Transnational Surrogacy and Objectification of Gestational Mothers

SHEELA SARAVANAN

A study conducted in Anand and Ahmedabad in Gujarat found that one of the important criteria for choosing gestational or surrogate mothers is their submissiveness to the demands of the medical practitioners and intended parents. Aggressive or assertive women are rejected on medical pretexts. After they enter into an agreement, many of these women are expected to stay in surrogate homes away from their own children and have very little say in any of the decisions, including those pertaining to their own bodies. The monetary fee they receive is considered adequate compensation for all these factors.

Sheela Saravanan (*saravanan@asia-europe.uni-heidelberg.de*) is a post doctoral fellow at the Karl Jaspers Centre for Advanced Transcultural Studies, University of Heidelberg, Germany.

India is the second favourite global health destination for medical tourism[1] providing as it does high quality medical care, equipment and facilities at a comparatively lower cost (Crompton 2007). One of the subsets of medical tourism is reproductive tourism, which entails travelling abroad to undergo in-vitro fertilisation (IVF)[2] and other assisted reproductive technology (ART) treatments[3]. IVF and birth with the assistance of gestational mothers[4] (GMs) has recently emerged as a rapidly expanding reproductive tourism enterprise in India. According to the National Commission for Women, there are about 3,000 clinics across India offering surrogacy[5] services to couples from America, Australia, Europe and the other continents (Kannan 2009).

Commercial surrogacy makes GMs vulnerable to exploitation. The gestational mother's agreement that prior to (embryo) transfer she[6] will submit to all medical procedures, keep all appointments and follow all instructions during the course of pregnancy while prioritising the interests of the surrogate agency, intended parents[7] and the child is an indication of "inertness" (Berkhout 2008). Her disadvantaged socio-economic background and motivation based on household financial hardships add to the risk of exploitation (Bardale 2009; Jadva et al 2003; Ber 2000; Blyth 1994). The subordination of her decision-making capacity is also described as "denial of subjectivity" (Berkhout 2008). Moreover, surrogate mothers are easily "interchangeable" if they are unable to successfully conceive after six months of IVF trials (Berkhout 2008).

Commercial surrogacy challenges the assumptions of maternal bonding based on the concept of a natural and instinctive link between the mother and her foetus/child during the process of pregnancy and birth (van Zyl and van Niekerk 2000; Rowland 1987). Recently this is contested by the argument that most surrogate mothers do not bond with the babies they relinquish to the social parents[8] (Teman 2008). The detachment has been measured by the success rate of relinquishment (Blyth 1994), percentage of surrogates reporting satisfaction with the process (Jadva et al 2003; van den Akker 2007) and evidence of no psychological problems as a result of relinquishment (van den Akker 2003). However, empirical studies have revealed that despite experiencing a close maternal bond and even psychological problems, most surrogate mothers have relinquished babies (Jadva et al 2003; Baslington 2002). Others argue that the surrogates are "not free" to interpret their pregnancy like non-surrogate mothers as they willingly sign such a contract (Bhadaraka 2009; McLachlan 1997). This very aspect of the surrogacy contract requiring self-denial of maternal instincts is criticised as a form of "objectification" and "alienated labour" (Tieu 2009; Berkhout 2008; van Zyl and van Niekerk 2000; Maier 1989).

My study aimed at examining selected aspects of the objectification: inertness, denial of subjectivity, interchangeability and denial of maternal bonding among GMs in India. Certain forms of objectification specific to the Indian context were also examined: submissiveness in relinquishment and denial of subjectivity in surrogate homes. My findings were drawn from participant observation and personal accounts of 13 GMs, six of their spouses, five intended parents and five doctors in two IVF clinics (Anand and Ahemdabad) in Gujarat conducted in 2009. Most of the GMs (7/13) had relinquished the baby/babies, four were in the post-natal stage of caring for the babies and the remaining two were pregnant for the first time.

Objectification

Most empirical studies observe that surrogate mothers tend to be of a lower socio-economic class than the intended parents (Blyth 1994; Ragone 1994; van den Akker 1998). There is unanimous consensus and concern among researchers about the risks of exploitation due to the differences in socio-economic status between surrogate mothers and intended parents. GMs

in India are vulnerable to exploitation and coercion due to their disadvantaged socio-economic status. A practising IVF doctor in Mumbai, Aniruddha Malpani insists that exploitation is a norm, saying "doctors exploit their patients; lawyers exploit their clients, everybody exploits every other person, so what?" (Field notes, Saravanan 2009). Another doctor, Nayna Patel of the Akanksha Fertility clinic, Anand, says that since women choose to become surrogates, and it is not forced on them, it cannot be termed exploitation. Patel insists that this is a win-win situation where both parties (GMs and intended/social parents) stand to gain. The GMs get much needed money and the couples return home with babies. However, the appropriateness and the extent of informed choice is questionable when such decisions are taken under the pressures of domestic economic crisis.

The GMs are not consulted about their place of stay, the medical procedures and the compensation appropriate for this service. Submissiveness was observed to be a hidden criterion adopted by medical practitioners/surrogate agencies for selecting surrogate mothers. The surrogacy contract ensures that the decisions related to pregnancy are made by the intended parents or physicians. Failure to submit to all recommendations is considered a breach of contract. This is demonstrative of the limitations of her input into the course of the pregnancy. The well-being of the baby takes precedence over her health and the pregnant woman becomes the property of the medical practitioners and the intended parents and subject to their monitoring and control.

The GMs were found to be on the edge of poverty either because they were in debt or homeless. None of the surrogates were educated beyond the higher secondary level. All had some sort of family problems like debts taken due to sickness or for events such as marriage, an unemployed or alcoholic husband intensified by meagre and inadequate family income. The involvement in surrogacy increases their average monthly income from Rs 3,000-15,000 per month to Rs 20,000-40,000 per month for the nine months of involvement in surrogacy and relinquishment. This income changes the economic status of the family and also modifies the autonomy and power situation within the household. Further research is needed to understand power complexities within households before and after relinquishment. The households studied showed increased trust between the GM and her husband as in most cases only the couple in the family knew about the surrogacy. Moreover after one surrogacy, women become identified with their magic wombs that are capable of reducing the poverty of the family.

Inertness

Inertness and submissiveness are the traits sought by IVF clinics in a surrogate mother. Failure to display submissiveness results in replacement with another surrogate and there is polite rejection on medical grounds when they are observed to have aggressive characteristics. GMs were expected throughout the pregnancy to submit to medical procedures, a predetermined compensation, stipulated accommodation arrangement, to attend all appointments and behave in a certain manner within the surrogate homes. The GMs are deprived of basic rights that are provided to any wage labour in the country. They are not given a copy of the signed contract and cannot openly bargain for the remuneration.

Several mothers carry twins as a result of the IVF procedure. This is because up to five embryos have been transferred into the womb despite the provision of only three embryos in the ART[9] Bill. One mother I met in Ahmedabad was carrying triplets. The ART Bill does not stipulate the maximum number of babies a woman can carry in one pregnancy. Apart from these expectations, GMs and intended parents are instructed not to discuss money during their meetings. Intended parents are advised to refrain from any direct monetary transaction with the GM and any payment is made through the clinic.

In the Anand clinic even one unsuccessful attempt is enough to change the GMs. She can easily be replaced so she is under constant pressure to perform (show qualities of submissiveness). After being selected by the intended parents, the embryos are transferred into her womb. In case this is unsuccessful, she has to go through the same procedure with another couple. In the Bavishi clinic in Ahmedabad, the same gestational mother and intended couple together are allowed three attempts of embryo transfer before changing the mother.

Denial of Subjectivity

A clinic in Anand makes it mandatory for the GMs to stay at surrogate homes during pregnancy whereas others send them back to their respective homes (e g, the Bavishi clinic), and yet others help them to stay at separate family accommodations away from their permanent place of residence (Rama's IVF centre). In Anand, GMs are required to stay in surrogate homes away from their family for almost a year including the period of embryo transfer, pregnancy and post-natal care. GMs who had concealed their involvement in surrogacy from neighbours and relatives found living in surrogate homes more convenient. However, several mothers were open about their surrogacy to others and preferred to stay at home with their families. One mother could not visit home even when a close relative had passed away. Dr Bavishi differs in his opinion about surrogate homes "the mother is the backbone of the family. If she is taken out of the family, the entire family is disturbed (cooking, children´s school). It is not just the children but old people who depend on the women and hence it is not correct to snatch her from the household" (Field notes, Saravanan 2009). He also expressed concern that the women may be impoverished and would be unhappy about eating healthy food without sharing it with their children. Occasionally women request accommodation for a few months when the pregnancy becomes visible and the clinic helps them to move into a temporary residence.

GMs have to submit to several rules inside the surrogate homes: children were allowed to visit their mothers only on Sundays; however they cannot sit on her bed and can see their mother only from a distance. They are told that their mother is sick and if they go near her they could get infected. Children were forbidden to come to such a home after some GMs complained about their presence. In others, they are allowed to enter but if anybody complains they are asked to leave. The GMs are not allowed to use the staircase during pregnancy for fear that they may fall down. In home deliveries all women

are generally encouraged to walk and move about during the final stage of pregnancy and during labour to ensure an easy delivery (Saravanan et al 2009). However, in contrast women in surrogate homes were hardly seen walking around; they are typically always lying on the bed. The cesarean rate is very high. The common reason given was that the baby was too big, or she was carrying twins or triplets. Surrogate homes are also overcrowded resulting in water and hygiene inadequacies. Most mothers in the early stages suffer from vomiting and bleeding thus causing serious hygiene problems without adequate water in the surrogate homes. The surrogate home above the Akanksha clinic had used syringes thrown near the window panes and spit stains.

Submissiveness

The GMs had no right to choose the when and how of relinquishment. That was decided by the clinic to suit the convenience of the genetic/social parents. The social/genetic parents spend a considerable time in India varying from two months to two years often over the children's passport formalities. Some parents arrive late and medical practitioners consider the GMs to be the best caretakers of the baby in the interval. Depending on the convenience of the social/genetic parents GMs were accommodated in children's hospital (those waiting for their arrival), surrogate homes (breastfeeding through pumps or waiting for payment) and hotels rooms (along with the parents helping them in caring, tending and occasionally breastfeeding the babies). In Anand, none of the mothers relinquished the baby immediately after birth. However in the Bavishi clinic, the babies were handed over soon after birth. This decision is generally made by the clinic and the parents.

Maternal Bonding

Most GMs who had relinquished the babies had bonded with them in the process of pregnancy and post-natal care. The pregnant mother expressed a desire to protect the foetus and to see the baby on birth. The GMs were also involved in breastfeeding and tending to the infants after birth. The GMs in Anand had expectations related to interaction with the baby after birth, as they knew most mothers spent a short while with the babies. The GMs and their spouses had also bonded with the babies as they cared for the baby until the social/genetic parents arrived. The medical practitioners' argument is that the gestational mother is paid for all her services including infant caretaking and should therefore have no complaints. Social/genetic parents felt that the GMs were not meant to bond as they have been reminded by the doctors from the beginning of the process that the baby belongs to someone else. However, the constant reminders that the baby is not hers have been criticised as depriving her of the "freedom of intimate association" (Shanley 1993; Karst 1980). In Anand, the theory applied to maternal bonding between GMs and the child by the clinic is that "no feelings ever develop for the child, so the question of resolving any feelings does not arise" (Bhadaraka 2009: 52). The doctors advocate this opinion to the intended parents and their monetary motivation is given precedence over emotional involvement. Since the GMs and the intended parents often do not speak the same language, the employees of the clinic act as interpreters. The clinics hence played an important role in the communication and understanding between the GMs and the social/genetic parents.

Conclusions

The GMs have the freedom of choice only until they commit themselves to the surrogacy contract. After signing the contract some clinics expect the GMs to stay in surrogate homes while others let them go back home. Within the surrogate homes, they are monitored and controlled. The maintenance of these homes is poor in terms of availability of water and hygiene. Similarly, the selection process and interchangeability of the GM differs from clinic to clinic in India. The asymmetric power relationship within surrogacy gives hardly any decision-making power to GMs as compared to the intended parents and medical practitioners. There is no consensus on the definition of parenthood, maternal-foetal attachment even among those directly involved in the surrogacy process. GMs in India expressed emotional attachment to the babies and considered themselves at least one of the mothers of the child. On their part the social/genetic parents perceived themselves as the sole parents due to the contribution of their genetic material or intention of parenthood. The doctor's echo the same opinion; however they use the social context and ideology of motherhood to exploit the GMs in taking care of the baby during pregnancy and after birth.

NOTES

1 Medical tourism is a concept whereby people travel from one country to another for their medical and relaxation needs.

2 In-vitro fertilisation – Typically the egg from the biological "mother" is fertilised by the father's sperm in a test tube, and the resulting embryo is then transferred to the womb of the GMs.

3 ART includes all techniques that attempt to obtain a pregnancy by manipulating the sperm or/and egg outside the body, and transferring the gamete or embryo into the uterus.

4 Gestational mother – gestational mother is not the genetic mother of the child. The eggs (oocytes) are extracted from the biological mother (or egg donor) and mixed with the sperm from the biological father (or sperm donor) in vitro (in a test-tube culture plate or similar vessel) that has an environment that will simulate the fallopian tubes. The embryo is then transferred into the gestational mother's uterus. Surrogates in India are not allowed to utilise their own egg for this purpose.

5 Surrogacy – a surrogacy arrangement is one in which one woman (the gestational surrogate) agrees to bear a child for a couple (the commissioning parents) and surrender it at birth.

6 In India, surrogate mothers are not allowed to use their eggs in the surrogacy process and therefore they will be referred to as GMs throughout this paper)

7 Intended parents are those who intend to bring up the child conceived through IVF technology and born through the GMs. They may or may not be the genetic parents. The parents are identified as intended parents before the birth of the child.

8 Social parents are the parents who have the legal rights to bring up the children (they may or may not be the genetic parents). After the birth of the child parents are referred to as social parents.

9 Despite over a decade of existence, there were no regulations legally binding the practice in India. The first national guidelines for ART Clinics were published by the Indian Council of Medical Research (ICMR) in 2005, following unpublished draft guidelines issued three years later. Presently the situation in India is that it is neither legal nor illegal to practise surrogacy as there is no law about it. The Assisted Reproductive Technology (Regulation) Bill 2008, provides a national framework for regulation and supervision of assisted reproductive technologies in India. However there are several criticisms that the ART Bill caters largely to the medical private sector's interests and reinforces social inequalities.

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