

Transnational Commercial Gestational Surrogacy:  
Cultural Constructions of Motherhood and their Role in the  
Development of National Indian Guidelines

by  
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## ABSTRACT

The advent of advanced reproductive technologies has sparked a number of ethical concerns regarding the practices of reproductive tourism and commercial gestational surrogacy. In the past few decades, reproductive tourism has become a global industry in which individuals or couples travel, usually across borders, to gain access to reproductive services. This marketable field has expanded commercial gestational surrogacy—defined by a contractual relationship between an intending couple and gestational surrogate in which the surrogate has no genetic tie to fetus—to take on transnational complexities. India has experienced extreme growth due to a preferable combination of western educated doctors and extremely low medical costs. However, a slew of ethical issues have been brought to the forefront: the big ones manifesting as concern for reducing the worth of a woman to her reproductive capabilities as well as concern for the exploitation of third world women.

This project will be based exclusively on literature review and serves primarily as a call for cultural competency and understanding the circumstances that gestational surrogates are faced with before implementing policy regulating commercial gestational surrogacy.

The paper argues that issues of exploitation and commodification hinge on constructions of motherhood. It is critical to define and understand definitions of motherhood and how these definitions affect a woman's approach to reproduction within the cultural context of a gestational surrogate. This paper follows the case study of the Akanksha Infertility Clinic in northern India, a surrogacy clinic

housing around 50 Indian surrogates. The findings of the project invoke the critical significance of narratives of these Indian surrogates. From their narratives, I find that the surrogates construct the practice of surrogacy so that it fits into cultural comprehensions of Indian motherhood in which motherhood is selfless, significant, and shared.

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## Chapter 1

### BACKGROUND OF MEDICAL AND REPRODUCTIVE TOURISM

#### **THE EMERGENCE OF MEDICAL TOURISM**

Countries that heavily promote medical tourism usually do so for the following reasons: (1) increasing that country's gross domestic product, (2) upgrading and advancing medical services, (3) establishing foreign relationships and generating a better trading relationship with other nations, and (4) boosting tourism. Those advocating for growth of the medical tourism industry consistently stress the monetary gain that the industry can provide. There is an assumed trickle down effect. Proponents suggest that increases in revenue can be funneled back into the national health care system, thus increasing the overall health of citizens.

*Arguments for medical tourism.* Proponents of medical tourism cite that the industry bridges the gap between patients unable to afford or gain access to treatment in one area of the world and medical facilities located in other regions. Marketing low airfare, low-cost telecommunications as well as communication through the internet promotes the concept of affordability. International medical travel is marked by its "shifting toward a more institutionalized and bureaucratized process. This means we might see a rapid increase in the number of patients traveling in search of health to countries such as India" (Turner, 2007, p. 322).

*Arguments against medical tourism.* On the other hand, many find that marketing medical tourism does not always address the harms of a globalized health care. Additionally, there is the fear that the establishment of for-profit hospitals will cater to more to foreign clientele and undermine local public health care. The best health care clinicians have the potential to be drawn away from public hospitals by higher salaries and better facilities at for-profit hospitals. And medical tourism could lead to commodification of health services. Furthermore, “physicians at many leading medical tourism destination sites pay low premiums for medical malpractice insurance. As a result, medical tourists who are victims of negligence of medical malpractice might find themselves unable to obtain compensation for their suffering” (Turner, 2007, p. 322).

## **REPRODUCTIVE TOURISM & GESTATIONAL SURROGACY**

Prior to the advent of reproductive technologies such as artificial insemination and in vitro fertilization, women who suffered from infertility were presented with only two alternatives—either accepting their infertility or going through the adoption process. However, the surge of advances in reproductive technologies have provided women the option of assisted reproduction and one of its derivatives—surrogacy.

The advent of advanced reproductive technologies (ART) has generated a number of debates regarding the fertility process—from conception, to gestation, to the actual birthing process. “Reproductive tourism” denotes a practice in which individuals travel long distances, typically across borders, in order to receive



reproductive services that may not be available in their home country or may not be available at an affordable price (Voigt & Laing, 2010). As such, the primary driver behind reproductive tourism is a desire to access either cheaper reproductive services or a wider range of them. Thus, citizens who would otherwise be subject to their home country's restrictions have morphed their identity into that of a global consumer—one that is able to cherry pick services based on access, geographic convenience, and price (Martin, 2009).

Commercial surrogacy is defined as a contractual relationship wherein a surrogate and/or surrogacy agency are paid compensation for a 9-month gestation period, including any sort of reasonable medical, legal and psychological expenses (Brinsden, 2003). Fundamentally, then, surrogate motherhood becomes an economic transaction. This brings up a number of ethical issues, first and foremost, the concern that commercial surrogacy violates or cheapens the traditional view of reproduction as an act of love, marriage, and/or sexual intercourse. Instead the identity of reproduction shifts to that of commodification of the body and of offspring; the act of commercial gestational surrogacy is often perceived as payment for reproductive services as well as for the relinquishing of parental rights to a child in return for monetary compensation (Pande, 2009).

Thus, we ask whether commercial gestational surrogacy is ethical. What's more, we ask if it is ethical to outsource this form of reproduction to women in developing countries. Additionally, layered on top of the ethics of reproduction as an economic transaction are issues of bodily autonomy, exploitation, and women's rights.

**Types of surrogacy arrangements.** Surrogacy is defined as a procedure wherein an intending parent or couple contracts a woman, a surrogate, to conceive and carry a child, relinquishing parental rights upon the birth of that child. Surrogacy has brought about a number of types of arrangements—artificial insemination surrogacy, in vitro fertilization surrogacy, and finally, donor surrogacy.

***Traditional surrogacy—artificial insemination surrogacy.*** Traditional surrogacy involves an embryo generated by fertilization of a surrogate's egg by the sperm of the intended father. The surrogate mother is artificially inseminated with the sperm of the intending father. She proceeds to carry the fetus to term. Upon the delivering of the child, the surrogate turns over parental rights of the child to the genetic father and his partner in return for payment for nine months of labor. The intended father or couple then adopts the child (Kerian, 1997).

***Gestational surrogacy—in vitro fertilization surrogacy.*** Gestational surrogacy involves an embryo that is created in a petri dish with the egg and sperm of the intending mother and father, respectively. After fertilization of the egg, the embryo is transferred to a gestational surrogate to carry to term. The child born from the surrogate, then, is biologically and genetically related to the intending parents but not at all to the gestational surrogate (Kerian, 1997).

***Donor surrogacy.*** Donor surrogacy involves an embryo that is created from the egg or sperm of one of the intending parents and the sperm or egg of an anonymous donor. An embryo is then implanted in a surrogate mother to carry to term. Just like in vitro fertilization surrogacy, donor surrogacy requires the only role of the surrogate to be a gestator (Kerian, 1997).

**History of surrogacy.** The concept of surrogacy is by no means a new one. One of the first mentions of the practice of surrogacy is in the Old Testament. The Old Testament tells the story of Sarah, Abraham's wife. Sarah was unable to conceive and in a desperate attempt to carry on the family line, she persuaded Abraham to impregnate her maid, Hagar. Hagar conceived and gave birth to Ishmael whom Sarah and Abraham raised as their own son (Kerian, 1997). Hindu mythology also gives a narrative of surrogacy in the Bhagvata Purana, Upon having been informed by the oracles that he would be killed by one of his nephews, the evil king of Mathura, Kansa, imprisoned his sister Devaki along with her husband, Vasudeva. Every time she gave birth, Kansa smashed the child's head to the floor, killing it. When Devaki conceived for the seventh time, she and Vasudeva prayed desperately to gods to intervene. The gods responded, summoning the goddess Yogamaya to transfer an embryo from the womb of Devaki to the womb of Yashoda— Vasudeva's other wife who lived across the river. Yashoda gave birth to Krishna, and secretly raised the child, informing Kansa that Krishna was stillbirth and as such indicated no threat. Thus the genetic

child of Vasudeva and Devaki is incubated in and delivered from another womb (Smerdon, 2008).

Even before surrogacy became publicized and caught in heated legal debates, informal surrogacy was widely practiced. Women would carry and deliver a child for an infertile couple altruistically—without any sort legal contract. These arrangements often existed between infertile couples and surrogates who were either friends or family members. It was often labeled as “altruistic surrogacy.” The mid 1970s brought about some of the earliest forms of contract surrogacy in California when an anonymous couple sent out an advertisement asking for a woman to conceive and carry a child through artificial insemination. Noel Keane wrote some of the first surrogacy contracts, circumventing adoption statutes to arrange for the legal system to pay surrogate mothers. Until this point, payment to a mother for relinquishment of parental rights had been prohibited. As such Noel Keane is termed “the father of surrogate motherhood” (Kerian, 2007, p. 118), setting the precedent for modern surrogacy arrangements.

By the 1980s, contract surrogacy was a prominent practice in California. 1986 saw the success of the first gestational surrogacy arrangement—surrogacy through in vitro fertilization in which the intended parents were the true genetic parents of the child, while the gestational surrogate held no genetic relationship with the child she carried (Kerian, 2007).

*Historical cycles of public reactions to new reproductive technologies.*

Though the practice of surrogacy arrangements has been around since the biblical ages, there has been no established acceptable precedent for dealing with the relinquishment process. Trends are changing however. When literature about donor insemination first hit the journals in the 1940s, they stirred up mass mounts of controversy — generating high levels of resistance. The storm of debate eventually reached a calm, but the cycle of resistance and then acceptance hit again with the advent of in vitro fertilization in the 1970s and again with oocyte donation in the 1980s. Perhaps surrogacy will follow a similar cycle (den Akker, 2007).

Even more confusing than the definition of parenthood with the advent of advanced reproductive technologies is the classification methodology used to establish a parental identity. In its present stage—both on legal and cultural platforms—parenthood is defined by biological terms. This alludes to the importance of the genetic and biological tie in the legal and cultural comprehension of parenthood, at least in the Western world.

The general public perception of gestational surrogacy seems to be cautious and worried—however, the great majority of surveys conducted are likely to be swayed by the negative cases evident in the media (den Akker, 2007).

The latest trend, and complicating factor, in advanced reproductive technology is gestational surrogacy implemented on a transnational scale. This phenomenon has been rising in prominence in the first decade of the twenty-first century in which the middle class took to traveling to emerging countries for

reproductive technologies. This trend of reproductive tourism occurred in tandem with aggressive marketing campaigns that allowed American hospitals and biotechnology companies to use their connections in Asia to grow a reproductive tourism business into a powerful economic force (Gray & Poland, 2008).

Unfortunately, this trend has been latent with ethical issues—arriving without international standards without much government oversight, or legal review.

Thus, the rise in the practice of surrogacy has been flooded with legal, moral, and ethical issues involving contractual issues, commodification issues, and confusion in the assignment of parental rights.

## Chapter 2

### ETHICS OF GESTATIONAL SURROGACY

#### **ADVOCACY OF GESTATIONAL SURROGACY**

Proponents of surrogacy believe that surrogacy should be protected as a procreative choice. It allows infertile individuals and couples the ability to have children, elevating their freedom, specifically their reproductive choices. They believe that fears of potential harms—commodification, exploitation—are outweighed by the potential benefit of surrogacy, the birth of a *wanted* child. Surrogate mothers give a “gift of life” to infertile couples in return for monetary compensation that they generally need creating a mutually beneficial relationship. Surrogacy then is not necessarily about commodification and exploitation of children and women. It can exist as a mature decision between rational human beings. As such, surrogacy advocates support surrogacy arrangements determined prior to conception with clearly expressed intentions of both the intending parent(s) and the surrogate (Kerian, 1997).

*Reproductive freedom transcending into female empowerment.* Radical feminist writers argue that reproductive technologies have a “gendered nature” which centers on the misuses of woman’s bodies as mere means to meet patriarchal ends. As such many feminist scholars argue that advances in reproductive technologies do nothing more than further privilege the genetic desires of men and simply reduce the role of women to their procreative capacity (Pande, 2009).

However, there is a new movement that argues that surrogates have a different take on both the significance of the genetic ties to the embryo as well as the role of men in the surrogacy process. Surrogates view themselves as much more than a simple “receptacle” for male seed. The husband’s role has been taken over by medicine and technology—an injection in the case of surrogacy. A survey of women in a surrogacy clinic in Anand, India—a case that will be further expounded upon later in the paper—expresses attitudes that de-emphasized the role of the male in the reproductive process. In doing so Indian surrogates are simultaneously reinforcing and emphasizing the woman’s contribution as very active role in reproduction. In that same clinic, surrogates also tended to demonstrate a sense of entitlement to the financial compensation they were to receive from the commissioning parents. Some even expressed an unwillingness to discuss earning and spending of the money with their husbands. The questioned their role in the surrogacy process, asking, “what does he have to do in this? He did nothing. At least the other man gave his sperm” (Pande, 2009, p. 386).

Women participating as gestational surrogates are able to use the act of reproduction as a means to remove herself from the traditional female role of caretaking and mothering by making the choice to gestate a child and gift it to a couple who is unable to reproduce themselves. As such, the Indian surrogate transcends the traditional reproductive duties by achieving validation in that she is employed and that she is able to help provide life for another.



## **COMMERCIAL GESTATIONAL SURROGACY AND ETHICAL CONCERNS**

When it comes to commercial gestational surrogacy, the primary issues appear to be that of commodification of the womb, true autonomy and subsequent exploitation, objectification of the surrogate, promotion and strengthening of societal inequalities, and proper informed consent.

**Commodification of the body; commodification of the womb.** The concept of “renting out” one’s womb is unnerving and is often viewed as a form of prostitution, organ selling, or slavery, as each of these activities involve the payment for use of someone’s body or parts of someone’s body for another person’s benefit (Rimm, 2009). Thus there is divide as to whether only “altruistic” surrogacy, surrogacy that usually takes place within a family or between friends— i.e. a woman carrying a child for her sister—is permissible while commercial surrogacy should be outlawed for reducing the reproductive process to financial terms.

**Autonomy and the potential for exploitation.** One of the most concerning issues of transnational surrogacy—particularly when surrogates are outsourced from third world countries and tend to be women living in dire economic circumstances—is whether the surrogates are fully autonomous agents or whether or not they are coerced into the vocation. The majority of surrogates contracted in international surrogate agreements are economically impoverished.

It is of great concern that women are enticed into surrogacy with the prospect of earning an income worth what they would only make over a span of 10 to 15 years in just a nine month gestation period (Rimm, 2009). These chunks of money, though almost always less than what a surrogate in Western, developed countries would be compensated with, represent large sums of money which are in and of them self, exploitative. As such, there is concern for whether economically impoverished women will agree to contract surrogacy arrangement without fully understanding the psychological and physical burdens they will be faced with (Palattiyil, 2010). Additionally, the contractual obligations set within international surrogate agreements are often demonstrative of the limited rights of the surrogate mother and her lack of input of the actual reproductive process.

**Objectification.** Objectification in and of itself deals with the treating of a particular being as if it were nothing but an object. In the case of commercial surrogacy, surrogate mothers are treated as instruments—as tools for the commissioning genetic parents to obtain a child that is related to them (Berkhout, 2008). Often, the genetic parents along with the surrogate mother view the surrogates as “incubators” or “maternal environments.”

**Promotion of inequality.** The lack of national or international guidelines regarding commercial surrogacy has brought up a number of moral concerns—specifically whether a nation has the ability to comprehend if reproductive tourism infringes on human rights and subsequent reproductive autonomy. The

prevalence of globalization and global consumers seems to undermine the power of the nation-state to sufficiently impinge on its ability to regulate just how reproductive technologies are being used and understood by its citizens (Rimm, 2009). However, it is important to note that reproductive tourism is not an option that is easily acceptable to classes of people. In fact, it is almost exclusively available to the privileged upper class. As such, the “global citizen” is a member of a miniscule elite class and should in no way be understood to represent the accessibility of reproductive technologies—including gestational surrogacy—to the majority of the population.

**Issues of informed consent.** A common view of informed consent is that it exists as a baseline condition implemented so that a health care institution and health care professional fulfill their ethical duties. It is defined by three main components—voluntariness, information, as well as an individual’s capacity to consent (Freedman, 1975). Voluntariness is established when an individual can freely make a decision to undergo an intervention, free of any coercive outside factors. Providing adequate information is done on three different standards—professional, objective, and subjective. The professional standard is defined as a physician disclosing information that would be relevant for other physicians. The objective standard is what a physician should disclose to any reasonable person including the nature and magnitude of potential risks as well as other available options. Finally a subjective standard is when a physician discloses what a patient would want to know. The capacity to consent is the third aspect of having a full

informed consent. It requires a patient to have full consciousness, understanding and reasoning.

The superior educational and economic resources of the commissioning parents virtually guarantee that the negotiation situation will favor them. Unless the surrogate herself is proactive in advocating for her interests, no one in the negotiation has an incentive to ensure that the surrogates does not bear the full weight of the risks associated with these agreements (Scott, 2009).

## Chapter 3

### GLOBALIZATION & ADVANCED REPRODUCTIVE TECHNOLOGIES

#### **GLOBALIZING ASSISTED REPRODUCTIVE TECHNOLOGIES.**

Assisted reproduction clinics are now found all over the world, including the Middle East, Africa, Asia, Latin America, and India. Global market forces play a huge role in the spread of ART as technologies are transferred through international clinical partnerships. As such, choices regarding the purchasing of ART equipment are determined by both the country in which a clinician practices as well as where he or she received training in ART. For the most part, fertility clinicians are trained in the United States or in Europe, subsequently driving up the demand for Western techniques and products.

Assisted Reproductive Technology has also established international markets for the trade of reproductive body parts and services, expanding upon the already lucrative medical tourism industry. Thus, “sperm, ova, embryos, and wombs are all desirable and profitable commodities, the trade of which serves the intersecting interests of many parties (donors, recipients, infertility specialists, and IVF brokers) and is facilitated by advances in global communications” (Ryan, 2009, p. 813). When reproductive services are paired with active government support, as is the case in India, it becomes a market specifically targeting foreign clients, particularly those with the means and desire travel long distances for lower-cost reproductive services.

Four countries express the range of regulations regarding reproductive technologies, loosely representing four modes of biopolitical regulations—

conservative Germany, pronatalist Israel, liberal UK, and laissez-faire United States (Martin, 2009). Germany has some of the strictest regulations regarding the use of ART with the establishment of the Embryonic Protection Act, which allows for in vitro fertilization and artificial insemination but does not allow egg and embryo donation or any type of surrogacy arrangement. Israel takes a pronatalist stance. However egg donation is restricted except for women who have had infertility treatments in the past and have excess eggs to donate. Israel's Embryo Agreement Carrying Law legalizes surrogacy arrangements under the approval of a public committee.

The UK takes a liberal stance guided by the Human Fertilization and Embryonic Authority (HFEA). HFEA places age limits on egg donors as well as egg recipients, forbids sex selection and unreasonable payment to egg donors and permits prenatal screening and pre-implantation genetic diagnosis. The UK is constantly updating their guidelines. The US has a laissez faire approach to advanced reproductive technologies (ART), lacking federal regulations. State-based policies vary greatly and the assisted reproductive technology industry is guided primarily by market forces.

### **The setting of a global standard for implementation of ART.**

Currently, there is an unbelievable amount of variation within and between nation-states. This does not necessarily mean that a universal policy is out of the question, but many scholars claim that a baseline universal "minimal regulation" will be more likely. Another source for aiding in the establishment of global

standards for the implementation of assisted reproductive technologies are intergovernmental as well as non-governmental organizations—the World Health Organization (WHO), the United Nations Education, Scientific and Cultural Organization (UNESCO), and the World Medical Association (WMA). Each of these organizations have released statements specifying bioethical standards, each individual statement provides minimal baseline of ethical practice. None focus on consistency between one another to achieve a “harmonization of regulation” (Martin, 2009, 263).

Additionally, the Hague Convention on the Protection of Children and Co-Operation in Respect of Intercountry Adoption is another resource of the achieving a global standard when it comes to ART. It is an agreement involving the regulation and monitoring of transnational adoption among over seventy nations. The agreement sets baseline standards to ensure the enactment of full informed consent and the achievement of the best interests of the child. Additionally, the agreement mandates that all countries provide a central authority that enforces rules, keeps records of the adoption process, and establishes an open communication with the international national counterparts.

Reproductive tourism demonstrates that, though there are national regulations in certain countries, citizens with the means to leave their homes in order to bypass restrictions will do so, whether for legal or monetary reasons. Thus in some sense, there is a diminished power of the nation-state in that the “spirit of globalization and multilateralism facilitates reproductive tourism and may in fact undermine the power of the nation-state to regulate uses of

reproductive technologies of its citizenry” (Martin, 2009, p. 258). Globalization makes it easier for a privileged upper class to cross borders to gain access to reproductive services. Local inequalities can be exaggerated on a global stage in the creation of a global citizen that can transcend their own nation-state. Again, it is important to note that this global citizen is a member of a very small elite group and is not at all representative of the majority.

Reproductive tourism allows couples to pass borders and bypass cultural, ethical, and legal regulations of a particular nation-state. Martin (2009) cites globalization as an active transformative force in advanced reproductive technologies, both in that it offers opportunities and mobility for barren couples yet simultaneously maintains and even enhances existing societal inequalities.

**Liberal feminist framework—ART in the global south.** This project focuses on the establishment of reproductive tourism and market niche in the global south. It is important, then, not only to understand the profitable benefits of this business, but also to understand why embedding the institution of ART in the global South may be problematic. When viewed through liberal feminist framework, focusing on women’s health in the global South, there are issues when dealing with notions of reproductive autonomy.

*Mohanty.* Chandra Mohanty finds that, for poor women of color, the notion of a ‘woman’ right to choose’ to bear children has always been mediated by a coercive, racist state...for many



women of color, reproductive rights conceived in its broadest form, in terms of familial male/female relationships, but also more significantly, in terms of institutional relationships and state policies must be the basis for [correlations across race and class lines (Mohanty, 2003, p. 54).

Thus, Mohanty pushes the general public to question exactly under what conditions can ARTs actually protect and promote women's freedom. She also asks that more attention be paid to the multiple power structures (for example caste, family, and governmental structures) that position women in society as well as for a better understanding of how women relate to one another. The transnational flow of reproductive products—gametes and embryos—re-emphasizes pre-existing power imbalances, with globalization creating “new regimes of consumption” , driving the “reposition[ing] of women in new systems of inequality” (Gupta, 2006, p. 31).

*Qadeer.* Qadeer focuses on the issues of the “indivisibility of reproductive autonomy from the ‘daily endeavors of women’s agency’” (Correa, 2003, p. 21). She finds that feminists working in developing countries or economically impoverished regions fight against a generalized “single-issue” approach to reproductive policies and philosophies and calls for policies regarding ART to better understand the intersection of “poverty, gender, inequality, and cultural/religious norms underlying sexual and reproductive health challenges” (Ryan, 2009, p. 816).

We must understand why women seek out assisted reproductive technologies in order to achieve a rich reproductive health system. A reproductive rights agenda will have to understand just how women participate in shaping economic and political fields on both a local and a global level. This project takes a stab at understanding why Indian women from rural communities become surrogates—specifically focusing on the vehicle of understanding of “motherhood” in the Indian cultural context.

## Chapter 4

### RESEARCH METHODS

#### **INITIAL RESEARCH QUESTION**

What role, if any, should the broad cultural development of female self-empowerment, expressed as reproductive and economic freedom, play in future regulatory enactments regarding the practice of commercial gestational surrogacy in South India?

However, as I researched the project, I found that in order to address these questions, I needed to understand something much more fundamental—the role of bioethics in an Indian framework. By making claims about autonomy, commodification, and justice, I was already implementing a system of bioethics entrenched in Western philosophy on an Indian culture that functions much differently than the Western world. So, my new question became much more basic.

#### **EVOLVED RESEARCH QUESTION(S)**

How do conceptions of motherhood affect the meaning of bioethical principles—autonomy, beneficence, non-maleficence, justice—when applied to the cultural context of an Indian gestational surrogate?

I followed this up with the question:

How should the aforementioned affects, if at all, play a role in the generation of policy and regulations regarding commercial gestational surrogacy?

## **METHODOLOGY**

### **Literature review.**

My literature review hits several main topics—I use the ASU databases as well as Google Scholar searching for Assisted Reproductive Technologies, Surrogacy, Transnational Surrogacy, Commercial Gestational Surrogacy, Surrogacy in India, Ethics of Gestational Surrogacy, Feminist Ethics, Third-World Feminism, Reproductive Rights, Surrogacy as Reproductive Freedom, Indian Women and the Law, Narrative Ethics, and Meanings of Motherhood.

## **PROPOSED ARGUMENTS**

I ask whether commercial gestational surrogacy is ethical. What's more, I ask if it is ethical to outsource this form of reproduction to women in developing countries. Additionally, layered on top of the ethics of reproduction as an economic transaction are issues of bodily autonomy, exploitation, and women's rights.

Commercial gestational surrogacy fragments the role of motherhood—separating the roles of genetic, gestational, and social motherhood. The bringing together of a surrogate with the commissioning mother can either create alliances and a form of shared experiences between women, or it can bring about certain hierarchies and inequalities—especially when the surrogates comes from lower socio-economic backgrounds than do commissioning parents.

I argue that issues of exploitation and commodification seem to hinge on the concept of motherhood, or more specifically, on what defines motherhood.

Many western frameworks that outlaw or severely limit reproductive technologies, including commercial gestational surrogacy, appear to construct “legitimate” motherhood in a genetic sense. This is evidenced in the United States by the precedent setting court case—Johnson v. Calvert, in which the genetic mother was granted rights to a child over the surrogate mother. The judge found that relatedness as proved by a blood test was superior evidence of parenthood to the actual birthing of the child, thereby promoting genetic motherhood as more legitimate than gestational motherhood. Thus, if genetics is, in fact, what determines motherhood, the gestational surrogate’s worth is reduced to her reproductive capabilities and she becomes a “womb for rent.”

However, in the case of transnational commercial gestational surrogacy, it is important to define and understand the concept of motherhood within the cultural context that surrogacy exists. If they too find genetic ties to be the most important component in defining motherhood, then we can more accurately evaluate claims of exploitation and commodification. If not, which I believe to be the case, then we must more carefully consider their cultural construction of motherhood and how this affects the way in which they engage in and approach reproduction. This culturally competent comprehension of motherhood will allow us to fully evaluate whether commercial gestational surrogacy can be seen as a reproductive freedom or as a purely exploitative practice for surrogates in India.

With the evolved research questions, I further argue that the application of Westernized bioethical principles have the potential to take on new meanings when applied in a different cultural context. Because gestational surrogacy does

fragment the role of motherhood, it is of vital importance to not only understand the religious, social, and legal frameworks of the Indian woman and Indian surrogate, but also to understand the meaning of and definition of Indian motherhood. In order to achieve this understanding, the use of narratives is employed.

Narratives represent a worldview, a framework of knowledge, and a set of principles interacting with each other within the context of a story, scene or situation. It is also important for authoritative structures—fertility clinics, policymakers, governments—to properly derive information from narratives, making sense of the small details in order to find the significant values and traditions. The use of narrative contributes to an understanding of moral discernment as well as arguments and principles that a patient holds dear. Narratives, then, serves as a means to establish a sense of truth and authenticity regarding the moral issues surrounding case studies in medicine.

## Chapter 5

### INDIA'S MARKET FOR GESTATIONAL SURROGACY

In the past few decades, India has experienced an extreme growth in commercial surrogacy cases. This is due primarily to two factors—(1) medical tourism practices in India are defined by a preferable combination of low medical costs and western-educated doctors—“first-world treatment for third-world prices” (Nussbaum 1998) as well as (2) individuals from the Western middle and upper classes originate from countries whose surrogacy legislation is either highly restrictive or banned altogether.

Surrogacy in India, while legally permitted, has only recently been regulated. Even then, regulations are not always enforced. This makes India extremely attractive to commissioning parents unable to have a child of their own. They are, to a certain extent, guaranteed the successful birth of a child as well as the delivery of the child both physically and legally into the arms of the commissioning parents, conforming to Indian and American legal standards.

India's structure for commercial gestational surrogacy is unusual in that there are no federal regulations. It most closely resembles the rather liberal market structure apparent in California in which surrogacy contracts are managed almost exclusively by private agencies with little to no state involvement. India is currently the top destination for reproductive tourism, selling Western patients with their western-educated clinicians and low costs.

## INDIA'S REGULATIONS

In 2005, the Indian Council of Medical Research (ICMR) established a set of national guidelines regarding reproductive tourism. However, they are not legally enforced—allowing foreigners to take advantage of India's lack of regulation. Journalists are calling India's lack of regulation “the ultimate outsourcing” (Rimm, 2009, p. 1429).

Though there is no current legislation, India's Ministry of Health and Family Welfare has drafted a bill to regulate cases of commercial surrogacy in the subcontinent after India's first major legal case involving commercial gestational surrogacy—the Baby Manji case. ICMR presented a national regulation addressing not only commercial surrogacy but also other reproductive technologies. India's health minister Anbumani Ramadoss stated that,

“In light of the recent controversy (involving a Japanese couple and an Indian surrogate mother), I think it's time we had a law on surrogacy. It's become more than sporadic and is lending itself to commercial exploitation like the kidney (transplant)” (Jayaram, 2008, p.1 ).

Several prominent health care providers, including directors of infertility clinics, supported the legislation claiming that it would help deal with issues of an international black market and the potential for a bidding war for Indian surrogates. Ramadoss further stated, “the surrogacy laws will give confidence to those who come to India for fertility treatment that they are well within the laws of the country and at the same time protect the rights of the surrogate mother and baby (Points, 2008, p. 8).



The following Acts are the current legal parameters that India can apply to the regulation of gestational surrogacy.

**Indian Contract Act 1872 (the 1872 Act).** The 1872 Act states that “all agreements are contracts if they are made with free consent, and for a lawful consideration and a lawful object” (Mangaldas, 2010, p. 1). A contract may be treated as unlawful if it involves injury to a person or a person’s property or if a court decides it to be immoral or against public policy.

**Hindu Adoption and Maintenance Act 1956.** The Hindu Adoption Act states that no payment can be presented nor received to create an incentive for the adoption of any individual. In relation to surrogacy, this 1956 Act equates surrogacy and adoption, finding that no payment should be given for the labor of a surrogate mother—even for the costs and expenses of pregnancy.

**Hindu Minority and Guardianship Act 1956 (the 1956 Act).** The 1956 Act prevents a contracting father from obtaining legal rights to a child, stating that “in the case of a Hindu minor, whether an illegitimate boy or an illegitimate unmarried girl, the mother – and after her the father – is the natural guardian” (Mangaldas, 2010, p. 1). Once it is proved, usually through blood tests, that a child has no genetic relationship to the surrogate’s husband, the child is treated as illegitimate.

**The Assisted Reproductive Technology Bill of 2008.** India's National Guidelines and Proposed ICRM Guidelines along with the recently passed ART (Assisted Reproductive Technology) Bill are the first pieces of legislation responding to the jump in India's surrogacy practice. It requires a prospective surrogate to be under the age of 45 and to have children of her own—a mandate implemented to lessen the chance of her feeling connected to the child she is contracted to give away.

The Assisted Reproductive Technologies Bill of 2008 permits gestational surrogacy though it is restricted to when it is medical impossible or medically undesirable for the genetic mother to carry a baby to term. Not only must Indian women be under 45 to act as a surrogate, they are only allotted 5 successful live births, including their own children (Hochschild, 2009).

The Bill defends commercial surrogacy as a permissible business/marketplace in India, but also suggests the need for an application of labor rights framework to help reconcile the competing values of contractual autonomy and protection from exploitation. It makes recommendations for modifying proposed regulations—these include “recognizing minimum standards of care and compensation for surrogates, limiting contractual obligations enforceable against the surrogate, and requiring that neutral intermediaries facilitate surrogacy arrangements” (Rimm, 2009, p. 1438).

## **SURROGACY LEGISLATION IN INDIA**

Concerns regarding surrogacy arrangements from legal and ethical stances involve three types of contract participants—the commissioning/intending parents, the surrogate, and the child born of the surrogate. The following court cases were legislated in India and demonstrate the relationships between the three aforementioned parties involved in surrogacy contracts as well as the need for regulation of surrogacy on national and international levels.

**Baby Manji.** In 2007, a couple from Japan, Ikufumi and Yuki Yamada, made their way to the Akanksha Infertility Clinic in northern India to discuss a potential gestational surrogacy with the clinic's head doctor, Dr. Nayna Patel. Dr. Patel arranged a meeting with a married Indian mother, Pritiben Mehta, and generated a surrogacy contract between Mehta and the Yamadas. Patel created an embryo using Ikufumi Yamada's sperm and egg from an anonymous Indian donor. The embryo was implanted in Mehta who carried the baby to term (Points). By mid June of the following year, the Yamada's had divorced. In July, their baby, Baby Manji, was born. Ikufumi Yamada desperately wanted to keep and raise the child, but Yuki Yamada wanted nothing to do with the situation. Baby Manji was left then with three mothers—a surrogate who was forced to relinquish him due to contractual terms, a donor mother whose anonymity prevented any sort of relationship, and an intended mother who changed her mind.

Dr. Patel's surrogacy contract had no guidelines for a situation like this. India's lack of laws and regulations regarding the practice didn't help either.

Baby Manji was stuck in a legislative limbo for over a year—courts unable to determine the parentage or nationality of the child, both in Indian and Japanese law. Baby Manji was eventually given back to Ikufumi Yamada, though it was a complicated process. Parental rights were granted to the child's grandmother, for a brief period of time making Ikufumi Yamada his daughter's legally adoptive brother. However, once in Japan, Ikufumi Yamada legally adopted baby Manji into his own custody (Points, 2008).

**Balaz v. India.** Jan Balaz v. Union of India was a court case based in North India in the Gujarat High Court. The Balaz case surrounds the issue of the citizenship of twins born through commercial gestational surrogacy by a German couple—Jan Balaz and Susanne Lohle. The actual surrogacy process went well—the twins were successfully delivered and the surrogate mother gave up parental rights. However, because Germany does not recognize the practice of surrogacy, the twins were not able to get German citizenship if they are not first recognized as Indian citizens. This brought up questions in the Indian legal system as to whether a child born to a surrogate mother in India whose biological parents are foreign would be able to achieve Indian citizenship. For two years, the twins remained stateless.

In 2009, the Supreme Court of India found a solution. It held that children born to a gestational surrogate are citizens of India and therefore are able to get an Indian passport. However, this did confer parental rights to the surrogate mother, and the twins had to be adopted by the Balaz couple.

## **THE DEBATE CONTINUES**

Thus, both cases demonstrate the need for stricter regulations of commercial surrogacy from both a national and international perspective. The Baby Manji case solidified India's need to develop a comprehensive national policy regarding commercial gestational surrogacy. The fact that the struggle to determine Manji's nationality and parents remained in question for over a year after the child's birth is unacceptable. The growth of advanced reproductive technologies in India is surging far beyond what India's current legal system can handle. As the case of Baby Manji demonstrates, the lack of regulations has raised issues for international relations as well as for private surrogacy clinics. India's public, led by a dynamic NGO sector, is currently debating whether or not commercial surrogacy should be legal at all in the subcontinent. The Balaz case demonstrates the confusion transnational gestational surrogacy brings about when it comes to defining the citizenship of a child. It additionally brings to light the lack of communication between countries with different perspectives on gestational surrogacy.

Both cases also bring up questions,

What is a mother? What is a father? What does it mean to be a human? A citizen? How do we recognize and validate the identities of people and families formed through emerging technologies? And if, in doing so, we change our core definitions of family, have we made progress? (Points, 2008, p. 8).

Internationally, stakeholders in transnational commercial gestational surrogacy have begun to state their views on the ethical issues brought about by fertility tourism. 2008 saw the first national decision in India regarding commercial surrogacy and fertility tourism. Since then, advocates and legal scholars have started to study the Baby Manji and Balaz cases more in depth and give a more detailed analysis to the number of ethical issues surrounding them.

Globally, the International Federation of Social Workers issued a statement in which they voiced severe concern regarding the ethical and social dynamic of transnational commercial gestational surrogacy. The European Society of Human Reproduction and Embryology has also weighed in, calling for a “reduction in cross-border reproductive care referrals and more aggressive measures to ensure safety and quality when patients do seek treatment abroad” (Points, 2008, p. 8). The fertility tourism industry itself has started to propose regulations, presumably as a way to soothe and reassure their consumer base. The industry has set up online forums that engage potential customers in policy debates regarding transnational surrogacy.

## Chapter 6

### FINDINGS

I asked how definitions of motherhood affect how Western bioethical principles are applied to the cultural context of an Indian gestational surrogate and then how this should be interpreted when generating policy regulating commercial gestational surrogacy. In order to understand these questions, I find the need to understand the types of motherhood gestational surrogacy creates, how bioethical principles are understood in the Western context as well as understand what “Indian motherhood” is defined as. Once I define these, I use one case study—the Akanksha Infertility Clinic—to determine just how bioethical principles are affected in the cultural context of the Indian surrogate.

### **BIOETHICAL PRINCIPLES**

In health care, it is difficult to invoke universal principles. There are just too many unaccounted for variables that have the ability influence the context of clinical cases. Additionally, medical principles and rules can be applied in many situations and be implemented differently. However, Western biomedicine subscribes to four main principles—though their limitations are acknowledged. These principles are autonomy, beneficence, non-maleficence, and justice.

**Autonomy.** The bioethical principle of autonomy stresses the importance of an individual’s freedom and choice. Autonomy stresses “freedom from external constraint and presence of critical mental capacities such as understanding,

intending and voluntary decision making capacity” (Beauchamp, 2007, p. 4).

Autonomy is also linked to the belief that each individual has intrinsic value, separate from outside circumstances that normally confer value. That is, autonomous individuals are those that are ends in themselves and thus should be treated as a means to an end.

**Beneficence.** The principle of beneficence is abstaining from doing harm to others, often by helping “others further their important and legitimate interests, largely by preventing or removing possible harms” (Beauchamp, 2007, p. 5). More simply put, it is the principle of maximizing the benefit to a patient while minimizing harms. William Frankena defines this principle as, “One ought not to inflict evil or harm, One ought to prevent evil and harm, One ought to remove evil and harm, One ought to do or promote good” (Beauchamp, 2007, p. 5).

**Non-maleficence.** Non-maleficence is the obligation to not harm others. This obligation is distinct from the principle of beneficence in that it usually more stringent—not harming a patient is more crucial than doing good. The duty to not harm is more of an expectation, particularly in the medical field. Applications of the duty to do no harm is “supported by rigorous risk-benefit analyses” (Beauchamp, 2007, p. 4). Breaking this obligation is defined as “negligence.”

**Justice.** Justice is achieved if an individual is treated fairly according to what they are owed. Beauchamp discusses distributive justice as well as a formal



principle of justice. The latter is defined by the idea that like cases should be treated similarly. Justice, then, is often looked at through the concept of entitlement as well as of distributive justice. It is a common holding that equal people should have access to equal treatment (Beauchamp, 2007).

## **CONCEPTIONS OF MOTHERHOOD**

In many cultures, women are closely tied to the role of motherhood—so much so that it is viewed as intrinsic to the female identity. Often times, especially in Indian culture, females are not perceived as “real” or “true” women unless they have proven their reproductive capabilities—by producing a child. Feminists have argued fervently against this definition of womanhood and have pushed for a greater “attention on the continued ways women are more socially disadvantaged than men by analyzing the sexual oppressions women suffer, and by proposing interpersonal as well as political and legal solutions” (Lorber, 2001, p. 4).

Understandings and definitions of motherhood, however, are quite fragmented in the feminist community. Some feminist groups even object to the use of the term, “surrogate” claiming that it does not correctly or fully explain the process of contract surrogacy since the woman carrying the baby to term is a legitimate mother and should be thought of as such. Conversely, others believe that social motherhood is the only type of motherhood that should be viewed as legitimate. They find that parenthood is not defined by biological ties—citing

adoption as an example—and that parenthood is established by individuals meeting social expectations regarding parental responsibilities.

The individuals in the first group are known as liberal feminists. They find that the division of motherhood brought about by advanced reproductive technologies—the genetic mother, the gestational mother, and the social mother—has the ability to establish reproductive freedom for women. These technological advances are able to liberate women from the expectations of their reproductive biology as well as the societal expectations of women to be both child bearers and caretakers. In this view, social motherhood becomes a defining feature in motherhood rather than the biological and genetic relationship. Liberal feminists find that “motherhood rooted in biology is a cultural myth that overlooks the intense social conditioning that women receive throughout their childhoods and adult lives to desire children” (Hammons, 2008, p. 272). Hammons also finds that this fragmentation of motherhood gives women an active role and a choice in the reproductive process—empowering them. As such, the technologies have the ability to

bring women closer together rather than further apart. Already there are reports of contracted mothers living in close proximity to the couples who commissioned them and sharing the joy of the new life. Such reports bolster the claim that contracted motherhood can be viewed not as the male-directed and male manipulated specialization and segmentation of the female reproductive system, but as two women getting together...to achieve, in unison, something neither could do alone (Tong, 1989, p. 92).

Other feminist positions hold that the genetic definition of motherhood should be given primacy to or at the very minimum and equal grade to social motherhood. This perspective finds that advanced reproductive technologies commodify women as well as reduce the role of gestation to a mode of production. This perspective also raises the issue of exploitation of poor women for their wombs and/or eggs to produce children that will be raised by a wealthier women. Rich (1986) noted that

female biology and the diffuse intense sexual radiation out from the clitoris, breasts, uterus, vagina; the lunar cycle of menstruation; the gestation and fruition of life, which can take place in the body—had far more radical implications that we have yet come to appreciate...(Rich, 1986, p. 32-33).

The follow ases involving ARTs reflect these differing understandings of motherhood:

**Baby M.** In 1987, the concept of traditional surrogate motherhood grabbed the public's attention with an onslaught of legal and media attention—the great majority of it, negative. The landmark case was between the Sterns, a well off couple from New Jersey, and their surrogate, Mary Beth Whitehead. Because it was a traditional surrogacy, Mary Beth Whitehead contributed her own egg to the pregnancy, fertilized by Mr. Stern's sperm. After giving birth, contrary to what Whitehead had agreed to with the Sterns, she decided she wanted to keep the child. After months of the debate regarding what constituted appropriate

motherhood, the New Jersey Superior Court held the surrogacy contract and gave rights of Baby M to the Sterns.

The case was at the center of media attention for a year; it had brought to the forefront a “worst-case scenario” in a surrogacy contract—a surrogate who attempts to break that contract, a custody battle, and moral ambiguity of rights of parenthood. Baby M became a critical moment for the United States legislative system—serving as a discourse on the problems of unregulated commercial surrogacy. Following the case, “twenty-six state legislatures introduced seventy-two bills on the issues of surrogacy. Hundreds more bills were introduced in the following years, split fifty-fifty on whether to permit or prohibit all forms of surrogacy” (Markens 2007, p. 22).

Surrogacy arrangements also began to move from mere contractual agreements between to parties to being regulated by an objective third party—that is, began to involve lawyer and a subsequent contract. The late 1980s saw an informal set of industry guidelines for commercial surrogacy developing (Ragone, 1994) in response to the negative Baby M coverage. These included strategies that protected the surrogacy industry from receiving more negative attention by avoiding views of surrogacy that depicted the practice as exploitative or immoral (Ragone 1994). However, these industry guidelines were accepted and implemented informally by surrogacy clinics.

They were helpful, though, as gestational surrogacy increased from making up less than 5 percent of surrogate births to over 50 percent by 1994 (Ragone & Twine 2000). Ragone’s belief is that while these legal factors and

industry guidelines brought about by the Baby M case have contribute to the jump in gestational surrogacies, what is also at work is “people’s adherence to ‘traditional’ American kinship ideology and ideas of biological relatedness” (Ragone & Twine, 2000, p. 57).

**Johnson v. Calvert.** The Johnson v. Calvert case is the first case in the United States where a ruling was made regarding parenthood in a gestational surrogacy case. The case was brought about by Mark and Crispina Calvert. Crispina had undergone a hysterectomy, and, though her ovaries were still capable of producing eggs, she could not carry a child. So, she and her husband turned to gestational surrogacy, entering into a contractual agreement with surrogate, Anna Johnson. Both parties signed a contract where the Calverts agreed both to pay Anna \$10,000 for her services as well as buy her life insurance in return for Anna relinquishing parental rights after the birth.

The in vitro fertilization of Crispina and Mark’s embryo was successfully completed, but while still pregnant, Anna demanded payment immediately. She threatened that if not paid, she would not relinquish the child after birth. The Calverts filed a lawsuit searching for a judicial confirmation that, based on the contract Anna signed, she could have no parental rights to the baby. The courts eventually ruled in favor of the Calverts, deeming them the child’s “natural” parents. This was further affirmed when the trial was taken to the California Supreme Court. California Family Code section 7610 finds that a woman can establish proof of maternity in three ways: proof of having given birth to the

child, proof of a genetic relationship with the child; or proof of adoption” (Walton, 1996, p. 1). By signing the gestational surrogacy contract, Anna Johnson conceded that the Calverts were the genetic parents, and as such qualified in a legal sense to parental rights by virtue of a genetic relationship. However, Johnson qualified as well by her role as the birthmother. Thus, both women had legitimate maternity claims under California law. The California Supreme Court decided to “break the tie” simultaneously indicating that there cannot be two women with natural maternal rights. The Supreme Court ruled that Crispina was the natural mother.

The Calvert v. Johnson case ruled that the individuals who enter a surrogacy contract with the intent to care for the baby resulting from the surrogacy process are the child’s legal parents. Thus, “since the intent to care for a child at the time of the contract will always lie with the prospective parents, the Johnson holding created a decision-making process that ignores other pertinent factors” (Walton, 1996, p. 1).

***The result of the Johnson holding.*** The other “pertinent factors” ignored by the Johnson case included consideration of the situational and social circumstances within which the surrogacy contract exists, the contribution of the surrogate, as well as the potential bonding between a surrogate mother and the fetus. According the California Supreme Court’s decision, cases similar to Calvert v. Johnson would not be able to consider changes that occur over the course of a pregnancy, for example, a divorce. In this case, perhaps the surrogate could give

better home and upbringing for the child. Also ignored is the genetic contribution. The California Fourth District appellate court stated that under *Calvert v. Johnson*, “biology is destiny,” perhaps more accurately reflecting the idea that “genetic origin is destiny” (Walton, 1996, p. 1). Thus, though the surrogate mother is genetically unrelated to the fetus, she does nourish the fetus with hormones, antibodies, proteins...etc.

*Johnson v. Calvert* is one of the first and only cases involving a commercial gestational surrogacy as well as in which a legislative ruling gave clear preference to a certain type of motherhood. The California Supreme Court ruled that the intending and genetic parents, the Calverts, were the legal parents and not the gestational surrogate, Anna Johnson. Specifically the court claimed that

since Crispina [Calvert] is the child’s mother under California law because she, not Anna [Johnson], provided the ovum for the in-vitro fertilization procedure, intending to raise the child as her own, it follows that any constitutional interests Anna possesses in the situation are something less than those of a mother (*Johnson v. Calvert*, 1993, p. 19).

**Moschetta v. Moschetta.** All cases revolving around traditional surrogacy—that in which the surrogate donates her eggs—have held that surrogates, and not the intending mothers, were the legitimate mothers. *Moschetta v. Moschetta* (1994) occurred when a surrogate was artificially inseminated with the sperm of an intended father. Upon giving birth, the surrogate, who was the

birth as well as biological mother, fought for custody of the child. The courts however, did not recognize her legitimacy as a mother, respecting the surrogacy contract and each party's intent at the time the contract was signed (Hammons, 2008).

The court also stated that for individuals or couples who cannot afford in vitro fertilization or who turn to traditional surrogacy practices (artificial insemination) because a woman does not have enough eggs or eggs suitable for IVF are not assured that their *intentions* will be respected and honored in a court of law. As such, the genetic tie is stressed, this time in a different manner, as the surrogate holds rights to the child born of a surrogacy agreement and not the intended mother.

**McDonald v. McDonald.** In *McDonald v. McDonald*, a surrogate birthed twins created from a donated egg and her own husband's sperm. The Court drew from the *Johnson v. Calvert* case to determine that the legitimate mother in the case was the intending mother and not the genetic mother. (The intending mother is the mother who commissions the surrogacy—separate from the genetic mother in this particular case as a donor egg was used.)

This demonstrated a preference gestational ties as a defining feature of motherhood over genetic bonds despite the fact that that all parties in the case recognized and emphasized the importance of genetic bonds (Hammons, 2008).



It is quite evident then, that based on the mixed findings of the courts, specifically in the United States, there are various and often times conflicting understandings of motherhood within American case law. Some find that surrogacy is just a variation of artificial insemination and should be treated no differently while others firmly believe that gestational surrogacy establishes a strong and lasting connection between a surrogate and the child she is carrying. Similarly, gestation has also been argued to be a definitive act of motherhood, more so than providing eggs. While egg donations do require a great degree of invasive process, a surrogate donates her body for nine-months. She is more than an incubator—the experience is both miraculous and meaningful. Thus, many chalk up egg donations to being on par with sperm donation and find the gestational mother to be the legitimate mother of a child born of surrogacy.

So then, the courts have made no authoritative decision on the definition of motherhood. Whether it is seen as a social bond or a biological reality seems to be decided on a case-by-case basis. Social motherhood seems to be downplayed in cases involving artificial insemination when the biological mother is involved on both a gestational and genetic level. *Moschetta v. Moschetta* stated that,

In traditional surrogacy the so-called ‘surrogate’ mother is not the only woman who gave birth to the child, but the child’s genetic mother as well. Thus when both gestational and genetic motherhood are present in the surrogate, the intended mother has consistently lost her claim to be the

child's legal mother even though it may have been her desire to have a child that initiated the surrogacy process (Hammons, 2008, p. 277).

Reproductive technologies make the definition of motherhood even more confusing as they establish and make possible a number of new relationships between mother and child. Society still has to catch up—to develop a new framework for recognition of these new processes and the new relations they create. Old conceptions regarding the notion of family fail to address the situations advanced reproductive technologies create. As such the general public is put in the position of either rethinking our current definitions of the maternal and of motherhood, or to force new technologies old “ill-fitting” social frameworks.

To reiterate, the American judicial system seems to hold that there are certain aspects of biological and genetic motherhood that are definitive measures of motherhood while finding social motherhood “transient.” More research is needed in order to understand whether and how judicial rule will affect the use of advance reproductive technologies. Cases such as *Johnson v. Calvert*, *Moschetta v. Moschetta*, and *McDonald v. McDonald* help bring to the forefront the processes and factors that are changing our current understanding of motherhood and family.

**Baby Manji.** Baby Manji's case is often viewed as the “Baby M” of India in that both cases led to an awakening to the need of stricter and more enforced regulations in the realm of commercial surrogacy. Both cases, Baby M in 1987

and Baby Manji in 2008 gave visibility to the “worst fears” of surrogacy cases—to a sharp change in the way we define kinship, parenthood, and family. It is, however, important to recognize the differences between these cases. Baby M emphasized that the nurturing characteristic of motherhood was not a strong enough trait to hide the inconsistencies in an American tradition that places heavy value on the concept of the blood tie. Traditional surrogacy was inconsistent with this, and the controversy brought about by Baby M exacerbated this discomfort.

Baby Manji’s case, however, brought about a new set of cultural and legal concerns regarding surrogacy—even more so in that it was done on a transnational scale. One of the stark differences was that Indian law does not allow a single father to adopt. It is extremely inconsistent with the opportunities advanced by reproductive technologies, which allow a single man to have his own child. Indian law finds that parenthood is not legally permissible without a mother involved. But as has been evidenced by numerous court rulings, even surrogacy is fractured on who the mother is and how she is defined.

## **INDIAN MOTHERHOOD**

Cultural understandings of motherhood and the experiences of mothering and motherly love are derived from definitions of motherhood within the context of the Indian kinship system (Lynch, 1990). Lynch, (1990) also claims that the biological and genetic tie between an Indian mother and her child has always been de-emphasized. This ensures that a mother will never become too possessive of her child. Thus an Indian mother is

expected to deindividualize her relationship with her child to the extent that any member of the family can be entrusted with its care. Thus, every day behavior in Indian families self-consciously recognizes the fact that the process of mothering, unlike the process of childbearing, can involve a number of surrogates in addition to, or instead of, the real mother (Lynch, 1990, p. 167).

Indian motherhood then, is an odd sort of contradiction. The majority of Indian families are patriarchal in nature. Despite this, the role of mothers and motherhood is glorified and praised for the contribution it makes to the overall health and happiness of the Indian family unit. The image of an Indian mother makes a significant impact on the Indian social system. Yet her role as a mother is not selfish—the Indian family unit ensures that certain aspects of mothering should be shared among all family members, especially intimacy, the relationship with the child.

Surrogates then, are both fulfilling this ideal or glorified role of mother as well as treating motherhood as their culture has trained them to—as a shared practice.

**Case study: the Akanksha Infertility Clinic.** The Akanksha Infertility clinic is located in Anand, a sleepy dairy town in the western state of Gujarat. Though Anand's population is small, just 150,000, it is now at forefront of India's booming reproductive tourism business. The clinic is directed by Dr. Nayna Patel. She put Anand on the map when she constructed a gestational surrogacy

arrangement for her own biological daughter. Patel's daughter had been having trouble conceiving for years and Patel took it upon herself to implant an embryo generated by her daughter's egg and son-in-law's sperm into the womb of a local Anand woman. The surrogate gave birth to twins—Patel's own genetic grandchildren. Once news of Patel's success spread, she was swarmed with requests to orchestrate more surrogacy arrangements. The clinic now houses just over 50 surrogates, with more than 150 couples on the waiting list—requests ranging from Taiwan, to the United States, to Japan, and to much of Europe. Between 25 and 30 surrogates are pregnant at any given time and are paid between 5 and 7 thousands—an estimated 10 years worth of salary for a rural Indian. All surrogates are required to relinquish maternal rights upon birth and hand the baby over.

This thesis focuses on the concept of motherhood based exclusively on pre-existing literature regarding surrogate relations in the Akanksha Infertility Clinic.

*Stigma and Indian surrogacy—surrogacy as dirty work.* Pande (2010) defines commercial gestational surrogacy as engaging in a labor practice that is particularly stigmatized. As such, surrogates develop unique emotional and ideological frameworks to cope with the stigmas they face. The father of the academic approach to studying stigma, Erving Goffman, argues that “bodily signs that depart from the ordinary can be deeply discrediting” (Pande, 2010, p. 293). Surrogates are also involved in “dirty work,” a term used to describe certain

occupations that are viewed by society as degrading or disgusting. The “dirty” aspect of these jobs, then, refer both to concepts of the amount of filth involved in the labor (for example, janitors, street sweepers, butchers) and or as well as a perceived lack of moral conceptions (for example, sex work). Certain types of dirty work fall into a category where the work is both applauded as selfless and brave though still perceived as deviant from the way in which society operates. Surrogacy falls in this category with surrogates often describes as “angels” giving the “gift of life,” while simultaneously shrouded in ethical concerns of the renting out of wombs or the commodification of motherhood. Indian surrogates seem to face a higher degree of stigma than those in other countries. As a result, the majority of surrogates work in secrecy—leaving their communities and families during the pregnancy to take refuge in the fertility clinic or in hostels specifically for surrogates. If they choose to reside in their homes, they will tell neighbors that the baby is hers and will claim miscarriage after giving the child to the intended parents.

**Coping with stigma—the narrative of the Indian surrogate.** Surrogates at the Akanksha fertility clinic exist in a world where the people around them—the media, their communities, medical professionals, other surrogates—construct a number of meanings to the surrogacy process. A surrogate’s family will often justify a surrogacy as a familial duty so that the woman may contribute to the household finances. The media and surrounding community often see it as “dirty work,” the selling of one’s body and reproductive capability. The medical field

has an impersonal approach to surrogacy, often times reducing the role of the surrogate to simply that of a vessel. Pande finds that in order to respond the multitude of approaches to commercial surrogacy, surrogates invoke the use of four narrative strategies:

First, they created symbolic boundaries between surrogacy and sex work and between surrogacy and giving a child away for adoption. Second, they downplayed the element of choice in their decision to become surrogates. Third, they resisted their disposability in the "labor" process. Finally, the women simultaneously distanced themselves from and make claims on the baby (Pande, 2010, p. 307).

*More than just “baby-sellers.”* The identity of India’s rural working class is defined by “boundary work” in which individuals construct ideas of self-worth by understanding and interpreting the distinction between them and those who belong to other classes (Pande, 2010, p. 300) . This interpretation allows the working class to affirm their dignity by developing high moral standards regarding their work ethics.

When boundary work is applied to “dirty work,” participants in particular “dirty work” field make comparisons with other social groups that they find to be in a similar position, but more disadvantaged in one way or another. Ashfort & Kreiner (1999) claim, “these groups are sufficiently similar to justify the comparison, but are ‘inferior’ enough to gratify the need for self-esteem” (p. 423). The surrogates in Pande’s study seem to use commercial sex work as their

comparative occupational field. Thus, one way the surrogates in the Akanksha Infertility Clinic deal with stigma is by comparing themselves to sex workers— noting the similarities in the commercialization of body parts, but noting the sex workers inferior position in that they don't get to provide a life for another.

*Choice vs. necessity.* The concept of “Majboori” or “necessity” becomes an important narrative for the Indian surrogate. Though many proponents of Indian surrogate actually place emphasis on the occurrence of third world women gaining agency by making their own reproductive choices, the majority of surrogates in the Akanksha infertility clinic though, feel differently. Regarding their decision to become surrogates, they often suggested that it was in fact *not* their decision and as such they should not held responsible or face any sort of stigmatizations (Pande, 2010).

A way in which this was done was by invoking the concept of surrogacy as a “necessity.” One surrogate, Salma, claimed the following:

Who would choose to do this? I have had a lifetime worth of injections pumped into me. Some big ones in my hips hurt so much. In the beginning I had about twenty to twenty-five pills almost every day. I feel bloated all the time. But I know I have to do it for my children's future. This is not a choice; this is majboon [a necessity]. When we heard of surrogacy, we didn't have any clothes to wear after the rains- just one pair that used to get wet and our roof had fallen down. What were we to do? If your family is



starving what will you do with respect? Prestige won't fill an empty stomach (Pande, 2010, p. 301-302).

Thus, not only does the decision to become a surrogate become a necessity in order to keep the family afloat. Surrogates at the clinic in Anand also speak of providing for a better life for their children. Pande's interview with surrogate Anjali was extremely demonstrative of this:

I am doing this basically for my daughters; both will be old enough to be sent to school next year. I want them to be educated, maybe become teachers or air hostesses? I don't want them to grow up and be like me, illiterate and desperate. I don't think there is anything wrong with surrogacy. But of course people talk. They don't understand that we are doing this because we have a compulsion. People who get enough to eat interpret everything in the wrong way (Pande, 2010, p. 302).

***Greater than the womb.*** Scholarship on third world surrogates often emphasizes how the medical field makes surrogates feel as if they are “disposable” (Pande, 2010, p. 304) and as such are forced to question maternal roles. Akanksha's surrogates are given intensive training regarding their role as surrogates where it is explained that their primary function is to serve as a vessel. It is reinforced that surrogates have no genetic ties to the child and as such will voluntarily give up the child right after birth. Pande's (2010) interview with a infertility doctor at the clinic discussed the education of the surrogate,

I had to educate them about everything because, you see, all these women are poor illiterate villagers. I told them, "You have to do nothing. It's not

your baby. You are just providing it a home in your womb for nine months because it doesn't have a house of its own. If some child comes to stay with you for just nine months what will you do? You will take care of it even more because it is someone else's. This is the same thing. You will take care of the baby for nine months and then give it to its mother. And for that you will be paid." I think finally how you train them, showing the positive experiences of both the parties ... is what makes surrogacy work (Pande, 2010, p. 308).

However, the relationships Akanksha's surrogates form with each other as well as with the commissioning mothers actually depicts the rejection of this notion. Surrogates actually understand themselves as fulfilling a unique and special role. Certain surrogates claim that they held certain traits that made them more desirable than other women, while others honed in the strong bond they formed with their commissioning couple. This narrative of "being special" not only helps surrogates fight off the stigmatizations surrounding stigma, it also makes them better surrogates—more willing to take care of their health, and subsequently, the health of the fetus (Pande, 2010).

*The surrogate's relationship to the fetus.* Research on the understanding of surrogacy as dirty work demonstrates that surrogates often have contradictory belief systems that help them deal with everyday stigmas. The effects of these beliefs are twofold—they allow for reduced emotional investment in the pregnancy as well as allow surrogates to situationally reject or embrace their

identity as laborers. These fractured belief systems transfer into fractured and often contradictory views of motherhood. Pande finds that “surrogates resort to contradictory narratives that simultaneously distance themselves from the babies and make claims upon them” (Pande, 2010, p. 307). Thus, though surrogates are constantly reminded that they have no genetic connection to the child they carry; making some sort of “claim” on the baby allows them to view themselves as more than just a womb for rent.

In order for surrogates to justify their self worth and view themselves as more than a vessel, Indian surrogates often turn to particular narrative stories to deal with the complexities they are faced with. In the Akanksha clinic, a surrogate, Parvati, explained how surrogacy is not a new concept to Hindu women: “We can’t really call it [surrogacy] either work or social service. I personally feel it’s nothing strange to us Hindus; it’s in our religion. It’s something like what Yashoda ma did for Lord Krishna” (Pande, 2010, p. 308-309). Another manner in which surrogates normalize their unique gestation process is by comparing it to the act of giving away daughters during marriage. Pande’s interview with the surrogate, Jyoti, revealed the following:

Of course I'll feel sad while giving the baby up. But then I'll also have to give up my daughter once she gets married, won't I? She is paraya dhan [someone else's property] and so is this one. My daughter is my responsibility for eighteen years, then I have to give her up but I still remain responsible for anything that goes wrong. At least with this child I won't be responsible once I give her up. Also with this one I'll be happy

that she is somewhere where she will be happier. These people will send her to school, college, pamper her much more (Pande, 2010, p. 309).

**Kinship in the Akanksha Clinic.** In the Akanksha Clinic, Amrita Pande (2009) studies the idea of everyday forms of kinship between the surrogates housed there. She defines these ties as the result of a “conscious every day strategy, and, at times, a vehicle for survival and/or resistance.” She explains how these constructions of kinship remove surrogates from their patrilineal duties and roles. These forms of kinship are borne in the sharing of bodily fluids—sweat, blood, and breast milk—, as well as the sharing of spaces, of the gestation period, and in the process of giving birth. These connections based on the sharing of bodily fluids are emphasized and heightened by surrogates. When paired with a surrogate de-emphasizing genetic ties fetus has with its biological mother as well as the men who are involved in the commercial surrogacy process (the genetic father’s as well as the surrogate’s husbands), Pande finds that Indian surrogates actually fight against pre-existing hierarchies in the Indian social system, where typically genes and the male sexual product are placed on a higher level than any sort of social or female contribution.

As surrogates are forming these bonds with each other, with the fetus, and with the intended, genetic mothers, they are simultaneously establishing ties across religious, class, and caste divisions by focusing on the notions of shared substances—blood and sweat—as more legitimate means for establishing kinship bonds.

Jyotsna Agnihotri Gupta argues against the radical feminist mindset in which third world surrogates are viewed as a “caste of breeders” whose role in society would be to carry the embryos of high-class white women. Gupta instead finds that the affect of assisted reproductive technologies is multifaceted—that “while some women use these technologies has meant a shift from being ‘objects’ and ‘victims’ to ‘knowing subjects’ and ‘agents’ of control over their own bodies, for other they have brought more outside control and expropriation” (Gupta, 2006, p. 28). Thus, this type of surrogacy scholarship focuses on commercial surrogates as laborers rather than the victims of exploitations.

**The role of narratives.** Surrogates implement narratives to help minimize the stigma attached to surrogacy. Narratives invoke the language of morality, allowing surrogates to recognize their self-worth and dignity. They also allow surrogates to justify their situation—letting them either emphasize their dire economic circumstance, by being pushed into the surrogacy to take care of their children, or by demonstrating a higher power make the decision for them. These narratives fight against the discourse of surrogates as “dirty workers,” equivalent to commercial sex workers. In one sense, narratives function as a form of resistance to negative discourses of surrogacy—from the media, from family, from the community, and from medical practitioners. Simultaneously, surrogacy plays into a narrative that fits in with the Indian construct of motherhood—in which motherhood is selfless, significant, and shared.

## **SHIFTS IN BIOETHICAL PRINCIPLES**

How then, do these narratives affect the bioethical principles of autonomy, beneficence, non-maleficence and justice? In the Western sense, we autonomy emphasizes individual freedom and having the mental capacity to make decisions rationally. However, when it comes to the Anand surrogate, autonomy appears to be narrowed down to the achieving a reproductive freedom. Gestational surrogacy allows these women to experience pregnancy outside of an expectation and a duty and instead as a choice and a source of employment. Beneficence is defined as the duty to do good. Surrogates experience this by expressing the surrogacy experience as the gifting of life to an infertile woman or infertile couple. They experience non-maleficence in a more familial sense in which they view partaking in the surrogacy as the only means to keep their family afloat and to give their children more options in life—something they view as a parental duty. Finally, the principle of justice is reduced to monetary means. Anand surrogates feel that justice is achieved by receive a paycheck equivalent to 10 to 12 years worth of salary for them.

The position this project takes, then, is that, yes—the four tenets of bioethics are universally applicable. However, they should be flexible—interpreted in response to cultural differences and thereby able to shift or alter in their application.



## Chapter 7

### DISCUSSION & CONCLUSION

#### CONCLUSION

**The role of culture in bioethics.** Studies in bioethics have often taken a rather narrow approach to understanding the role of “culture” within the field. Definitions of culture have been constructed in such a way that it becomes essentialized or over-reduced; defined simply as a thin distinction and diversity, which are then used to make blanket claims about a “people.” However, the concept of culture is a rich one, steeped in epistemological complexities that hold the power to manipulate meanings of health and illness.

Culture is too often perceived as a synonym for “ethnicity” as opposed to understood as a reference to cultural processes that shape and are shaped by institutions and behaviors. This distinction is important—it allows us to question our own cultural assumptions and to reflect on who we are, more specifically, who we are in relation to the institutions and people around us.

So where does the idea of a universal template for bioethical principles stand in the midst of a strong urge for cultural relativism? It is important to recognize the significance of being able to understand and apply meta-ethical principles. But it is in the application process that there should be some flexibility. Marshall & Koenig (2004) find that “flexibility in the application of ethical rules is consistent with adherence to more fundamental ethical principles” (p. 260).

Thus, when applying universal bioethical principles in a culturally relevant manner, we should take into consideration just how social and cultural values



intersect with commercial interests. Once these ideas have been layered upon each other, we can apply them to assisted reproductive technologies (ART)—specifically commercial gestational surrogacy. We can explore under what (assuming that there are) cultural conditions that ART can promote a woman’s agency in the process of reproduction. It requires attention to power structures as well as understanding the position of women in society and how they relate to each other and to other actors within a culture.

The position this project takes, then, is that, yes—the four tenets of bioethics are universally applicable. However, they should be flexible—interpreted in response to cultural differences and thereby be able to shift or alter in their application. These alterations in application are defined and shaped by the narratives used by various groups. In this case, they have different meanings to medical practitioners, to surrogates, and to advocacy and/or opposing factions.

**The role of narratives in bioethics.** Humans look to stories for guidance, as a sort of moral compass. Whether these stories come in the form of written narratives or spoken word, the moral principles woven within the words exist as a stepping-stone for individuals to make their own moral decisions. With stories being such an integral part of the human existence, it is inherent that stories come into play in all aspects of life—including in sickness and in health. Thus, the concept of narrative ethics has naturally found its way into the medical field—individuals bringing forth their own personal histories as well as the stories that

guide their moral choices into the decision-making process. It is interesting to compare these stories from a secular and religious viewpoint.

Secular bioethics often places great emphasis on the importance of case studies while religious individuals look toward forms of scripture for guidance. These two variations of a narrative are typically viewed as distinct and separate forms of guidance—each playing a different role within the context of bioethics. However, when looked at in the framework of narrative ethics, both case studies and religious narratives play a similar part in medical decision making—existing as textual examples of a complex problem and as the moral conclusion or decision that came from them.

Narratives serve as a means to establish truth and authenticity regarding the moral issues surrounding mutable case studies in medicine. The use of narrative ethics in the medical field claims that fictional stories allow individuals to confront the severity and confusion of complex clinical situations by allowing for the application of moral claims in action. This provides individuals the capacity to relate to a situation that, without a fictional narrative, would appear outside of their circumstances.

Thus, case stories, such as those told by the surrogates at the Akanksha Infertility Clinic, have great power. With this power comes a social responsibility. In this context, literary narratives have the power to help shape decisions made in bioethics and subsequently comes with and required examination of “the reciprocal responsibilities incurred by the writer who encodes thoughts and

feelings into language by the reader who rescues words from their secrets”  
(Charon, 2002, p. 22).

Narratives represent a worldview, a framework of knowledge, and a set of principles interacting with each other within the context of a story, scene, or situation. The end result of a narrative makes an authoritative decision regarding a problem that presented itself within the story. So only by paying attention to how a narrative affects an individual do “we see more clearly where we are in the story, and this ultimately shows us something like the way out of the case, the denouement, the back door to the outside world” (Charon, 2002, p. 25). I have specifically been focusing on narratives on an individual level—from the perspective of the surrogates in the Akanksha Infertility Clinic. However, another narrative, unique to India and to the Anand surrogates, is the Hindu narrative of new technologies.

**The adaptive Hindu worldview.** In India, these narratives are first and most obviously evident in how the media explains new technologies—nuclear bombs, for example are constructed as “Brahmastra”—a weapon of Brahma. With technologies such as IVF and surrogacy, India is turning to the first chapter of the Mahabharata in which it is claimed that members of the royal Kaurava family were born from stem cells. The media also projects the Hindu trinity as demigods of fertility (Bhardawaj, 2006). Fertility doctors not only play the parts of Brahma and Vishnu, creating and sustaining life, respectively, but also play the part of destroying life—the role of Shiva. Additionally, there is the story of Krishna’s

birth—his embryonic form removed from the womb of his genetic mother and into the womb of a surrogate mother.

Occurrences like these are not conscious attempts to revert back to a cultural, historical and religious origin, but simply exist as a natural tendency to explain a new event, technology, or cultural system within the Indian context. It is also not unique to India. Worldwide, people convey ideas via stories and narratives unique to their own cultural background. This layering of traditional “self” on top of a modern ‘other’ is referred to as a double entrenchment of tradition. It is a belief that tradition is first rooted in institutions such as the caste system or religious institutions and then again in “modern institutions” such as bureaucracy and law (Bhardwaj, 2006).

As such, in India, the traditional and modern are continually redefined. Modern institutions are continually placed in a cultural context in which they are given meaning and sense based on the virtue of the geographic location within which they exist. A prime example of this is the presence of biomedicine in India, used as a means to circumvent the issue of infertility. Biomedicine, then, is colored by Hindu traditions in India (Bhardawaj, 2006).

Metaphysical explanations have become increasingly acceptable with the uncertain nature of assisted reproduction. These cultural methods of making sense of modern technologies indigenizes biomedical practices and also demonstrates how biomedical modalities work with Hinduism’s pluralistic tendencies. It is was allows a number Indian citizen to go beyond generalizing technical and clinical application of science in the European and American frameworks, and personalize

it to their own culture. As such, biomedicine set against the Indian backdrop so quickly assimilated into a cultural framework that is transforming the way that it is perceived as well as practiced.

It is understood then, that this project finds the use of narratives a successful means to understand how bioethical principles shift in their application when applied in different cultural context. So how should this phenomenon be considered in the generation of policy and regulations regarding commercial gestational surrogacy?

The flexibility in the application of universal ethical principles is something that I find can be extended into a policy realm. I believe this can be done by (1) setting a global standard that fertility clinics all over the world must exemplify (2) by establishing local programs that bring to light the experiences of marginalized women; pushing to understand their motivations for becoming a surrogate, and (3) coordination between national and international structures to ensure that surrogacy regulations are being enforced and the women involved are receiving appropriate compensation.

The flexibility illustrated by the application bioethical principles exists in the utilization of narratives, this time through the medium of local groups that specifically seek to understand and protect the position of surrogates, to account for a sense of cultural competency in a medical setting.

It is important, then, to recognize that the overall goal of generating policy for transnational surrogacy is to *reduce injustices* that have been brought to the

forefront by both narratives of surrogates as well as by legal precedents set by cases such as the baby Manji case and Balaz v. India. Thus we need to consider policy from both a human rights and structural/institutional perspective. This invokes a dual-lens ethics.

*Dual lens bioethics.* This particular form of bioethics extends beyond simply identifying ART challenges in developing countries and asks to look further into issues of the negative consequences of globalization. Dual-lens bioethics brings three main points to the forefront,

first, as a “terrain of continuing political struggle,” human rights principles are a means for reasserting the priority of investments in health over freedom of the market; second, advocating for social and economic rights (rights of development) for the disenfranchised (e.g., in the context of local and global disparities in access to primary care) explicitly recognizes that all debates over medicine, science, and technology take place on unlevel playing fields involving haves and have-nots; finally, promoting women’s rights as human rights grounds activism in a strategic commitment to the least well-off in every area of the world (Ryan, 2006, p. 822).

The clinical field of fertility is rooted within the subcontinent’s cultural topography with the transfer of “Western” assisted reproductive technologies not simplified to the basic exchange of clinicians offering treatment and patients

receiving treatment but rather, encompasses how doctors and consumers assimilate “the technoscience of conception” (Bharadwaj, 2006, p. 452).

Bharadwaj (2006) argues that either the success or failure of assisted reproductive technologies in India will become a critique of the Western “science” of fertility/conception, especially when embedded within the context of the Hindu faith. He finds that when assisted reproduction is paired with the Hindu faith, specifically, it appears to merge the otherwise seemingly separate entities of the traditional and the modern, “the sacred and profane, the human and the superhuman, science and religion” (Bharadwaj, 2006, p. 455).

Bharadwaj discusses an enchanted understanding of a disenchanted worldview of biomedicine and that this enchantment is a part of a cultural indigenization process of biomedicine. This is very apparent in the speed of growth and assimilation of assisted reproductive technology in India. Technologies such as in vitro fertilization (IVF) do not necessarily easily surpass “cultural voids” and local views—cultural, social, economic, or political—shape how technologies from the West are promoted and received by non-Western individuals. In the context of assisted reproductive technologies in India, this is expressed as a battle between the traditional and the modern. Western traditions are often understood as the normative tradition with essentialist imaginations of India’s traditions simply standing at the confluence.

Scholars of the Hindu tradition explain that those invested in the Hindu worldview has a unique ability to relate back to its cultural past allowing modern world views to emerge as embedded in the traditional worldview. Milton Singer

finds that “this traditionalism of Indian civilization lies elsewhere—in its capacity to incorporate innovations into an expanding and changing structure of culture and society. This capacity is reflected in a series of adaptive mechanisms and processes for dealing with the novel, the foreign, the strange” (Bharadwaj, 2005).

**A human rights discourse.** When it comes to establishing policy regarding Assisted Reproductive Technologies, it is important to ask whether the exchange between consumers and sellers of reproductive technologies can mutually benefit the women involved. One sect of bioethicists and feminists firmly believe, yes, that if proper informed consent is obtained, particularly on the surrogate or egg donors end, exploitation can be avoided (Ryan, 2006). However, many believe that this answer is naïve—missing completely the understanding of larger networks of power that hold control over the value of goods as well as access to them. Gupta finds that the establishment of a market relationship between infertile women desperately seeking surrogates and/or egg donors and fertile women selling these services and reproductive “products” is more than just a thin relationship between producers and consumers and needs to be better understood as women caught in a “capitalist global economy that needs women and yet marginalizes women’s labor both as producers and reproducers in search profit” (Gupta, 2006, p.35).

A human rights model is also used as means to critique power imbalances in the globalization of medicine and assisted reproductive technologies. Virginia Sharpe finds this approach to be “more extensive than utility maximization, more



democratic than paternalism, more mutual than informed consent and more responsive to social inequities than are consumer preference satisfaction and caveat emptor” (Sharpe, 2004, p. 454). However, human rights paradigms can also serve to elevate the over all health by presenting it as a public good, calling to the forefront issues of power hierarchies and the distribution of health care services on a local, national, and global level. Ryan (2006) finds that “for all its limitations, the language of human rights is one of the most powerful vehicles for translating awareness of social injustices into political and strategic claims” (p. 821).

**The discourse of development.** Power structures and dynamics are also called to attention in the context of a development discourse. When looking at development relations, the role of financial movements, trade patterns, and economic growth are made explicit in the establishment of a woman’s reproductive agency (Ryan, 2006). This is evident into the transaction over wombs in transnational commercial gestational surrogacy making apparent the gap between the powerful elite and impoverished women. Thus to fully understand the integration of assisted reproductive technologies within a developing country must look beyond ART as a simple solution for the problem of infertility an instead focuses on the potential impact of these technologies on a woman’s health and cultural status. To do this, attention is paid to the conditions under which a woman makes decisions regarding her health, her sexuality, and

her reproductive agency. The development perspective then identifies structural injustices by bring light to problems in polices, programs and practices.

The Indian subcontinent is in a unique position where it has a government that fully supports reproductive tourism—specifically the enormous amount of tourist money it brings into a still developing country. At the same time, the country deals with the backlash of belief that they are allowing for the exploitation of impoverished women as well as clear examples—the cases of Baby Manji and the Balaz twins—that they’re legal system is not equipped to handle issues of transnational surrogacy in an effect manner. One potential way to regulate transnational surrogacy could be by invoking Marion Young’s social connection model.

**Marion Young: social connection model.** Young finds that “social structures are not limited to formal institutional rules of cooperation but also include interdependent processes of competition and cooperation that link social positions with relations among individuals” (Donchin, 2010, p. 323) Young believes that by breaking a social system down and understanding all of the agents that exist within it have a shared social responsibility to understand and fix any structural injustices. She recognizes that different individuals or groups experience different degrees of power and influence within a system—those with the most power seek to experience the most benefit. However, when injustices manifest, they also bear a larger share of responsibility for any unjust outcomes.

Anne Donchin finds that when it comes to assisted reproductive services, the social connection model of responsibility is not being implemented. Instead, there is fractured relationship between globalized economic structures and social structures. This allows for women in developing countries to be commodified and exploited to make up for the infertility of Western women. Thus, immediately apparent as a structural injustice is the “asymmetrical constructions of social roles of women and men and reinforce[d] stereotypes about women as primarily sexual beings” (Donchin, 2010, p. 324).

Thus, there is the need to look at things on both the individual level—narratives—as well as a need to shift from “isolated acts of consent to evaluation of the full context surrounding such acts” (Donchin, 2010, p. 325).

Thus, though narratives of surrogates imply that impoverished rural Indian women find it a just behavior to sell bodily services if it keeps them from experiencing more poverty, it does not change an morally unfair offer into a fair one. There exists the exploitation of the situation and vulnerability of impoverished women. So then, in order to generate policy and regulations regarding commercial gestational surrogacy, surrogacy must be understood in both nonmonetary as well as monetary terms.

One way we could do this effectively on a transnational level could be to “harmonize regulation among jurisdictions in a manner that maximizes the long-term interests of all affected parties” (Donchin, 2010, p. 331). To do this, Donchin suggests setting up a means to internationally certify fertility clinics using a global set of “standard” criteria. There also needs to be a way to address both internal

and external factors that exist in the reproductive tourism trade. Specifically, with the Indian government, there needs to be a pressure to actually enforce and respect regulations of assisted reproductive technologies. Additionally there should be a “framework for ethical norms and regulations and situate debate on ARTs within the context of women’s health, human rights, and social justice” (Donchin, 2010, p. 332).

By paying special attention to the interplay between issues of gender inequalities, of poverty, and by considering cultural and religious traditions as factors that generate threats to reproductive health while simultaneously pushing for the coordinated efforts of national governments and international structures to enforce regulation of surrogacy, I find that we can develop a successful beginning point to develop policy of transnational reproductive tourism, particularly the service of gestational surrogacy.

## **DISCUSSION & FURTHER RESEARCH CONSIDERATIONS**

The literature regarding surrogacy is rich with narratives seeking to understand the complexities that manifest during and after the gestational process. This occurrence is most clear in the study of the surrogates in the Akanksha Infertility Clinic. Amrita Pande’s 2009 ethnographic studies of an infertility clinic in Anand India study the cultural understandings of surrogacy from the surrogates’ points of view. She looks at the narratives they invoke to cope with the stigmas associated with the institution of surrogacy and the narratives surrogates use to simultaneously separate themselves from and hold some sort of

claim to the child they are carrying. Pande also looks at the narratives of the kinship that forms between the surrogates in the clinic and how these bonds help women view surrogacy as a form of reproductive freedom.

Narratives are also evident on a national level. I explore this by focusing on the prevailing religion in India—Hinduism—and its surprising adaptability to modern developments. The adaptability provided by Hinduism’s flexible nature allow the nation an alternative way to understand the complexity of new technologies—by understanding them through traditional Hindu lore. Specific to fertility technologies, Hinduism explains stem cells by utilizing the story of the birth of the Kauvara family in the Mahabharata. Additionally, the birth of Krishna, who during gestation is transferred from the womb of his biological mother to the womb of his social mother, details a story of surrogacy. This purports the belief that tradition can first be rooted in religious institutions and then again in “modern institutions” such as bureaucracy and law (Bhardwaj, 2006).

Case law, then, also functions as its own kind of narrative. Case law exists to deal with conflict that occurs in human affairs. Cases are often set up as a sort of story that engages readers in a legal text. The statement of facts that are provided in case briefs have a story quality to them—complete with characters and drama that exist within a specific chronology. Furthermore, case law is a continuously building narrative. Outcomes and legal precedents are all based on pre-existing decisions and as such are deeply entrenched in a historical narrative.

What's unique about my study is that it seeks to incorporate all of these types of narratives in an attempt to understand how they relate to and build upon one another. During the course of this project—particularly the research portion—I found disconnect between how narratives are employed in ethics and subsequently how narratives and ethics come together to form policy. While the articles and studies I read focused on narratives told from *one particular* vantage point, they often failed to explain the significant of intersecting narratives.

I believe my own project starts to scratch the surface of understanding how narratives from different perspectives interact with one another. I first look at how gestational surrogacy fragments Western views of motherhood—separating out types of motherhood from one another; genetic, gestational, social, and adoptive. From there, I seek out different forms of narrative in order to understand definitions of motherhood—my ultimate goal being to attempt to understand how constructions of motherhood play a role in generating regulations of transnational gestational surrogacy.

Thus, cases such as *Johnson v. Calvert*, *Moschetta v. Moschetta*, and *McDonald v. McDonald* provide case law narratives for definitions of motherhood. I also looked at motherhood from the vantage point of the Indian surrogate—seeking to understand the definition of “Indian Motherhood” and whether surrogates feel they exemplify this definition. Finally, I look at how the Indian population utilizes traditional Hindu folklore to explain complex new technologies, specifically assisted reproductive technologies. As such, I begin to

look at the interplay between the local, national, and global through the medium of narratives.

However, there is still much to be explored in this type of project. I spend the bulk of my project understanding the narratives that occur from an individual level—from the perspective of Indian surrogates at the Akanksha Infertility Clinic. I use this as a starting point—making observations and judgments about how gestational surrogacy should be regulated based off how these individual narratives intersect with narratives that occur on a local and legal level.

However, studying a topic such as transnational gestational surrogacy, I need to better understand narratives that take place on a *global level*—that is to better understand how national structure and institutions are both shaped and shaped by global forces. I only briefly look into these issues—specifically in the Indian court cases of Baby Manji and Balaz v. India, both of which highlight how transnational surrogacy brings to light a slew of new ethical issues ranging from new practices of adoption to questions of the citizenship of a child born from surrogacy.

However, a thread of commonality that exists within the narratives at all levels is a desire to protect the best interests of the children born from surrogacy. This could be a good starting point to explore more in depth the interactions that are occurring between individuals and their communities, communities and their states, states and their nations, as well as between nations themselves. By using one common theme to link the various narratives that different structural levels

they exist in, I could better understand how narratives intersect or build upon each other.

Additionally, the individual narratives that I explore in this project only focus on the vantage point of the Indian surrogates. It is also important to understand why Western women are so desperately seeking out reproductive services—to understand the cultural context that *they* exist in. The end goal of the regulation of assisted reproductive technologies to reduce injustices and protect the rights of all parties involved—the surrogates as well as the infertile women and couples.

Thus to more effectively provide policy suggestions regarding commercial gestational surrogacy, there must be a more holistic picture provided. The complexities of transnational gestational surrogacy must be approached and understood on the many levels from which surrogacy is experienced—from the perspective of global structures (market forces, human rights, economic development), to national structures (hospitals, fertility clinics, legislatures), to the nuanced and personal experiences of individuals themselves.



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