news/article/india-draft-legislation-regulating-assisted-reproductive-technology-published/

Balaji R (2015) Plea in Supreme Court to ban surrogacy. *The Telegraph*, 26 February. Available (accessed 5 June 2016) at: http://www.telegraphindia.com/1150226/jsp/nation/story_5600.jsp#.V1Z_zUuLR94

Basu A (1985) Family planning and the Emergency: An unanticipated consequence. *Economic and Political Weekly* 20(10): 422–425.

Bharadwaj A (2002) Conception politics: Medical egos, media spotlights, and the context of test-tube firsts in India. In: Inhorn MC and Van Balen F (eds) *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*. Berkeley, CA: University of California Press, 315–334.

Boris E and Parreñas R (eds) (2010) *Intimate Labors: Cultures, Technologies, and the Politics of Care*. Stanford, CA: Stanford University Press.

Connelly M (2009) *Fatal Misconception: The Struggle to Control World Population*. Cambridge, MA: Harvard University Press.

Cooper M and Waldby C (2014) *Clinical Labor: Tissue Donors and Research Subjects in the Global Bioeconomy*. Durham, NC: Duke University Press.

Dhar A (2013) Gaps in Surrogacy Bill. *The Hindu*, 27 October. Available (accessed 5 June 2016) at: http://www.thehindu.com/features/metroplus/society/gaps-in-surrogacy-bill/article5276062.ece

ESHRE ART Fact Sheet (2016) Available (accessed 8 October 2017) at: https://webcache.googleusercontent.com/search?q=cache:3d9juYklJIQJ:https://www.eshre.eu/~/media/sitecore-files/Guidelines/ART-fact-sheet-2016.pdf%3Fla%3Den+&cd=1&hl=en&ct=clnk&gl=us

Hansen R and King D (2013) *Sterilized by the State: Eugenics, Race, and the Population Scare in Twentieth-Century North America*. New York, NY: Cambridge University Press.

Hartsock N (1998) *The Feminist Standpoint Revisited and Other Essays*. Boulder, CO: Westview Press.

Hochschild A (2003) *The Commercialization of Intimate Life: Notes From Home and Work*. Berkeley, CA: University of California Press.

Jeejamon P and Stephen M (2009) Health outcomes in Indians in comparison with other countries: India specific summary findings based on World Health Statistics (2008). *Indian Journal of Medical Research* 130: 570–572. Available (accessed 10 October 2016) at: http://icmr.nic.in/ijmr/2009/November/1114.pdf

Krishnan V (2013) India's draft Surrogacy Bill bars homosexuals, live-in couples. *LiveMint*, 7 August. Available (accessed 9 June 2016) at: http://www.livemint.com/Politics/ZsS2zs7KvqHlk4FCguW0EN/Draft-surrogacy-Bill-bars-homosexuals-livein-couples.html

Kusum S (n.d.) Public interest Litigation (PIL) challenging commercial, overseas, same sex, single surrogacy in India—Contemporary legal judicial developments. Available (accessed 7 June 2016) at: http://www.familiesthrusurrogacy.com/wp-content/uploads/2016/05/Indian-Surrogacy-Bill-Background-latest-developments.pdf

Ladegaard I (2013) Surrogacy changes perception of family. *ScienceNordic*, 18 May. Available (accessed 11 June 2016) at: http://sciencenordic.com/surrogacy-changes-perception-family

Ledbetter R (1984) Thirty years of family planning in India. *Asian Survey* 24(7): 736–758.

O'Brien M (1981) *The Politics of Reproduction*. Boston, MA: Routledge & Kegan Paul.

Pande A (2010) Commercial surrogacy in India: Manufacturing a perfect mother worker. *Signs* 35(4): 969–992.

Parreñas R, Thai H C, and Silvey R (2016) Introduction. *Intimate Industries: Restructuring (Im)material Labor in Asia*. Durham, NC: Duke University Press.

Patel R (2013) The long Green Revolution. *The Journal of Peasant Studies* 40(1): 1–63.

Perkins KM, Boulet SL, Jamieson DJ, et al. (2016) Trends and outcomes of gestational surrogacy in the United States. *Fertility and Sterility* 106(2): 435–442.

Pileggi T (2015) After new Nepal earthquake, Israel to evacuate more surrogate-born babies. *The Times of Israel*, 12 May. Available (accessed 9 June 2016) at: http://www.timesofisrael.com/after-new-nepal-quake-israel-to-evacuate-more-surrogate-born-babies/

Points K (2009) Commercial surrogacy and fertility tourism in India. Kenan Institute for Ethics at Duke University. Available (accessed 11 June 2016) at: https://web.duke.edu/kenanethics/casestudies/babymanji.pdf

Qadeer I (2010) The ART of marketing babies. *The Indian Journal of Medical Ethics* 7(1): 209–215.

Ram V (2002) Karnataka's unabating kidney trade. *Frontline*, 30 March–12 April. Available (accessed 7 October 2016) at: http://www.frontline.in/static/html/fl1907/19070610.htm

Roberts D (1997) *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York, NY: Random House.

Robertson JA (2015) Surrogacy, Israel, and the Nepal earthquake. Available (accessed 9 June 2016) at: http://blogs.harvard.edu/billofhealth/2015/06/04/surrogacy-israel-and-the-nepal-earthquake/

Rudrappa S (2010) Making India the "Mother Destination": Outsourcing labor to Indian surrogates. In: Williams C and Dellinger K (eds) *Gender and Sexuality in the Workplace (Research in the Sociology of Work, Volume 20*). Bingley: Emerald, 253–285.

Rudrappa S (2012a) Working India's reproductive assembly line: Surrogacy and reproductive rights? *Western Humanities Review* 66(3): 77–101.

Rudrappa S (2012b) India's reproductive assembly line. *Contexts* 11(2): 26–27.

Rudrappa S (2015) *Discounted Life: The Price of Global Surrogacy in India*. New York, NY: NYU Press.

Sarojini NB and Sharma A (2009) The draft ART (Regulation) Bill: In whose interest? *The Indian Journal of Medical Ethics* 6: 36–37.

Shah C (2009) Regulate technology, not lives: A critique of the draft ART (Regulation) bill. *The Indian Journal of Medical Ethics* 6(1): 32–35.

Sherwell P (2015) Indian surrogacy ban dismays British couples. *The Telegraph*, 18 November. Available (accessed 9 June 2016) at: http://www.telegraph.co.uk/news/worldnews/asia/india/12001903/India-surrogacy-ban-dismays-British-couples.html

Shroff S (2009) Legal and ethical aspects of organ donation and transplantation. *Indian Journal of Urology* 25(3): 348–355.

Singh A, Ogollah R, Ram F, et al. (2012) Sterilization regret among married women in India: Implications for the Indian National Family Planning Program. *International Perspectives on Sexual and Reproductive Health* 38(4): 187–195.

Thompson C (2005) *Making Parents: The Ontological Choreography of Reproductive Technologies*. Boston, MA: MIT Press.

Unnithan M (2010) Infertility and Assisted Reproductive Technologies (ARTs) in a globalising India: Ethics, medicalisation and reproductive agency. *Asian Bioethics Review* 2(1): 3–18.

Waldby C and Cooper M (2008) The biopolitics of reproduction: Post-fordist biotechonology and women's clinical labor. *Australian Feminist Studies* 23(35): 57–73.

Watkins ES (2012) How the Pill became a lifestyle drug: The pharmaceutical industry and birth control in the United States since 1960. *American Journal of Public Health* 102(8): 1462–1472.