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# Experimental Sociality and Gestational Surrogacy in the Indian ART Clinic

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**ABSTRACT** *This article marks experimental modes of sociality in a transnational Indian assisted reproductive technology (ART) clinic as a contact zone between elite doctors, gestational surrogates, and transnational commissioning parents. It examines efforts within one ART clinic to separate social relationships from reproductive bodies in its surrogacy arrangements as well as novel social formations occurring both because of and despite these efforts. Draft regulative legislation in India marks a shift in the distribution of risk among actors in the clinic that parallels a shift in medical practice away from a technique of caring for the body to producing bodies as instruments of contracted service. The clinic provides an opportunity to observe forms of sociality that emerge as experiments with modernities, with different relationships to the body and the social meaning of medicalized biological reproduction, and with understanding the role of the market and altruism in the practice of gestational surrogacy.*

**KEYWORDS** *Assisted reproductive technologies, Indian gestational surrogacy, medical tourism, reproductive labor*

**T**he number of assisted reproductive technology (ART)<sup>1</sup> clinics that offer surrogacy services in India is growing but is still relatively small compared with other medical specializations. Using material from observations and interviews conducted in 2008 in North India, follow-up interviews with doctors and commissioning parents up until the present, and archival documents and media debates around pending ART legislation in India, this article examines some of the ways that participants negotiate the meaning of surrogacy arrangements through experimental modes of sociality, both in practice and imagination, in the context of the clinic. Here middle-class but demographically elite doctors, elite Indian commissioning parents,

non-resident Indian (NRI) and transnational commissioning parents,<sup>2</sup> and rural women who wish to become surrogates and have comparatively few resources, including finances, education, connections, and governmental investment, are meeting and inter-relating in addition to exchanging money and services. In the tradition of medical anthropology, I observe these interactions and practices as constituting an important site of social analysis without the goal of making claims about individuals' social worlds outside the clinic. This article also draws upon longer-term observation of the rise of other globally oriented and technology-based industries in India through fieldwork conducted intermittently between 2004 and 2006.

As a space of mediated social interaction, the transnational market in surrogacy as it manifests in the Manushi clinic shapes the ways that doctors, commissioning parents, and surrogates can interact. The space of the clinic is already defined at least in part through the relationship of exchange materialized in the surrogacy contract and the intervention of medical technologies and knowledge that makes gestational surrogacy possible. These conditions in turn impact the way that people understand their bodies and modes of engagement in relation to one another, producing modes of social experimentation that

[emerge] as a subjective orientation towards the world and towards society, moving [experimentation] beyond the realm of medical anthropology into the larger field of material culture and consumption as these are characterized by a mode of inhabiting rapidly shifting and increasingly global social/market contact zones. (Towghi & Vora 2013)

As embodied in Mohandas Gandhi's experiments with decolonizing political philosophy, experimentation with different modes of being and subjective orientations to the world becomes central to the very meaning of what it means to be modern (Towghi & Vora 2013). Structures and practices in the clinic endeavor to separate social relationships from reproductive bodies, and the negotiation of this separation is one of the most evident efforts in the experimental social relations formed and imagined in the clinic. Other experimental socialities form as the result of the way this clinic has structured its practice, such as in the relationships that form between surrogates and their experience of camaraderie and kinship in surrogate hostels. Though these relationships are not at the heart of the clinic's intended goals for surrogacy, they support its success while also providing opportunities for conversation and collaboration between women residing there. These experimental relations can be under-

stood to reflect or react to, in part, an intentional shift in medicine and governmentality<sup>3</sup> away from a technique of caring for the body, or pastoral care, to one of producing bodies as the instruments of service work and surrogates as entrepreneurs of the contracted use of those instruments. This project is reflected in draft legislation proposed to regulate commercial surrogacy in India, and entails an uneven distribution of risk among participants in gestational surrogacy that has become an issue of national debate as well as impacting the way that participants imagine their relationships to one another through surrogacy arrangements and beyond.

## Background

The Manushi clinic is housed in a modest out-building in part of a hospital complex in the middle of a small city in northern India. Difficult to find without local advice, the clinic consists of a large waiting room in which there is a free-standing registration desk and an adjacent restroom, three examination rooms along a hallway that is separated from the waiting room by a fabric curtain, a nurses' station, and two office suites for the co-directors of the clinic. Dr T's<sup>4</sup> office serves as the *de facto* public relations office, and as the reception and waiting area for wealthy Indian and foreign visitors, clients, and patients of the clinic. With cushioned rolling chairs arranged around Dr T's large desk and a recently renovated wash room with a western style toilet, this office offers a more familiar and comfortable experience for these client-patients. It also serves to juxtapose the private style of medicine offered by the clinic to the large tiled waiting room where local patients wait barefoot (leaving shoes outside as customary) in plastic chairs pushed against the walls for the general OB/GYN practice that operates as part of the hospital's services.

The clinic's transnational practice began when NRIs, home to visit family in the area, began to seek treatment for reproductive ailments from the highly trained Dr B. Already performing *in vitro* fertilization (IVF) and laproscopic reproductive surgeries with great success and for prices that were far lower than those in their home countries, in the early 2000s she agreed to a request by a former patient to attempt gestational surrogacy. This patient had arranged for a family member to act as her gestational carrier. The case was a success, and through word of mouth and newspaper articles in the UK and India, the surrogacy practice began to grow. A decade later, the clinic receives as many as 10,000 emails regarding their gestational surrogacy practice per month, and though it is a very small clinic, it has hired a staff person entirely in charge of managing its correspondence generated by press coverage and visitors to its

Web site. In 2008, there was an average of 50 active gestational carrier pregnancies at a given time, the maximum the clinic could support in terms of its personnel and housing resources. The clinic directors emphasized that women interested in becoming surrogates came after hearing about them through word of mouth, and were strictly self-referred, a significant difference from other clinics who rely on brokers to recruit surrogates. The clinic attributes their successful word-of-mouth recruiting to the efforts it has made to teaching women to invest their surrogacy fees in newly constructed homes, education, and setting up small businesses. The wait list for people meeting the initial criteria for eligibility for gestational surrogacy has as many as 500 entries.

The formation of something like a small tourism industry around the Manushi clinic has occurred in the fashion of a growing set of cottage industries. Foreign clients arrive to the clinic in different ways, but for most Dr T arranges in advance to send one of the two brothers whom he employs as drivers for the clinic. One or the other will drive over an hour to the nearest airport to fetch patients back to the clinic, at the patient's expense. Many clients later choose to hire one of the drivers to give them tours through the greater area and for day-trips out of town during their visit to the clinic at the encouragement of Dr T. He also arranges for clients to stay in the local hotel, nice by local standards but not qualifying for the international hotel star ratings system. At the time of my visit, plans for building an internationally rated hotel for foreign patients were being discussed, and suggest that expansion and profitability is part of the clinic's future plan, though the directors emphasize their disinterest in being a business and described the hotel plan as a way to make foreign guests more comfortable during their visits.

### **Commissioning Parents and the Developing Transnational ART Clinic and Market**

During the day, foreign commissioning parents pass in and out of Dr T's office as they wait for various tests or procedures at the clinic. One couple that frequented this room during my visit were British Indian parents whose twins had been born to their gestational surrogate just one week earlier. They were now in the three-month waiting period required by British law for bringing home their new child because of its legal status of being born abroad through gestational surrogacy. Their twins were housed in the neonatal intensive care unit (NICU) where they would stay until they reached a stable weight after being born through cesarian section. The couple stepped into the office between visiting hours in the NICU or where the gestational surrogate who

delivered the twins would visit to breastfeed them. This surrogate, whom I never had the opportunity to meet, was a Hindu woman from a town near the clinic, and was reportedly recovering without incident. Though clinic directors told me that surrogates usually only breastfeed newborn infants for two or three days after delivery to give them some immune benefits, a number of recently delivered and former surrogates were currently or had in the past been breastfeeding infants for two weeks to three months after delivery.

Dr T's office offered no entertainment for those waiting other than conversation, and new arrivals were anxious to hear the stories of this couple from the UK that represented their own possible success in having a child. Reeta, the new mother, described to a rapt and often emotional group of intended parents how she had spent large periods of time over the last 20 years trying to become a mother, first through hormonal fertility therapies and then primarily through IVF. She mentioned that at different points she and her husband Sanjay had considered adoption, but it was essential to them that their child be Indian and vegetarian from conception. They learned about the clinic when Dr B. gave a lecture on her work at the Manushi clinic to their local chapter of the Vishwa Hindu Parishad, an international Hindu diaspora organization and one stop in her speaking tour of Anglo-Indian communities in the UK. After hearing about her work in gestational surrogacy in India, they realized that this was the perfect opportunity to finally have a child that fit their ideals both in terms of its genetics-based identity and through the nature of the gestational carrier's womb. They would use the clinic's egg bank, where all donors are local Indian women, and an Indian gestational surrogate.

In talking about their attempts to start a family over the last 20 years, Reeta and Sanjay also expressed frustration with what he described as the limitations of the British legal system, where commercial surrogacy is illegal and only allowed as an altruistic arrangement. Commissioning parents from other countries with legal limitations on commercial surrogacy discuss these limitations as central to their decision to come to India. Such limitations include the number of embryos allowed for implantation (an indicator of the likely success of a given IVF cycle or gestational surrogacy attempt), laws about when infants born through surrogacy abroad may be repatriated, and laws concerning the stance of public or private medical institutions toward financial coverage of fertility technologies. Sanjay described Reeta's periods of depression that alternated with desperation and determination to conceive a child, describing how despite having a good job as a manager in a financial institution, and other stability in her life, she could not be happy until she had a child. As



high-caste Gujarati Hindus living abroad, who clearly maintained an investment in Gujarati Brahmin notions of vegetarianism and bodily/spiritual/caste purity around diet, Reeta and Sanjay found in the Manushi clinic an opportunity to both skirt British laws governing surrogacy and insure the conventions of Gujarati Brahmin vegetarianism from the moment of conception.

Another couple that was part of group discussions with Reeta and Sanjay was Karen, a homemaker, and her husband Jim, a salesman from the USA. Karen explained the feelings of alienation and hopelessness they had suffered after more than three years of failed IVF cycles in the USA. She described the experience of being referred to exclusively by her patient number at her clinic in the USA and of having no consistent relationship with a given clinician. She contrasted this to the 10 days she had spent at the Manushi clinic thus far, where she felt she received very personalized attention and care. Their reasons for coming to India were primarily cost-based, though Karen added that they had shopped around, looking into a few other fertility clinics offering gestational surrogacy in India before finally choosing Manushi:

[The other clinics] felt like such a business. I mean obviously everyone does things for financial gain, but it just had a very negative feel to it, and being here it feels like you are helping someone who really needs it and they are doing something amazing for you. It is such a positive feeling for you. This clinic seemed much more open and like they weren't hiding anything.

Karen's comment about 'helping someone' is in reference to the clinic's emphasis on assisting women who become gestational surrogates to manage their fees in a way that have lasting material impacts. Similar sentiments were expressed by a number of other non-Indian transnational commissioning parents who felt that the relatively high fees paid to these rurally based Indian women (roughly \$7000 – equivalent to eight or nine years of regular income), in conjunction with the clinic's emphasis on the social work imperative of the clinic, mitigated their own potential role in exploiting gestational surrogates through fee-based surrogacy arrangements.

This informal program of uplift for surrogates focuses primarily on encouraging the surrogates to manage their finances in particular ways. In January 2008 the directors of the clinic had just begun offering to place fees earned by surrogates into trust accounts so that the money could be preserved, upon the woman's request, until the time was right to use it for the purpose she wished. When requested, the clinic would pay the funds directly to a

home-builder, bank trust, etc. Staff described how, prior to this arrangement, women would 'misuse' their funds, choosing (with the influence of husband and in-laws) to buy cars, scooters, or other consumables, and in at least one case the money was spent on the husband's gambling. Another popular use for the sum was to fund large-scale religious ceremonies and rituals. Though such ceremonies could be interpreted as redistributing the wealth gained through surrogacy among the immediate community, the doctors saw all of these uses as wasteful, and began counseling the surrogates on how to use the money to buy a house, start a business, or fund the future education of their children. These were the only uses for surrogacy fees that were given to me by clinic staff members, though a number of surrogates talked about paying off debt or saving for dowries as goals in addition to the projects emphasized by staff. As mentioned above, these stories aid in recruiting potential surrogates as well as creating a platform for commissioning parents to imagine a form of benevolent, distant, and continued social impact and relatedness to surrogates' lives through the fees they pay for surrogacy.

### **Experimental Socialities, ARTs, and Embodiment**

The clinic protocol for matching egg donors and intended parents is that the directors choose fully anonymous egg donors for a given intended parent or couple. The same principle applies in the matching of gestational surrogates and commissioning parents. As far as psychological screening of women interested in becoming surrogates, Dr T, who interviews interested candidates, says, 'you know if they are the right type. You get a sense right away if this person is serious'. These practices of selection form part of the justification Dr B gives in arguing that the clinic is not in the business of producing designer-babies. She also supports this claim by insisting that the clinic only accepts commissioning parents who cannot successfully carry a pregnancy on her own (usually because of uterine complications with the intended mother or sustained failure of embryo-attachment in the uterus). Though they do not advertise it and in fact avoid discussing it, the clinic occasionally accepts single men as clients who wish to have a child through donor egg gestational surrogacy. Though the clinic expressly refuses to work with same-sex couples, their acceptance of single-parent clients does represent an opportunity for one partner in a same-sex household to apply. The other criteria for parents who wish to have a child through gestational surrogacy at Manushi clinic is that they have blood work done to make sure that they are healthy enough for sperm and egg donation, and also a woman must have basic tests done or provide evidence

that she is unable to carry a pregnancy on her own. Candidates for becoming gestational surrogates must have blood work done to clear them of any possible chronic medical conditions or illnesses, and their husbands also have their blood tested for diseases that could transmit to their wives. Candidates for gestational surrogacy are required to already have at least one child by birth and be married and under the age of 40. All of these requirements were individually designed by this clinic with consideration to safety, practicality, and marketability, as India has not passed legislation to govern ART practice as of March 2012.

Intended mothers are invited to view their embryos under the microscope in the embryology lab before implantation (there was no mention of inviting intended fathers during my period of observation). Dr T describes this as a means to help the intended mother feel she was centrally involved in the pregnancy despite the fact that most commissioning parents leave India after initial testing and the collection of semen samples and eggs for IVF. Intended parents are also invited to attend a 4D sonography session later in the surrogate's pregnancy if they are present before the surrogate's delivery. Though none of the women who had been or currently were working as surrogates mentioned their interpretation of such an ultrasound session, based on substantial studies on similar uses of visualizing technologies (Stabile 1998; Rapp 1999; Martin 2001), this process which aims to create intimacy and sociality between the commissioning parents and the fetus can be assumed to simultaneously work to erase the woman acting as a gestational surrogate, at least in the perception of the intended parents. The high-tech aspects of the Manushi clinic, and special services like the viewing of the embryo before implantation, are emphasized by directors through the way they speak to clients upon arrival and to visiting press agents, on their Web site, and in their correspondence and communication with prospective clients. Meanwhile, current and former gestational surrogate mothers at this clinic noted that they had not had prior exposure to such technologically mediated care, particularly not in pregnancies with their own children (Vora 2011, forthcoming). This emphasis on the cutting edge technologies available in the clinic, together with attention drawn to the high level of obstetrics training that Dr B has received in India and abroad in the clinic's promotional materials fit into a larger pattern of the marketing of medical treatment and services by Indian hospitals, facilitators, and brokers, as does the emergence of cottage tourist industries for travel and tourism around medical services (Crooks *et al.* 2011: 5). This may all change as insurance plans in countries with privately funded medical programs adjust their

requirements to accommodate the lower-priced treatments and therapies available internationally.

The successful attempt of Reeta and Sanjay, the British NRI couple described above, to have twins through gestational surrogacy in keeping with their embodied standards of race/ethnicity and caste and/or religious purity ('vegetarian') highlights some of the more subtle ways that people continue to attach physical and cultural traits to a process that seeks to downplay the connection between inheritance and the physicality of individuals who are egg donors and surrogates. The Manushi clinic makes efforts to separate real people and social relations from the components of conception and gestation that will eventually produce a child for the intended parents. They do this by emphasizing the depersonalizing effects of IVF and generally describing the process of gestational surrogacy to commissioning parents and potential gestational surrogates as one that yields only one set of parents, with the surrogate performing a role that is altruistic yet ultimately a service. Despite these discursive efforts, actual individualized bodies and the relations they entail linger in clinic interactions. Clerical staff mentioned that a number of the egg donors for the clinic were actually working in the clinic as custodial and nursing staff. As mentioned above, the clinic protocol for matching egg donors and intended parents is that the directors choose fully anonymous egg donors for a given intended parent or couple,<sup>5</sup> but one staff member told me unofficially that the directors choose egg donors with 'light skin and eyes' for foreign client parents. The clinic directors did not wish to discuss how they made decisions when matching egg donors to commissioning parents and so offered no other specific information about the physical characteristics or caste backgrounds of egg donors, though I was assured by one of the directors that foreign clients did not concern themselves with the caste of the egg donor.

The work of the clinic's medical and upper administrative staff to distance individuals involved in conception, as egg donors, and in gestation, as surrogates, from intended parents, occurs alongside the self-conscious efforts of clinic staff to train surrogates from the point of recruitment to think of the gestational surrogate's body through a Western medical lens. The narrative of doctors and staff is that it is necessary to explain how surrogacy works in a very rudimentary way to women interested in becoming surrogates, because most surrogates have not had the level of formal education that would expose them to the basics of IVF. At the same time, directors and staff cite this coaching as essential to assuring potential surrogates that there is nothing sexual involved in surrogacy and to guide them into the desired

understanding of the relation to the infant they will bear. Potential surrogates are coached to see the uterus as an empty space that they can loan to a childless couple, where someone else's child will temporarily stay and, that most importantly, they will not have a connection to it in the same way that they would to their own child, because it will not look like them and is only part of their life very temporarily as the beneficiary of space (the uterus) and service (care around the pregnancy).

The clinic staff's medical explanation of reproductive technologies to potential and active surrogates works to distance actual individuals from the embodiment of reproduction, and creates a framework for commissioning parents, doctors, and surrogates to imagine the act of gestating a child as a paid occupation, where a service (gestation and childbirth) is exchanged for a fee. This does not mean that the exchange is limited to these terms, but the way that medical discourse isolates the reproductive body and gametes from the social context in which they originated makes women 'free' to sell gestation and childbirth as services to commissioning parents who are 'free' to hire these services from a woman as labor. Without the alienating discourse of medical science and reproductive technology, the nature of gestation and childbirth would remain tied to bodies and sex for women working as surrogates, just as it continues to be among those in their home communities. It would also potentially be more difficult for many commissioning parents to understand their relationship to the surrogate as ending with delivery, and to understand the surrogate as anonymous in terms of shaping the individuality of the infant. In these ways, biogenetic explanations of kinship and the separation of bodies from social reproduction in the clinic participate in the experimental production of surrogates as a type of laboring subject rather than strictly a subject of altruistic giving (as is ostensibly the case in countries like the UK where it is illegal to arrange a surrogacy outside of an altruistic agreement) or of kinship.

Market logics, which structure access to gametes, gestational surrogates, and the technologies of assisted reproduction work alongside the aforementioned medico-genetic discourse to further anonymize the role of participants in human reproduction. These logics work efficiently with the current legal status of the ART clinic in India as private enterprise largely outside of government regulation, though as I will explain below, they are still highly surveilled and informally regulated. Experimental forms of sociality arise both because of this regulation as well as in addition to it, or even despite it, as in the example of relationships formed in the hostels where surrogates are more or less required to live during their pregnancies.

### **Experimenting with Socialities in the Surrogate Hostel**

One of the social structures that forms around the disciplining of possible relationships in support of what is seen as a desirable distance between actors in the clinic is a system of support and feeling of kinship between surrogates. The clinic's practice of strongly encouraging gestational surrogates to live in one of several surrogate hostels nearby is folded into this discourse of being responsible for the well-being of women acting as surrogates as described above.<sup>6</sup> Their room and board is paid for by the commissioning parents and is promoted to both potential clients and to potential surrogates as a way to spare the latter the work of caring for their own families or doing waged work, which is often manual in nature, and also as a place where nutritious meals prepared by a hired cook and access to medical care is always available. The practice of housing surrogates also serves to control the variables of behaviors and exposures that are understood to potentially endanger the fetus or the surrogate's health while pregnant, and more generally to give peace of mind to commissioning parents and in the clinic's narrative, to the surrogates themselves.

After acknowledging how difficult it was to see their husbands and children only once a week, as well as to manage the isolation of living away from their homes in general, women I spoke to who had or were currently staying in the hostel described the benefit of living there throughout their pregnancy and post-delivery as an experience of sisterhood with other surrogates. The vast majority of current and former surrogates, and all of those I spoke with, had not had the opportunity to attend college, and some described imagining their experience away from the demands of family in this feminine space to be analogous to living in a student dormitory or hostel. Some women described missing others who had left after they had given birth, and one woman noted that she dreaded the time when she would leave her sisters at the hostel behind after she completed her surrogacy. At the same time, many women explained that there is also a pressing need to keep this work a secret from their extended families to escape social stigma imposed by community members, and so living in the hostel is a necessary separation from home and therefore an undesirable measure. This need for anonymity underlines the potential for shame in this work, though surrogates emphasize that the work is in fact morally defensible, which Amrita Pande's study of commercial Indian surrogacy also reflects (Pande 2009b). Case studies by Sheela Saravanan of four Indian women who were gestational surrogates in a similar clinic in 2009 suggest that there are also power struggles in such hostels that make some

women's lives there tense or unhappy. Her case studies also assert that the grief of giving the infant to its intended parents can be extensive (Saravanan 2010). In a related discussion of the impact of postmodern and neoliberal global political and economic restructuring in the Philippines and on the concomitant formation of political subjects and projects, Tadiar (2009) insists that

In the midst of the [increasing reliance] on service labor and the social logics of cooperation invented by the private sector . . . these practices of care are fundamental because they create and sustain the subjective conditions of that labor . . . At the same time, these practices of experience are tangential to [those strategies]. (260)

Tadiar's observation of the social logics and 'practices of care' that evolve out of service labor organized by private interests both supports those interests as well as being tangential to them. The bonds that form between women living in the hostel as the result of their shared conditions, their sisterhood, work simultaneously to keep them in the hostels where the clinic wants them to reside for purposes of surveillance, thus making the clinic more attractive to potential commissioning parents, while also creating new relationships between women acting as surrogates and discourse about the meaning and value of surrogacy outside the discourses of the market and the clinic.

Current surrogates also described the expectation of a sustained sense of obligation on the part of commissioning parents toward themselves and their families, a form of work Pande describes as fantasy 'kinship work' to build ties with commissioning families across caste, class, regional, and national lines (Pande 2009a, 2009b). Women living in the hostel for active surrogates related stories of former surrogates who had continued contact with commissioning parents as a model for what they hoped would come in the future from their surrogacy arrangements, even while acknowledging that not many surrogates have established extended relationships beyond a few initial phone calls after commissioning parents return home. Commissioning parents instead experimented with notions of rehabilitation and development of the job opportunities and material conditions of surrogates by imagining the ways they might use their fees to improve their lives. Several current surrogates described an expectation that commissioning parents would naturally feel a sense of duty toward her and her household following the delivery of their child. Even though no one expressed a sense of expected kinship with the future child resulting from the surrogacy agreement, they experimented with ways that a South Asian model of the duty of a patron toward a client could

play out. In these imagined scenarios commissioning parents might maintain communication and send gifts or money to support her and her family through the development of their child, such as remembering her at birth anniversaries, or make a larger investment through helping with the education of her own children.

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 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. In contrast, the exchange of money marks the end or even death of a social relationship. The insistence upon the open-ended nature of the surrogate's relationship with the commissioning family can be seen in this context as a relationship of continued life and connection as opposed to its end or death represented by the exchange of money and associated cutting off of social ties. What is read by commissioning parents as solicitation and manipulation for more money and resources by a surrogate can alternately be understood as a way for her to insist on the transcendental nature of what is bestowed through surrogacy, which necessarily exceeds the surrogacy fee and creates an opening that logically insists on continuing relationality and exchange, even if it can simultaneously be the pragmatic pursuit of an opportunity for accumulating resources.

While surrogates and commissioning parents alike experimented with fantasies of how their connection might or might not play out into the imagined future, in contrast to the open-ended future described by surrogates, commissioning parents spoke of the distance they imagined would always separate their surrogate from their family as part of the appeal of pursuing surrogacy in India. The future scenarios they described experimented with the social meaning of the excess gift nature of surrogacy by imagining fees as contributing to a project of uplift to be managed by the clinic in the future and accomplished through the same fees, and as such not entailing an extended interpersonal relationship between themselves and their surrogate. All of these imagined forms of reciprocity can be understood as experimentation with the forms of



sociality that might result from the obligation and creation of a relationship through the Maussian gift nature of surrogacy, which exceeds its contractual and fee-based nature as emphasized by the clinic, together with the entanglement of bodies and novel social contexts arising with ARTS and transnational surrogacy arrangements.

### **Discussion: Risk, Structural Inequality, and ART Legislation**

In debates about the regulation of commercial surrogacy in India raised by the ART bill first drafted in 2008, but still not passed into law, lawyers, scholars, activists, and the popular press have raised questions about the risk surrounding various participants, including egg donors, surrogates, commissioning parents, and the individuals born through surrogacy. The newness of the transnational service market in ARTs in India and the government's continuing hesitance to make hard laws rather than just guidelines to govern medical and commercial practices in ART clinics, and the corresponding lack of precedents on both the levels of national and international law, as exemplified by the 'Baby Manji' case, raise questions about the risk surrounding various participants.<sup>7</sup> Subjects facing the risks associated with the unpredictable social, legal, and medical risks arising with the development of this industry include egg donors, surrogates, commissioning parents, and the individuals born through surrogacy. The safety of egg donors as medical subjects as well as their informed consent may not be guaranteed. The surrogate undergoes risks as both an individual subject and as a support on which her family depends, and thus they also bear connected risk. Her physical risks include all the risks associated with pregnancy as well as with the higher-frequency multiple pregnancies associated with IVF. For example, despite the increased risks to their health, these subjects lack the insurance of long-term healthcare. One reason client parents stated for coming to India for surrogacy is that doctors are willing to transfer more embryos during implantation than in other countries such as the USA, UK, or Israel. This increases the chances of success within a given cycle of IVF, but it also means that there is a higher frequency of multiple births and more frequent embryo reduction when multiple pregnancies occur. At Manushi, there is a policy of permitting only single or twin pregnancies for the protection of the mother and remaining fetus, but because compliance with the currently existing national guidelines is voluntary, policy is implemented idiosyncratically at the level of the individual clinic. The clinic will store frozen embryos for clients, but there is concern in India about the need for regulation of what happens to unwanted frozen embryos. A surrogate does not have a say

regarding practices like embryo reduction and cesarian deliveries beyond her agreement with the clinic's general policy, and there is currently no state recognition of any legally defensible connection between the surrogate and her direct family with the child to whom she gives birth. The children born to surrogates are also subject to risk, particularly as preliminary research suggests that people born through IVF, particularly with eggs from women over age 35, may be subject to increased risk of Down's syndrome and other genetic diseases (Roberts 2011). The contracting or intended parents are also experimental subjects as they negotiate the legal meaning of parentage between national legal structures and ARTs.

The draws for commissioning parents to come to India for gestational surrogacy are many, and are interesting in how they reveal the interaction of culturally varied understandings of the meaning of gestation and childbirth with the choice and mobility offered by privatized and transnational structures of fertility therapies.<sup>8</sup> A recent study of medical tourism in India has identified that the two most common factors drawing travelers from wealthier countries to India are avoiding wait-times (in countries with socialized medicine), and seeking lower cost (in general) (Crooks *et al.* 2011). In addition to the availability of advanced technologies, highly trained physicians, and the low-cost of their services, there is also the seemingly easy availability of low-cost gestational carriers. I have argued elsewhere that there are false assumptions about the needs and necessary quality of life for Indian low-wage workers that underpin the naturalized 'cheapness' of Indian labor in general and the artificial production of the availability of inexpensive workers, including surrogates, in India (Vora 2009; Vora forthcoming). This ethnography adds two other reasons that may be statistically less influential, but add to the picture of why commissioning parents travel to India for gestational surrogacy. The first is that fertility clinics in places where there is a profit motive in medicine tend to accelerate their procedures to the point where patients feel dehumanized and anonymous. In Indian clinics, which are by contrast service oriented in their transnational practices, despite being profit-motivated, patients seeking surrogates may find a more attentive, individualized and even caring interface and experience. Another is particular to diasporic/NRI patients and others who find accommodation in India for cultural, religious, or caste-based understandings of the meaning of the pregnant body and in its role in the transmission of culture and identity beyond the medical and property-based definition of parenthood. The discrepancy between the Western medical narrative of genetic inheritance (Martin 2001) and conflicting cultural notions of what is inherited culturally

through the womb has also been documented as a concern in ethnographies of gestational surrogacy in Israel (Teman 2010), Egypt (Inhorn 2003), and the USA (Thompson 2005).

While at first the expansion of ART clinics to accommodate transnational demand seems to expand general access to ARTs, a number of scholars have emphasized that access to such technologies continues to be highly limited by class and racial inequalities (Spar 2006; Inhorn & Birnbaum-Carmeli 2008; Inhorn *et al.* 2008). Also, as Marcia Inhorn has pointed out, infertility rates in the Third World itself are high, and there is a (largely unmet) demand for fertility services and technologies. In fact, fertility problems are a significant source of suffering and stigma in India (Inhorn & Bharadwaj 2007), and are part of a large-scale 'global fertility problem' (Inhorn 2003: 1844). However, as she emphasizes, access to these technologies is limited only to those who are very wealthy in comparison to the majority of the population. She argues that improving access to primary care, more accessible than many ARTs, would have also have a significant effect in reducing infertility worldwide, because many infertility cases in her primary site of Egypt as well as other developing countries are caused by preventable conditions (Inhorn 2003: 1840). From her observation, we can add that increased emphasis at the level of the local clinic as well as at the national level as evidenced in draft ART legislation upon provision of fertility technologies to medical travelers from the Global North may redirect resources from the provision of care and the study, treatment and prevention of the causes and symptoms of infertility among the same classes in India from which gestational surrogates originate.

The infertility rate in the demographic subset that encompasses the largest percentage of people in India, including the communities from which many of the women who become surrogates originate, is estimated to be 8–10%. This population holds low-paying jobs ranging from day labor to entry-level clerical work, service and small-manufacturing jobs, or are transitioning from small family farming to urban-based work because of being dispossessed from their land for reasons of environmental, legal, and agribusiness-related change. While the infertility rate of this population is high, only 2% of that 8–10% actually require ARTs for successful treatment; the vast majority of fertility problems are caused by poor health, substandard nutrition, poor maternity services, and high levels of infections (Inhorn & Bharadwaj 2007; Qadeer & John 2008). The vastly more lucrative business of providing fertility technologies to medical travelers from the Global North will likely undercut the provision of care and resources for studying, treating, and preventing the causes and

symptoms of infertility among the same classes in India from which gestational surrogates originate.<sup>9</sup> Once a bill is passed by the Indian parliament as based on the current draft bill, governance of ART actors will continue to occur through highly problematic protections of market-based rights and market-compromised choice, identified even in the draft bill's preamble as oriented toward protecting the rights of commissioning parents as consumers first and foremost. As Sundar Rajan (2007) explains in his ethnographic work on 'experimental values' and clinical trials in India, when governments must compete to attract commercial research organizations to their countries, they do this in part by offering laws attractive to them, a situation which finds its parallel in national ART legislation that is oriented toward elite Indian and transnational consumers at the expense of surrogates and egg donors.

As political, economic, and cultural structures have been re-organized through independence and market liberalization in India, the relationship between Western medicine, power, and the body has been cast and recast in interesting ways reflected in the Manushi clinic. In his work on epidemic disease in nineteenth-century India, Arnold (1988, 1993) has demonstrated how the body and discourse about the body have historically been a site of colonization and conquest. This scholarship points to the corporeality of the British colonial project in India, and also how the body and discourse about the body emerge as sites for contestations of power in Indian history. Specific technologies, instruments of measure and examination, and materializations of the body manifest within medicine as institutions organized under colonial rule. Gyan Prakash argues that the mode of governmentality that was functioning in colonizing European nations could not be replicated in colonial India because the British could not rely on colonial knowledge and colonial regulation to function as self-knowledge and self-rule. For this reason, governmentality had to become part of imperial domination: 'The colonization of the body had to operate as the care of the native body' (Prakash 1999: 127). The colonial project was therefore an experiment in creating new types of governable subjects that both were and were not part of same organism as British modernity.

In the transnational ART clinic, we can observe medicine shifting from a technique of caring for the body to one of producing bodies as the instruments of service work as part of an experiment with engaging a transnational, technologically mediated market that depends on socially mediated arrangements with local, relatively low-resourced women surrogates. The body of the surrogate is rendered available as part of this experiment with gestation as a service. Transnational surrogacy in India points to some of the continuities

and contradictions inherent in the evolution of relations between foreign economic demands, projects of the Indian elite and middle-class, and low-income rurally based Indians that have precedent in the colonial period. The relationship between foreign governance, Indian elites, and the subaltern rural majority population of India tracked in the work of subaltern historiographies is evident in the nature of contact and socialities formed in the clinic, but with the added dimensions of the privatization and transnational commerce. To fully explore this topic is not within the confines of this paper, but the clinic's context does suggest some important details. A relationship of power between the Indian middle and upper-middle classes, here the doctors running the clinic and elite Indian commissioning parents, and the rural, less-educated, less-connected, and much lower-resourced women they hire to act as gestational surrogates represents in part a continuity with India's colonial past. At the same time, the transnational reach of clinic directors and their ability to command technology and resources at a global level represents something unique though not unrelated to that historical relationship. The foreign commissioning parents also do not fit into this paradigm in a tidy way, as they are both consumers of the labor of surrogates, but also experimental subjects themselves, as they engage with both real and imagined relationships to the women who are acting as egg donors and gestational surrogates for them. Women participating as surrogates also add complexity to structural relations of dominance as they experiment with mutually supportive sisterly relationships in the hostels as well as imagine the possible future relationships with commissioning parents that recast surrogacy as incommensurate with their surrogacy fee and leave commissioning parents beholden to them.

### **Conclusion**

Reproductive technologies are participating in the creation of new social contexts and forms of exchange between different groups in India and abroad including: upper middle-class clinicians, transnational and local patients with the means to undergo fertility therapies, and low-income local surrogates and egg donors. These exchanges, which include both market-based transactions as well as exchanges and exchanged of an altruistic and/or gift nature, require heavy management through narratives about the technologies and social relationships involved and created through surrogacy. Existing scholarship on transnational commercial surrogacy in India attends to concerns about the exploitation of women working as surrogates and their agency in the process of becoming surrogates/workers (Pande 2009a;

2009b; Vora 2009) and the pressing legal concerns highlighted by the unregulated nature of surrogacy practices in India (Smerdon 2008). These concerns are woven into the ways that actors in the clinic experiment with different forms of sociality that allow them to try on different roles and meaning through the surrogacy relationship, creating new modes of understanding the social implications of ARTs.

### Notes

1. Assisted reproductive technologies, which aid in conception and pregnancy, include practices such as hormonal induction of ovulation, the harvesting of human ova for IVF, and embryo transfer to the uterus along with hormones that aid in embryo implantation in the uterus and hence successful pregnancy.
2. I use the terms 'commissioning parents' to refer to the individuals or couples who initiate the surrogacy process, in part to remain consistent with the language of draft ART legislation in India. The terms 'intended parents' and 'gestational surrogate' or 'gestational carrier' are most often used in literature on ARTs and surrogacy in the Anglo-American academy. In the clinic, everyone referred to the women who carried pregnancies to term under contract to commissioning parents simply as 'surrogates'.
3. This term derives from Michel Foucault's lectures and publications where it is used to refer to techniques of government and citizen-subject that make a society governable in a given historical period.
4. All identifying information of people, places, and institutions has been changed to protect identities while preserving a sense of the atmosphere or climate of informality in the clinic.
5. Although exclusively local donors were used at this clinic, one of the two commissioning couples I met that were using donated eggs was unaware of this fact. See Vora (2009).
6. See Vora (2009, 2011) for elaboration.
7. In this case, a commissioning father from Japan was prevented from returning with an infant born to a surrogate in India because of legal complications concerning custody and citizenship between India and Japan. The intended parents divorced after entering a surrogacy arrangement through an Indian clinic, utilizing the intended father's sperm and donated eggs. The couple divorced before the delivery, and when the commissioning father attempted to return to Japan with the infant, a law in India preventing single men from adopting female children was invoked.
8. Bharadwaj (2003, 2006) has written extensively on the social contexts of ARTs in India, including discussion of the cultural, media, and political stakes involved for different populations of Indians in engaging with reproductive technologies.
9. Sundar Rajan (2007) has written about a parallel situation in the context of clinical trials run by US-based pharmaceutical companies in India, where the context of risk includes the situation that participants who have positive outcomes have no guarantee of access to the drugs developed as a result of their trial (78).

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