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Potential, Risk, and Return in Transnational Indian Gestational Surrogacy

by Kalindi Vora

Based on fieldwork at a transnational surrogacy clinic in India and analysis of assisted reproductive technology (ART) legislation under consideration in the Indian parliament, this paper examines how bodies become potentialized through a combination of technology and networks of social and economic inequality. In this process, the meaning that participants assign to bodies and social relationships mediated by bodies becomes destabilized in a way that allows some surrogates to imagine and work toward a connection to commissioning parents that will offer them long-term benefit. The politics that position the clinic to potentialize the bodies of surrogates—and as a result the relations between participants and their imagined outcomes—occur at a moment of global demand for ARTs. As such, they rely on differentiation of subjects culturally, geographically, and economically. This article examines how the potentializing of women's bodies as surrogates occurs at the nexus of political, medical, and social influences in one ART clinic and how the resulting social relations are negotiated between participants in the clinic.

Growing transnational demand for technological intervention in conception and gestation combined with the unregulated status of assisted reproductive technology (ART) clinics in India has resulted in rapidly growing numbers of ART clinics serving transnational and wealthy Indian clientele. This article focuses on how participants—including surrogates, commissioning parents, physicians, and clinic staff—attach meaning to bodies and relationships mediated through ARTs. I argue that the bodies of women are potentialized to become both surrogates and a locus for new social meaning by the availability of ARTs and highly trained physicians in a location where there is minimal regulatory oversight and where women's material context makes surrogacy a financial necessity. The relationship between physical bodies and social meaning becomes oriented toward seemingly multiple future outcomes when surrogates use the continuous shift between economic and interpersonal registers in the clinic to imagine a long-term beneficial connection to commissioning parents. The politics that position the clinic to potentialize the bodies of surrogates and the way participants imagine the outcomes of relationships established in the clinic occur at a moment in which India has both highly educated medical professionals with access to cutting-edge technology as well as a large population of people without access to sufficient resources. As such, the potentializing of women's bodies as gestational surrogates relies on differentiation of subjects culturally, geo-

graphically, and economically. While the goal of gestational surrogacy may be straightforward in the eyes of the commissioning parties (the production of an infant), the way that various participants understand the process and its resulting social relations—both current and future—are multiple. This article examines several ways in which the potentializing of bodies and the resulting social relations are negotiated as participants navigate the uncharted terrain of transnational gestational surrogacy.

The largely unrestricted ART clinic in India was produced through an accident of historical conjunctures and has been encouraged in growth by a transnational and primarily urban-based Indian consuming class's willingness to seize a moment of possibility. The clinic is a productive place in which to observe—as Taussig, Hoeyer, and Helmreich (2013) state in the introduction to this special issue of *Current Anthropology*—several “processes of becoming.” Tracking these processes is valuable because they offer a site in which to observe the “articulations and practices” through which diverse participants negotiate “the task of being simultaneously biological things and human persons” in the face of moral claims that emerging medical technologies make on people's bodies (Taussig, Hoeyer, and Helmreich 2013). The social structures and material conditions at work within the clinic shape the ways that actors negotiate their relationships with one another, processes that through the lens of potentiality can be seen to work to secure an otherwise uncertain situation.

This paper uses observation and interviews from fieldwork in the Manushi clinic;¹ consideration of the proposed ART

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1. All identifying names of people and places have been changed to retain anonymity.

bill and rules currently under discussion in the Indian parliament; and the work of anthropologists, activists, and theorists to examine the ways that risk and expectation of future return motivate participants. These participants must navigate between risk and expectation in relation to how they understand the social relations formed through the clinic (see also Simpson 2013). In the first section, I address the ART policies and practices of the clinic, including its general geographic and political context, showing how many social and economic relations are up for negotiation even as the clinic's basic medical practices are well established. I then turn to the ways the bodies of women as surrogates are potentialized through narrative and other forms of representation at the clinic, including scientific discourse, in combination with sharp differences in access to resources. The third section turns directly to the expectations of both surrogates and commissioning parents. Here the stories that both parties tell point to a wide gap in the imagined potential created through the clinic as well as risks these participants take in pursuit of the promise of future rewards. The rewards may be both financial and altruistic for surrogates, including a hope by some for long-term connection with commissioning parents. For commissioning parents, the reward is an infant that shares meaningful biological qualities, including genetics; for the directors of this particular clinic, the rewards are financial gain coupled with the representation of responsible conduct toward concerned parties. In the final section, I build on the discussion of risk and examine the clinic's description of the ways it "rehabilitates" the surrogates as an example of how participants negotiate registers of altruistic and economic relations as they work to secure their preferred outcomes for the potentiality raised in the context of the clinic.

The Potentializing Clinic

ART clinics in India are currently expected to follow national guidelines but are not subject to regulatory laws. This means that individual clinics can form idiosyncratic policies regarding practice based on discretionary adherence to these guidelines with only the market and the management's sense of responsibility and ethics limiting what a clinic can offer and what arrangements it might make. There exists current draft legislation, but it does not define reporting or surveillance instruments for the regulations it proposes, and so it is unclear how long it will be before clinics must follow uniformly applied and enforced rules. In the context of the rapid social change taking place in India and the transnational commissioning parents entering surrogacy contracts with Indian women, this potentializing of women's bodies as surrogates also creates a unique social context in which participants can imagine multiple outcomes for their relationships. I argue that the social relations and economic opportunities that emerge from the social and financial practice in the under-regulated clinic are heavily influenced by commitments that

clinics make to promoting and enforcing the meanings attached to relationships formed through surrogacy arrangements in the clinic as well as the limits on economic activity proposed in national legislation intended to regulate the industry.

After the Manushi clinic's first successful surrogacy case in the early 2000s and the resultant media attention, demand led the clinic—which then and now operates primarily as a standard OB-GYN practice catering to local patients—to begin hiring increasing numbers of self-referred surrogates. A set of clinic policies formed organically over time, and by 2008, when I observed the clinic and conducted interviews, the experience for most surrogates, and to a lesser extent commissioning parents, had been standardized. For example, when a client herself does not have viable eggs, eggs from Indian donors are used; the clinic stipulates that the surrogate and the donor must be separate individuals, both of whom the clinic selects without input from commissioning couples. After an initial interview, there is usually little contact between surrogate mothers and commissioning parents. The clinic houses surrogates in hostels that their family members may visit if they live close enough to do so; few of the surrogates originally come from the town where the clinic is located. Surrogates are said to receive a fee of roughly US\$6,000, which can be the equivalent of up to 9 years of their regular family income. The overall surrogacy process at this clinic costs clients about US\$20,000 in comparison to the US\$80,000–100,000 it can cost in the United States.

At the Manushi clinic there is a policy of permitting only single or twin pregnancies for the protection of the mother and remaining fetus(es). The clinic also mandates that surrogates be married with at least one child, both to prove the viability of her uterus and because the directors believe it makes attachment to the commissioned infant less likely.² While these self-imposed policies are uncontroversial, there have been stories in the news in India of unwed women undertaking surrogacy, a concept culturally scandalous enough to provoke a public reaction, and pregnancy with multiples greater than twins in addition to other culturally or legally dubious practices. Doctors at the Manushi clinic and commissioning parents who had chosen this clinic after visiting others in nearby cities mentioned that some of these other clinics seemed nontransparent and "fishy," and anecdotal evidence suggests that many more clinics are performing surrogacy arrangements than are advertising them.

Just as the Manushi clinic's ART policies and practices were formed as needed and with little standardization, social re-

2. When women are pressured or required to leave their homes to live in designated surrogate housing during pregnancy as surrogates, a structural situation is created that parallels what Colen (1995) has called "stratified reproduction" and that Parreñas (2000) has called the "international transfer of caretaking" (569) in the context of transnational care and domestic labor migration where women leave their children to invest that care work into the households of families with greater financial resources.

lationships appear similarly unstructured. The brief account below provides a sense of the comparatively informal and sometimes ad hoc nature of organization and social relations in the clinic. It sketches a scene in which social relations between doctors, commissioning parents, staff, and surrogates are in flux and open to negotiation as a result of the potentializing of women's bodies as surrogates.

I sat in one of the clinic's two office rooms one day as Dr. H., codirector of the clinic, described the typical process for the increasing number of foreigners going through the stages of egg harvesting and semen collection toward gestational surrogacy via in vitro fertilization (IVF).³ Listening in to our conversation was David, a commissioning father from the United States who was visiting without his wife and was in the early stages of IVF and gestational surrogacy using donor eggs. Also present was Sanjay, a commissioning father and nonresident Indian from the United Kingdom with extended family in the region, whose twins had been born by a surrogate a few days earlier. Sanjay had met one of the clinic directors at a public lecture about the clinic in the United Kingdom several years before and had been in touch with the directors since that time. Dr. H. said that after the administration of hormones and later inducement to ovulation for the commissioning mother (or for the egg donor in the case that the commissioning mother's eggs are not being used), an egg is fertilized and an embryo is cultured with the goal of transferring it to the uterus of the surrogate. He noted that on day 2 of the culture, parents can view an embryo under the microscope and that when an embryo is transferred, the (commissioning) mother may attend the procedure, though he did not mention how the preference of the surrogate mother figured into this decision.⁴ As we were talking, additional visitors came and left the office and engaged in short conversations with Dr. H. or others in the room.

Following up on a comment he had made the previous day that surrogate mothers at Manushi and in India generally are "different than in the West," Dr. H. elaborated that the purpose of becoming a surrogate mother is different for women in India. He said, "Women enter into surrogacy because of the desire to earn money to start a small business or educate their children. In that sense, their decision concerns the well being of their whole family." His impression was that women who become surrogates elsewhere want to earn spending money for consumables or leisure-time activities. He had previously explained that the clinic makes a practice of holding the fees earned by a surrogate until the surrogate is ready to use them toward a specific end. The reason he gave was that if the men in her family get ahold of the fee, "They will spend it on a new motorbike or on drinking, and even the women

who aren't necessarily that educated will spend it on elaborate religious celebrations." He explained that the clinic has made all of the financial interactions in the clinic transparent.

Ajay, the driver for the clinic and sometimes tour guide for guests, walked in to ask Dr. H. about the schedule for an arriving client. After he left, Dr. H. explained to David that Ajay spoke functional English. David mentioned that he would be interested in paying Ajay extra money to take him sightseeing. David then asked Dr. H. whether he could change money there on the premises, which Dr. H. did within a few minutes. Sanjay joked that the clinic is also a currency exchange. After some time, a man came in to get a stack of paperwork from Dr. H., who followed him out of the room. Sanjay offered that this man manages all of the birth certificates for infants born by surrogates to foreign commissioning parents, noting that "he can get things done in 2 hours that would take me 3 weeks." Sanjay implied that the man (whom I later found out is also a nonmedical assistant in the surgery theater) has some sort of internal connections in several Mumbai embassies. Later in the afternoon, Ekta, a woman who had just agreed to become a surrogate, came in to sign some paperwork. A few days before, I had been asked to step in for Dr. H. to translate part of an introductory conversation between her and David. We had spoken informally afterward, but in front of the doctor this day she was much more formal and did not engage in conversation. After she departed, Dr. H. said, "You do a surrogate mother's [intake] interview and you get a vibe—good or not. I get a good vibe from her, that she will carry the baby successfully." Dr. B., the codirector of the clinic, came in a little later and announced in English that David, who was also in the room, had three good embryos for transfer. She added in Gujarati, to Dr. H., that because of his advanced age (in his early to mid fifties) she had to create a high number of embryos. Dr. H. nodded in my direction, a gesture that I assumed was to remind her that I could follow the conversation, unlike David. Another surrogate mother who was not introduced to me came in a few minutes later to receive her second trimester payment. Entering the conversation after sitting quietly for more than 45 minutes, and perhaps in response to the informality he perceived in the clinic, David said that he was afraid someone "[would] shut the clinic down" before his surrogate delivers.

The above interactions, all taking place in one room of the clinic on the same day, illustrate not only the informal economies and inchoate relations in play but also the way that attachment of meaning to social relations formed through the clinic work toward desired outcomes. I argue that this interplay is the direct result of attempts by different participants to secure future outcomes based on competing notions of what those should be.

Bodies and Sociality

To begin to approach the social, economic, and ethical factors influencing the outcome of the potentialized bodies and the

3. This excerpt is from field notes describing events on January 29, 2008.

4. Dr. H. described this process as the fertilization, culturing, and transfer of a single egg and embryo, although in reality several embryos and occasionally more will be transferred, depending on how doctors calculate the likelihood of successful pregnancy.

creation of social relations around them represented in the transnational ART clinic in India, I will examine some of the bodily concepts in play in the context of this clinic. These include conceptions of the body as described by surrogates, commissioning parents, and doctors and other staff in the clinic. Women who become surrogates are first made potential surrogates by a combination of their financial needs and lack of other resources as well as the technologies that make surrogacy through IVF possible for commissioning parents. In addition, I will attend to how the discourses managing how the meaning of the bodily process of gestation as well as gametes from commissioning parents and/or paid donors matter to the relationships between participants in the clinic and influence different understandings of what outcomes should result from participation as commissioning parent or surrogate.

The surrogates I spoke to, including former and current surrogates and women full of hope waiting to find out whether they had become pregnant as surrogates, first described surrogacy to me in the manner they assumed I wanted to hear, as it was what clinic staff, doctors, and former surrogates counseled them to understand and accept: the uterus is a space in a woman's body that is empty when she is not expecting a child, and surrogacy is simply the renting out of that space for someone else's child (see also Pande 2009; Vora 2009). The empty uterus is also that which is emphasized in headlines across the world sensationalizing transnational commercial surrogacy as "wombs for rent."⁵ Surrogates at Manushi clinic described the effort to become a gestational carrier in terms of managing who knows about their pregnancy, of the stories they tell extended family and neighbors to hide their pregnancies, of intentions that are related to material and spiritual concerns, and in terms of the view of their bodies and pregnancies as these exist between what they know and what they are being counseled to understand. For example, Durgaben, who had been through the embryo-implantation process and was waiting to find out whether she was pregnant when I met her, explained how she came to be a surrogate: "I have a friend in my neighborhood who was a surrogate [at this clinic], and she told me about this opportunity. She explained to me that my womb is like an extra room in a house that I don't need and can be rented out. The baby stays there for 9 months so it has a place to grow, but it is not your baby" (Vora 2009:271). Clinic staff guide women into an understanding that the child will not have a blood relation to them because it is genetically someone else's child, because its genes will not be hers. Further research needs to be done on how people who are unfamiliar with the basic biology of genetics, as is the case with the vast majority of surrogates before their contact with the clinic, translate and understand what they are told about genes and genetics. The codirector of Manushi clinic, Dr. B., has explained to me and in interviews with the press that part of her job with regard

to recruiting surrogates, for which she emphasizes that the clinic does not charge a fee, is that she must educate the surrogates to understand that surrogacy does not require sex to create a baby, because they have not before encountered technologies of IVF. This narrative, which is also recounted by surrogates, repeats the metaphors of the uterus as an empty room and of surrogacy as letting someone else's child stay in your house for 9 months.

One of the potentializing features of gestational surrogacy that is represented in the notion of wombs for rent is a spatialization reminiscent of colonial figurations and fantasies of newly encountered land as empty and unpopulated. This figuring positions land (and resources within) as in need of organization and management to become productive, which in turn justified its seizure. Assisted reproduction, tissue engineering, and stem cell research all share in the process of using technologies to reorganize or reconceptualize the body as a site of potential productivity. This creation of productivity is reproductive, speculative, and as such valuable to the market.

The discourse of wombs for rent or in need of management also helps displace the narrative of exploitation where surrogacy is the sale of the use of one's body parts by wealthier couples and where physicians are actually business people. It deflects the complex social friction generated by the practice of commercial surrogacy and suggests that surrogacy is simply fulfilling unrealized potential on both the side of the surrogate and of the commissioning parents. As clinic staff coach surrogates in the utility of their otherwise unengaged uterus and in informational literature, its website, and staff conversations with commissioning parents about the role of the surrogate as a temporary guardian of someone else's child (K. Vora, unpublished manuscript), the clinic creates a narrative of using otherwise wasted resources in the form of employing under- or unemployed Indian women as surrogates, a situation that justifies intervention and change. As an "idle machine," the womb of the would-be surrogate is abstracted from her subject and body and marked as an offense to productivity, which in part justifies its own exploitation by deserving would-be parents.⁶

Feminist anthropologists and science studies scholars lead us to ask how the organizing metaphors through which we conceive of the body and its processes tie into the formation of social and power relationships. Donna Haraway underscores the indivisible material semiotics of tropes in technoscience. She argues that there are figures—such as the gene, seed, fetus, bomb, brain, and race, among others—that have entire worldviews and their histories built into them (1997: 11). They are simultaneously literal, because they reference identifiable things in the material world, and figurative, because their self-evidential quality covers the way they shape

5. See, e.g., Ali and Kelly (2008) and American Public Media (2007).

6. Emily Martin tracks the historical "horror" at lack of productivity among capitalist subjects in the global north, citing "the factory, the failed business, the idle machine" (2001:45).

social relations, knowledge, and practice. Refiguration therefore becomes a site of political possibility. Emily Martin (1995) has traced the evolution of the metaphor of the body as an industrial society alongside the historical process of industrialization down to the level of the cell as a factory up through the flexibilization of the global economy and the concomitant model of the flexible body elaborated through metaphors describing the immune system. She sums up the metaphors in obstetrics texts, including medical school textbooks (e.g., Pritchard and MacDonald 1985), as “juxtaposing two pictures: the uterus as a machine that produces the body and the woman as laborer who produces the baby” (Martin 1995: 63). The doctor is seen as “the supervisor or foreman of the labor process” (Martin 1995:63). The narrative produced in the clinic positions the surrogate as someone who lacks a genetic relationship to the fetus and therefore is providing a service to the commissioning parents as the owner of a uterus that is a machine to be let out and whose production is to be professionally managed through hostelry, medical surveillance, and coaching her to be the right kind of subject.

Genetics is the underlying justification for the nonrelationship between surrogates and the fetuses they carry, and in everyday language surrogates utilize this discourse through referencing knowledge that the child will not look like them, although the depth of their engagement with genetic discourse is not perfectly clear. Nonetheless, I argue that the work of doctors and staff at the clinic to induct surrogates into a form of “genetic essentialism” is a tool both to assure them of the moral soundness of surrogacy (it does not involve sex outside of marriage) as well as to make them understand that the baby will not be theirs and that it is rather a foreign presence in the otherwise empty space of the uterus.⁷ As I will explain below, geneticization, the process by which genetics has come to explain health and disease and to naturalize social differences as biologically based (Lippman 1991), is one piece of a larger project of social uplift imagined through benevolent education of surrogates by doctors, staff, and the matron of at least one of the hostels.

As mentioned above, commissioning mothers are invited into the embryology lab in sterilized suits and masks to view the forming embryo under the microscope.⁸ One of the directors cited this as an example of something you could not get in a more commercial and large-scale clinic in the United States or United Kingdom, and as such it was part of what made Manushi special: its attention to the clients. Also, she

said, it “helps (commissioning) mothers bond with the fetus.” Martin (2001:180) asserts that practices that push the level of analysis and observation down to the microscopic view in biology detach it from bodies and persons and from social structures and processes, and that forcing the scale of knowledge back above the microscopic cannot undo the effects of having seen things at that level. The very idea that there is “something” with which to bond depends on the externalization of the fetus from the uterus, the microscope as instrument, and the visualization and discourse of the fetus. DNA explains who is supposed to bond with the cells under the microscope. As a metaphor, DNA implies a hierarchical ordering, so that the intended parents as the source of DNA (even when working with donated eggs) have more right to control the process of surrogacy than the surrogate, because the fetus is their property and she is a service provider.

The way that surrogates at Manushi clinic talk about their relationship to pregnancy and their pregnant bodies rehearses some of the clinic’s metaphors, but it also insists on a commonsense notion that it is their body, its blood, and the food they eat and use that is growing the infant. Surrogates explain their influence through pregnancy on the outcome of the birth. For example, one former surrogate noted that the reason her commissioning parents would have a boy is because she was very successful in producing boy children, having produced two of her own. In addition to asserting the presence of competing ideas about the nature of surrogacy (see also Pande 2009), these other modes of embodiment in surrogacy point to other possible socialities than those indicated by geneticization.

The Imagination of Debt and Future Connection

After acknowledging how difficult it was to see their husbands and children only once a week as well as managing the isolation of living away from their homes in general, women who stayed in the hostel I visited described the positive aspect of living there throughout their pregnancy and postdelivery as an experience of sisterhood with other surrogates. Some imagined this feminine space and time away from the demands of family to be akin to staying in a student hostel, an experience most would not have had. Some women described missing others who had left after giving birth, and one woman noted that she dreaded leaving her sisters at the hostel behind after she completed her surrogacy. At the same time, many women explained that living in the hostel was a necessity because of the pressure to keep this work a secret from their extended families to escape the social stigma imposed by community members; living in the hostel gave them a place to stay away from home and out of sight. Many of the women I spoke to had told at least some neighbors and extended family, if not in-laws, that they were going to a distant city in India or as far as Dubai for a temporary job. Women whose homes were within a reasonable driving distance could en-

7. Sarah Franklin describes genetic essentialism as “a scientific discourse . . . with the potential to establish social categories based on an essential truth about the body” (Franklin 1993:34; cited in Haraway 1997: 147). Martin (1995:153) cites Latour (1990): “The essential features of modern power: change of scale and displacement through workshop and laboratories. In this change of scale, something very minute, discovered by science, comes to play a deciding role in human questions or concerns that are very large” (171).

8. I did not hear of any fathers, though I can imagine that they would be invited in the absence of a mother.

tain visits from their husbands and children on weekends, and these children were told different stories, sometimes that their mother was receiving special medical care for a health condition. In the case of one family I spoke to, the children were told that their mother was going to have a child for another family who could not have children. This desire for anonymity underlines the possible shame in this work, though surrogates emphasize that the work is morally defensible based on the fact that the embryo is made outside the body and inserted by the doctor.⁹

Commissioning parents express a spectrum of sentiments about their future relationship to their surrogate, ranging from a vague hope that her fees will help her improve the lives of her family members to specific goals of educating her children. These sentiments exist in the context of knowledge that given India's lack of legislation regulating surrogacy arrangements and the social and geographical distance between their family and that of the surrogate, any future connection is ultimately entirely within their discretion. One middle-class white couple that was visiting the clinic for egg harvesting and sperm donation for IVF and surrogacy offered several reasons for choosing this clinic over a clinic in the United States, including its affordability for them after several failed IVF cycles in the United States as well as the physical distance that would exist between their family in the United States and the clinic and their surrogate in India. Mentioning discomfort with custody claims made by former surrogates in US courts, she said, "I'm glad that she [the surrogate] will be in India and we will be in the US." The spatial imagination of distance is not only about geography but also the implicit acknowledgement that women of the class from which surrogates are recruited, primarily women whose family members can only find casual or day labor between longer jobs doing manual and service work, will not have the education or means to track them down in the future, even if the clinic somehow failed to protect their identifying information.

Despite being told that the only relationship they will have to the intended parents of the fetus they carry to term will be transactional and temporary, discussions in the surrogacy residence hostel and comments by aspiring and new surrogates point to different expectations. Former surrogates I spoke with said that in spite of their coaching, they missed the children after they left India and hoped to hear about their development and to receive pictures as the child continued its life away from them. That said, none mentioned the hope of an ongoing relationship with the child specifically. For example, Sita said that she "feels good" after delivering an infant as a surrogate 1 month before. She elaborated, "I feel connected to that person [the commissioning mother], as if I had known this lady for a long time. She continues to call me and I feel good because she keeps calling to talk and ask how I am doing. I hope it will continue this way for my

lifetime." When directly asked about hopes for the future relation to the commissioning family, one current surrogate offered that she "would be pleased" if the child attempted to meet her after it had reached adulthood, and another surrogate mentioned that, "they [commissioning parents] should remember me on the birthday." When I asked how she should be remembered, she said, "I would want them to call," and another woman offered that, "they should send a gift on the birthday." In this way, the hope, and in some cases, the attempt to create an ongoing relationship with the commissioning parents that would continue to benefit themselves and their families in the future was first and foremost. Pande has observed this fantasy as a type of "kinship work" that Indian surrogates do in building real and fantasy ties with commissioning families across caste, class, and regional and national lines (Pande 2009). Some women at Manushi described their efforts to establish a reciprocal relationship modeled on that of patron and client, where the surrogate expects the commissioning parents to sustain a sense of duty toward her after the child is given to them, and even though she makes no kinship claim on the child, the surrogate might feel that she can make a claim on the parents as patrons. Although women I spoke to admitted that it has not happened very often, there was a tendency to dwell on the stories of those rare surrogates who did receive continued or extended support or even just promises of support from their commissioning parents. In one introductory interview between a commissioning father and his assigned surrogate (because he was using donated eggs, his wife had elected not to travel to India for this first visit), she explored the extent of his intentions toward her and her family by asking whether he would be willing to bring her family to the United States and help them find jobs. He did express a vague intention to help educate her children and perhaps invite them to the United States, but by the end of their contract 9 months later, he described enormous frustration with her continued attempts to "get more money" from him and his wife whenever they communicated. Dr. B. had earlier explained to me that part of the reason that they discourage communication between surrogates and commissioning parents, in addition to the often insurmountable language gap, was to protect commissioning parents from being pressured by the surrogates, though she said that the structure of the clinic and its surrogacy arrangements made anything like blackmail impossible.

When I spoke to women who were currently pregnant as surrogates, many described the value and meaning of surrogacy as different from a job, as apart from categories of kinship new or old, and as apart from clinic and market discourses. There was instead an emphasis on a feeling that carrying a child for a couple that could not otherwise have a child was an extraordinary and even divine act and that this was more important than money as a motivation (Vora 2010). Discourse about the divine aspects of surrogacy point to simultaneous and competing logics for the social meaning and value of gestational surrogacy. These meanings cannot be

9. A position supported by Pande's (2009) and Saravanan's (2010) studies.

easily organized or communicated through the genetic definition of a biological parent, though it is a condition of possibility for commercial surrogacy, or even through the economic logic of the value of the labor of surrogacy as underpaid and technologically mediated “women’s work” in the global economy.

The feeling that commissioning parents owe something to the surrogate in kind for the magnitude of the gift of a child fits into a cultural logic outlined by Jan Brouwer (1999) in her study of small business culture and its disjunctures with global business culture in India. Brouwer argues that indigenous cultural ideologies spanning India posit an economy of debt and repayment that is partially sympathetic with the economic logics of global production but whose differences are essential. Her study of the Vishwakarma community of jewelry artisans in interior Karnataka State finds that debt and payment between goldsmiths and the commissioning businessmen who sell their work is about acknowledging the importance of open-ended social relationships.

What is read by commissioning parents as solicitation and manipulation for more money and resources by a surrogate can be seen as a way to insist on the transcendental nature of her gift, which necessarily exceeds the surrogacy fee and creates on opening that logically insists on continuing relationality and exchange even as it can simultaneously be a pragmatic pursuit of an opportunity for accumulating resources. This possibility of mediation that builds on indigenous and global systems simultaneously, working between the cultural logic or commonsense expectations of workers and other subjects in India and the logic of neoliberal exchange and financialization, sets up an interesting context for rethinking ethics, responsibility, and regulation in transnational surrogacy, which I will take up in the last section of this essay. At the least, it creates a precedent for taking seriously the ontological and material expectations of both surrogates and commissioning parents in establishing an ethics of practice and remuneration in the clinic.

Promise and Risk

In exchange for the promise of their fee and the possible future it represents, surrogates undertake uncertainty and unknown risks in terms of their social status, their health and wellness through pregnancy and thereafter, and even the chance that they will not receive the full fee promised to them. For commissioning parents who have deferred childbearing or who have ongoing medical obstacles, the promise is that reproduction is possible. The other side of the promise of the social experiment contained in transnational Indian surrogacy, for commissioning parents and surrogates alike, is the possibility of accidents or other unpredictable outcomes, and together these characterize the space of the clinic.

The promise that justifies the undertaking of risk can be as simple as the temporary end of a state of mundane crisis—the impossibility of getting by—but can also serve as a plat-

form to imagine possible futures. For example, the sum surrogates are promised is enough to create a small platform from which it is possible to imagine another future even if that future is simply coming closer to ends already mandated (dowry and wedding expenses, debt). On the part of surrogates, the promise also unfolds in the imagination of future assistance from commissioning parents and future employment through the clinic.

The health risks associated with pregnancy for surrogates include those inherent in all pregnancies, including but certainly not only complications such as preeclampsia, gestational diabetes, or problems leading to preterm birth. It is difficult to get comprehensive statistics for the nature and outcome of births associated with ART clinics in India right now because there is no required reporting (Sama Resource Group for Women and Health 2010). In 2008, the Manushi clinic was not offering any kind of risk-related counseling to surrogates. Several surrogates volunteered that they had not had this kind of high-tech intensive prenatal care and supervision during their other pregnancies, which suggests a feeling of less risk than they faced with prior births. These would likely have been at home attended by a midwife, or for those with the means to afford it, in the local maternity hospital, but without the interventions of ultrasound or blood testing unless there was illness and money for such care. Interviews between doctors and commissioning parents I observed did not include any kind of risk counseling, though this could be the result of limited access to client interviews with doctors. The medical risks for egg donation, IVF, and surrogacy exceed even those that are routinely disclosed through contracts and counseling in more highly regulated clinics outside India, and reports from Sama Resource Group for Women and Health (2010) indicate that there is little disclosure of risk in Indian ART clinics in general.¹⁰ Pregnancy with multiple fetuses is common in IVF, and these pregnancies are subject to higher risks for surrogates than single pregnancies. Current draft legislation does not grant a surrogate a choice in whether or not she wishes to undergo a multiple pregnancy. Also, the hormones injected by intended mothers and surrogates alike—hormones that organize the female reproductive system to synchronize it with the clinic’s schedule for egg harvest, IVF, and embryo implantation—carry risks.¹¹

Additional risks are posed to participants in surrogacy arrangements because of the lack of legal protection. The Indian

10. Sama Resource Group for Women and Health is a nongovernmental organization based in New Delhi, India (<http://www.samawomenshealth.org/>).

11. For example, Lupron (leuprolide acetate) is the drug used (off-label) most often to shut down ovaries before they are stimulated with other drugs to produce multiple follicles for egg harvesting in preparation for IVF and for egg donation. There have been no long-term studies of Lupron, but a long list of side effects have been reported to the US Food and Drug Administration. Studies also indicate a statistically significant higher risk of ovarian tumors among IVF patients as well as ovarian hyperstimulation syndrome (Sama Resource Group for Women and Health 2010:95). See also Lowry (2012).

government is excited about its position in the growth of the biotechnology industry worldwide, and as K. Sunder Rajan (2007) explains in his ethnographic work on clinical trials in India, governments must compete to attract commercial research organizations to their countries by offering laws attractive to them. Draft ART legislation in India would grant active surrogates claim to insurance through the commissioning parents “as per the agreement and till the surrogate mother is free of all health complications arising out of surrogacy” (clause 34.23). It is difficult to imagine that someone of the social class in which most Indian surrogates find themselves would or even could pursue commissioning parents, about whom they often have very little information, for long-term health problems attributable to surrogacy such as those indicated by the recent studies mention above. The law draws out a contracted period with limited obligations to the surrogate on the part of commissioning parents, mainly the maintenance of the surrogate and mandated custody of the child once it is born “irrespective of any abnormality” (clause 34.11). The surrogate meanwhile would be constrained by a more abstract and limiting clause, where she must not “act in any way that would harm the foetus during pregnancy and the child after birth” (clause 34.28). The child born to a surrogate may request information about egg donors or surrogates at age 18 (clause 36.1), as may their guardians before 18 with “prior informed consent of donor or surrogate mother.” There are no equivalent rights to information for surrogates in the bill.

“Life for Life”: Meaning, Politics, and Ethics of Surrogacy’s Exchanges

A combination of the inability to get by coupled with a creative imagination of possible future prosperity and reinvention through the connections and resources represented by the clinic leads women to pursue gestational surrogacy. Echoing defenders of the market in human kidneys, Dr. B. argues that the exchange involved in surrogacy arrangements is an exchange of “life for life.” This argument, equating the reproduction or preservation of life on the consuming side and the means of subsistence on the producing side, veils the differential material circumstances that make such an exchange uneven because it implies that there is some quantum of “life itself.” Examining the process by which “life itself” comes to be imagined as a unit of exchange is instructive for understanding how ARTs in the context of the Manushi clinic are not neutral instruments of human activity but rather vehicles for the perpetuation of unequal social-material relations as well as for the invention of new ones.

Dr. B.’s promise to would-be surrogates, through a word-of-mouth recruiting strategy, is that she will assist them in keeping control of their earnings even against the will of the husband and father-in-law in her house, whose money it ultimately is understood to be by the conventional patriarchal social logics of the joint family economy. Part of this project

is that the husbands’ relationship with the clinic does not end with signing the permission form for their wives to become surrogates but that they are also, at least by association, included in the clinic’s program of uplift, or restructuring. For surrogates and sometimes their husbands, working with the clinic becomes a career plan, and this also becomes a reason that women are interested in becoming surrogates at the Manushi clinic. Former surrogates have been hired into service positions such as nursing assistants or custodians, and when possible or in cases where the directors feel it will be particularly important, their husbands are also incorporated. For example, the cook in one of the hostels is the husband of a former surrogate who needed a job, as are a number of other ancillary clinic staff. The story of the husband who gave up vices such as alcoholism or gambling under pressure from Dr. B. is another trope of reform or rehabilitation of husbands.

The women undertaking surrogacy describe their understanding of the risks and future potential of their work in terms that acknowledge but also exceed the clinic’s discourse of surrogacy as simply the paid service of gestation and rented use of an otherwise unused uterus. Their “unreasonable” expectation of a sense of indebtedness on the part of commissioning parents could be seen as an attempt to potentialize relationships formed through the clinic and to stabilize one of the competing meanings of surrogacy as exceeding what is represented by the contract. In this sense, it could be seen as a risk-management scheme on the part of women undertaking surrogacy and as insisting on an alternative ethics for the practice and value of gestational surrogacy. Dr. B.’s explanation of the clinic’s project of bringing together needy surrogates and childless couples as an exchange of “life for life” is also a way of stabilizing the meaning of surrogacy, framing it in a way that recalls other commercial biological exchanges, such as the exchange of a healthy kidney for money on the part of an impoverished kidney seller (Cohen 2003; Schepher-Hughes 2000) or the participation of an impoverished or uninsured person suffering an illness in clinical trials for medical treatment (Cooper 2011, 2012; Sunder Rajan 2007).

Behind the material conditions underlying the willingness of women to enter into surrogacy are structural adjustments that began in 1991 in accordance with the terms of an International Monetary Fund loan to the government of India. These adjustments continue in the ongoing contraction of social welfare programs and governmental protections of the domestic economy against global free trade: the removal of farm subsidies, reductions in rural health programs, and new legislation that ignores protecting life and health (Sama Resource Group for Women and Health 2010) because the market will “naturally” take care of it through life for life exchange. The cutbacks to social welfare programs in India as well as in the nations from which commissioning parents travel fall most heavily on those who already go about their lives in the margins of society’s sphere of wealth and power, where more and more women cannot conceive without as-

sistance, largely due to preventable secondary causes such as malnutrition and unsafe routine gynecological surgeries (Inhorn 2003:1840). Instead, these cases of infertility are cited as justification for the expansion and protection of technological intervention, creating a situation where fewer and fewer people have the option of procreation without the intervention of biomedicine. “Life for life” materializes a dependent and arguably colonizing relation justifying the conditions that lead subjects into ultimately unequal exchanges. Ironically, as Sunder Rajan (2007:76) explains, the uncoupling of therapeutic access and experimental subjectivity means that experimental subjects such as those participating in clinical trials in India, and I would add surrogates participating in commercial surrogacy to a lesser extent, contribute to an abstract idea of “health” as a social good but have no access to the results in terms of their individual health.¹²

In a 2010 report, Sama Resource Group for Women and Health indicated that people from all parts of society in India are seeking ART treatments, though they are primarily accessed by middle and upper classes. The growth of the Indian middle class has been a precondition and indeed creates the conditions of possibility for the growth of commercial surrogacy in India along with the success of some sectors of India’s diaspora who have returned to India for reproductive health care. A lifestyle change where young families choose career advancement over procreation, the structural adjustments in governmental economic policies that favor the transnational capitalist class over the ever-growing numbers of those who earn less, and the cultural imperative to become a subject of consumption (K. Vora, unpublished manuscript) set the stage for the success of the transnational ART clinic as well as the continued growth of the surrogacy industry. In light of this possible and even likely future, it will remain essential to ensure rights that allow participants to control the risk they face through the intervention of the state legal apparatus. Such rights might include the right to elect whether or not to undergo a multiple pregnancy, which at this moment is not in their realm of choice despite it increasing their risk, and the right to arrange an open surrogacy and therefore future connection to the commissioning family; these are rights that are not supported by the ART bill in its current form. Feminist activists also advocate for media literacy training for future surrogates, donors, and parents rather than just reform of the problematic informed consent apparatus (Sama Resource Group for Women and Health 2010).

Conclusion

Dwelling on the tensions and dynamics that arise between doctors, commissioning parents, surrogates, and other actors in the clinic highlights how ART clinics, along with global

inequality, simultaneously potentialize bodies and social relations in unequal forms of exchange. The unregulated nature of ART clinics in India potentializes the bodies of Indian women who need financial resources as having reproductive capacity that can benefit others. This reproductive capacity benefits the commissioning parents, who receive a child in exchange for a fee that is very low for the international market. It also benefits the doctors and the brokers who connect doctors and patients and who reap profits by manipulating the vast difference in earning between surrogates and commissioning parents. This potentializing of bodies entails risks for participants and particularly surrogates, who risk their health, the stability of their families, and their reputations. The potentializing of social relations engendered through surrogacy arrangements allows commissioning parents to pursue a biological child through a form of surrogacy promoted as improving the conditions of women who act as surrogates while creating opportunities for surrogates to attempt to establish extracontractual connections to commissioning parents, the clinic, and other surrogates as a way to create future opportunities and resources for their families. It leads the clinic, including physicians and staff, to portray itself to both surrogates and commissioning parents as an entry point for women, through education and property ownership, into India’s seemingly endless promise of economic growth while building the foundation for a financially lucrative transnational medical practice.

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12. Sunder Rajan notes that in some rare instances, a particular trial-sponsoring company may elect to offer therapies to trial subjects through so-called compassionate use programs (2007:76).

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