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Thinking through Surrogacy Legislation in India: Reflections on Relational Consent and the Rights of Infertile Women

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As its main focus the article is concerned with explaining the proposed Indian Assisted Reproductive Technologies (ART) Bill 2010 (2008), and in particular discusses some of its limitations using a relational conception of consent and autonomy. It is argued that two major limitations arise from, firstly, the way the Bill attempts to introduce 'universal' notions of informed consent into a cultural context of socially determined decision-making, resulting in the failure to safeguard the welfare of Indian surrogates. A second limitation is that the proposed law entitles only some poor women (surrogates) in India to realise access to quality medical healthcare services compared to others (poor, infertile women). Given the significant class and gender based inequalities which frame reproductive healthcare service delivery in the country, legally guaranteed access to health services for surrogates becomes a privilege where the rights of some individuals and couples to reproduce and exercise procreative agency is valued and not others. The article argues that the Bill must give due consideration to the complex, relational and highly stratified contexts in which women undertake childbearing in India to understand why legally comprehensive consent procedures can co-exist with violations of personhood in practice. Without such consideration the article suggests that injustice toward infertile women can become part of the same legal process wherein overcoming infertility is recognised as a right.

❖ Key words: Surrogacy legislation, India, poverty, infertility, reproductive injustice, relational consent.

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Introduction

The global movement of infertile couples, reproductive tissue and medical technologies over the past two decades has been accompanied by a significant rise in state legislative and regulatory protocols, instruments and practices to do with assisted reproductive technologies (ARTs) worldwide. With the developments in reproductive science come the contested production of new kinds of social and legal relationships and the need for a new ethical discourse (see, for instance, Haker, 2006, Franklin 2005). Controversy regarding reproductive justice, autonomy and choice is particularly rife in the context of transnational commercial surrogacy where fertile women in the South undertake to gestate a child for wealthy, infertile couples across the world. Of particular contention is whether women choose freely to become surrogates, or whether their will is socially and economically constructed (Smerdon 2008:53). The legal interventions and state policies on ART, including surrogacy, have equally been subject to intense debate and contestation by feminists, activists and scholars across the global South and North, especially regarding the extent the legislation promotes a market in reproductive labour and exploitation of the maternal bodies of poor women in low-income countries such as India, a growing global hub of commercial surrogacy (Yasin 2011).

Surrogacy legislation in India is as yet an ethical terrain which is contingent and experimental. State efforts to legalise and regulate commercial surrogacy in India have taken place since 2000 (the Indian Council of Medical Research Guidelines 2002, 2005; Smerdon 2008)[1] but especially in the Assisted Reproductive Technology draft Bills (2010, 2008), brought out by the Ministry of Health and Family Welfare. Although not yet an Act (passed by the Indian parliament), the guidelines are being invoked to adjudicate in very specific court cases (e.g., PUCL file 2008).

The Indian ART bill (2010, 2008) is progressive in that it recognises the rights of the infertile to bear children as well as, more controversially, the rights of the surrogates to be paid for their reproductive labour and expenses incurred during pregnancy. And yet, while having the virtue of instituting and clarifying clinical procedures (to do with consent, for example) and supporting the rights of infertile couples to access ARTs, the Bill, as Indian feminists (Qadeer, 2009, 2010; Shah, 2009; Sarojini & Sharma 2009 among others) argue, primarily focuses on the clinics and commissioning couples and promotes ARTs without being concerned with surrogate welfare beyond the provision of standard ethical instruments used in clinics (SAMA 2011).

Focusing on the Assisted Reproductive Technology (Regulation) Bill and Rules 2010 (2008) in India, this article suggests that, although progressive in some respects, the bill only partially addresses the concerns raised above. Further, ethical procedures relating to surrogacy appear to co-exist with structural violence in a manner similar to what Sunder Rajan has observed in the context of the growth of clinical trials in India, and with the growth of global bio-capital more generally (2007)[2]. The limitations of the Bill stem firstly, from its attempts to introduce Euro-American notions of autonomy (with an emphasis on the distinctiveness and separateness of the subject)[3] and informed consent into a setting with very different cultural values. A second limitation is that the proposed law offers quality medical healthcare services for those who can afford ART intervention in a context of significant class and gender based inequalities in access to reproductive healthcare, thus determining who can fully participate in reproduction and enjoy the rewards of this labour. When seen from the perspective of poor Indian women and men who are infertile, the access to ART becomes a privilege: the rights of some individuals and couples to reproduce and exercise procreative agency is valued and not others.

The article examines how, though intended to minimise health inequities for surrogates, the Bill promotes inequality between women of different childbearing capacities based on their ability to pay for and access quality health services.[4] The emerging scholarship on the political, social-cultural and moral meanings of surrogacy outside the Euro-American context (Kahn 2000, Teman 2003, Smerdon 2008, Qadeer 2009, Pande 2009, 2010, SAMA 2010, Bailey 2011, Rudrappa 2012, Windance Twine 2011, Rao 2012) rightly focuses on how surrogates and trans-national couples negotiate the processes and cultural work involved. This article extends this work by approaching the issue of surrogacy from the perspective of poor infertile women living in the same social and moral world as the surrogate and for whom private sector infertility services are inaccessible due to the high costs involved.[5] It draws upon ethnographic research that intersects with, rather than overlaps with the population of women who are or have been gestational surrogates, to bring attention to wider processes of structural inequality in thinking through the proposed law.

The emerging legislation on surrogacy in India is used as a means to reflect on the first two of three interrelated conceptual issues: reproductive stratification, relational autonomy and the commodification of reproduction.[6] Toward this end it draws on anthropological studies of surrogacy as lived experience (Teman 2003, 2010; Kahn, 2000; Pande, 2009 a; 2010; Ragone, 1994, 1999), feminist notions of relational autonomy (the recognition that individuals are situated within an array of relations and ways of experiencing and expressing choices that constitute their lives; Meyers 2001; Mackenzie and Stoljar 2000; Thachuk 2004; Madhok 2004) and the idea of informed consent as a primarily 'communicative transaction' (where it is the quality of information that is provided and how it is received that is critical in ensuring

the process as ethical (Manson & O'Neill, 2007). An analysis of these texts as well as field based material, lead us to suggest i) that despite an explicit framing which acknowledges the rights of the infertile to bear children, the Bill promotes this right selectively, for those who have the resources to pay for assisted reproductive services, and, ii) that even though the Bill ostensibly focuses on the welfare of Indian surrogates, legal guarantees are not deep enough to ensure surrogate women's relationally determined autonomy to choose.

When viewed in the context of the rights of infertile couples overall, the ART bill can be regarded as promoting what Colen [1995 (1986)] has termed 'stratified reproduction', a concept developed further by other anthropologists (notably Ginsburg and Rapp 1995, Rapp 1999, Browner and Sargeant 2011, Twine 2011). The term is specifically used to refer to contexts where 'reproductive labour is differentially valued and rewarded according to the inequalities of access to material and social resources in particular historical and cultural contexts' (Colen, 1995: 78). In this article I use the notion of stratified reproduction in a wider sense, following Rapp to mean, 'A lens through which we can see how representations of pregnancy and parenting, gender relations, socio-economic futures and collective as well as familial aspirations for the next generation are also being reproduced' (1999: 311). Even though surrogacy may be experienced as positive by the women who undertake it (Pande 2009a, for example) and by the Indian State which considers itself progressive with regard to legislative provision, surrogate women remain symbolic of much wider systems and processes of inequality and reproductive justice of which they are a part (Bailey 2011, for instance).[7] As an 'assemblage'[8] surrogacy in India is not only an example of what Franklin has called the global biological (where the global comes into being as a bio-cultural condition; 2005:61) but also of an inherently stratified global biological.

The analysis presented in the article is limited in that it draws on field research with infertile women but relies on secondary sources for the experiences of surrogates. Field research with infertile women in Rajasthan has been undertaken since 2000, and with fertility specialists, gynaecologists, feminist activists and members of voluntary organisations over a six-month period in 2010, as part of a wider study on the use of 'rights language' and recourse to the law by health providers and communities in Rajasthan (of which questions on sex selective abortion and surrogacy were a part).[9] Secondary source material on surrogacy used in the article is drawn from scholarly texts, field based work and media reports primarily from Gujarat, the neighbouring state with a similar social and cultural composition of low income Hindu caste and Muslim communities. Private infertility clinics in Gujarat have been pioneering in the domain of surrogacy in the country and the focus of a range of analyses, including ethnographic investigation (Smerdon 2008, Pande 2009). Key insights were provided from the stories of 30 infertile women from Rajasthan aged between 18 to 45 years who attended

at a voluntary health centre on the outskirts of Jaipur city. The women came from different villages in a 5-10 km radius of the health centre and from diverse social backgrounds: 19 were from lower Hindu castes (mainly Raigar, Meena, Gujar and Brahmin) and 11 were Muslim. None of these women had sought relief for their condition at public health centres: this was due to the lack of provision (drugs, facilities and expertise) for treating infertility and also to (historically informed) perceptions that these were places of coercion and discrimination as we discuss briefly below.

Inequalities in Access to Healthcare

> Sanji and Gayatri of the Raigar ('untouchable') caste had been married for over 6 years and 3 years respectively. They had no children but had both suffered a miscarriage shortly after their marriage. Help had been sought from local midwives in the village community in which they lived on the outskirts of Jaipur city. Midwives were inexpensive, belonged to their community and could be paid back in kind and over time. Sanji had been to a Hindu healer and a Muslim (syyed) baba as well. I met them both at the voluntary health centre where they had come to consult the gynaecologist. Neither for the miscarriage, nor for their current condition did they consider going to the government run health centre in Jagatpura or the hospital in Sanganer as these were places of deception in matters of childbearing; places where 'ek hi bihoshi mein do kaam' (two jobs, of birth and sterilisation were carried out simultaneously)…places where things were done to them without their consent. Santosh another woman from a neighbouring village attending the voluntary health centre for her inability to conceive after a miscarriage 3 years previously had also consulted with a private gynaecologist, Dr Shashi. As she could not afford the injections prescribed by Dr Shashi, she came to the health centre to see if they could provide them free of cost. [Fieldnotes, 2002]

Women like Sanji, Gayatri and Santosh are representative of a pattern whereby women anxious of their fertility first undergo interventions (such as safai or cleansing) suggested by the local midwife, often complementing these by visits to local healers, partaking in specific rituals prescribed by them, and eventually if they find the finances, of recourse to private clinics. These are places, I was told 'where you are treated well, and caste issues don't matter as much, because you have the money'.

Maternal public health services Rajasthan continue to be of poor quality, marked by class and caste discrimination[10] with a complete absence of any public health provision for poor, infertile women and men (Qadeer, 2009).[11] By contrast, assisted procreation services and IVF centres have developed rapidly in the private sector to provide services at high costs and are frequented by the Indian upper middle class and affluent foreigners, the bulk of whom are Non-Resident Indians.[12] Despite the wide prevalence of

conditions of secondary sterility which is connected with reproductive tract infections (and therefore a significant health concern rather than simply an issue of reproduction) and poor living standards, it has received little policy-related attention in India (Oomen 2001; Gittelsohn et al 1994, NFHS 2005, Unnithan-Kumar 2010). This is the case even in the newly designed and implemented programmes of the National Rural Health Mission (2005 onwards).[13]

In marked contrast is the investment by the Indian state in the development of medical technologies, including technologies of procreation, to boost a modern and competent healthcare structure in the private sector. In order to build up a competitive health service infrastructure, the Indian government has provided a number of incentives (including financial), particularly to private hospitals. It has reduced import tariffs for medical equipment and set into place procedures which expedite medical visas and promote joint health insurance collaborations (Mukherjee & Nadimipally2006; Smerdon 2008; Anchayil & Raheem2009). The development of world-class healthcare facilities offering competitive costs is regarded as critical to India's ability to participate as a major global player in the world economy, but also in its ability to harvest foreign exchange reserves estimated to be in the range of US$445 million (Sunder Rajan 2007, Sama, 2010; Thomas, 2009; Anchayil & Raheem 2009).

Private clinics in India offer immediate and low cost services (relative to their western counterparts), two of the key reasons underlying the choice of foreign infertile couples to travel to India[14]. In addition, they provide a regular supply of surrogates and freedom from the service exclusions operative in other countries on the basis of age, sexual orientation,[15] marital status and perception of success rates (Palattiyil et al, 2010).

The ART Regulation Bill: safeguarding the surrogate?

The ART regulation Bill and Rules, as drafted by the Indian Council of Medical Research in 2008 (and its modified version of 2010) set out guidelines ranging from the duties of clinics to the rights and duties of patients, donors, surrogates and children.[16] Surrogacy is defined in the Bill as, 'an arrangement in which a woman agrees to a pregnancy, achieved through assisted reproductive technology, in which neither of the gametes belong to her or her husband, with the intention to carry it to term and hand over the child to the person or persons for whom she is acting as a surrogate'.[17] Surrogacy is considered as legal in the regulations if undertaken by a woman who (1) is between 21 and 45 years of age provided she acts as surrogate for no more than three live births for any couple,[18] (2) consents to giving up the baby and relinquish all parental rights to the commissioning individual or couple who has consent from her spouse if married, and, (3) consents to undergo medical tests relating to sexually transmitted diseases and other communicable

diseases which may endanger the health of the child (see Form J – Agreement for Surrogacy).

As a legal document, the ART bill is commendable for its detail and clarity. It clearly lays out the procedures involved, responsibilities, terms and conditions under which processes such as surrogacy are to be undertaken. The bill is progressive in the sense that it recognises the debilitating social, economic and stigmatising effects of involuntary childlessness. It also upholds the right of the infertile to bear, and to try for, children, and more radically acknowledges the responsibility of the state to fulfil this need through the provision of appropriate services, technology and regulation.[19] More controversially, it acknowledges the rights of surrogates to be paid for their reproductive labour (fuelling concerns related to the commercialisation of women's reproduction) as well as the expenses they incur during pregnancy. The specific amount is left as a matter for negotiation between the surrogate and the commissioning couple. The issue of payment is a cause for concern among feminists in the South and scholars who rightly suggest that financially poor victims of structural violence have less choice or bargaining power in such situations (Sunder Rajan 2007, SAMA 2010, Bailey 2011). [20]

In terms of the surrogate, the Bill safeguards her rights as meeting the surrogacy requirements in the case of a child born with birth defects. It also states that she can terminate her pregnancy at will (see Appendix 1 for Form J, Agreement for Surrogacy, pp. 91–94). The clause on the termination of the pregnancy at will, however, needs to be considered in relation to a further requirement which is that all payments received by the surrogate be refunded in such an event, except in case of medical complication. Given the extreme poverty and indebtedness which drives surrogacy in the first place, it is unrealistic to believe that the surrogate's choice to terminate her pregnancy will be exercised or that she has any real bargaining power when it comes to negotiating the terms and amount of money.[21]

More directly interventionist, the Bill subjects surrogates to invasive procedures such as foetal reduction in the event of multiple pregnancies, if desired by the commissioning couple, and Caesarean sections if recommended by the doctors. More routinely, the surrogate consents to a continuous medical regimen of injections, blood tests, screening and diagnostic procedures. Less explicit, but of major implication, is the discrimination against the surrogate which arises from the language (English) in which the agreement and consent form are written. Given that English is not the first language of most surrogates and that a majority are indeed illiterate rural women, the understanding of what consent entails is left to the vagaries of a conscientious translator, as discussed further below. In legal terms it is important to note that the surrogate is not provided any legal support by the state, with the clinic acting as legal representative including as representative with banks.[22] Given that the clinics also act as providers of counselling

services, it may be apt to regard the surrogate as a 'captive of the clinic' (Qadeer, 2010: 209).

Feminist and civil society organisations in India have particularly criticised the bill for predominantly upholding the research and promotion of ART services and the interests of the providers, especially private clinics and the commissioning couple, over that of the surrogate or the baby (Qadeer, 2009, 2010; Shah, 2009, Sarojini & Sharma, 2009). Other important criticisms of the bill raised by these scholars and activists include, i) the fact that in denying the surrogate the possibility to register as the birthing mother, the Bill protects the rights of the buyer, ii) in ensuring that the surrogate underwrites all the major risks of the procedures, including her own death, natal and postnatal complications, foetal reduction, any risk of HIV transmission, the bill clearly protects the interests of the clinics and sperm banks, iii) the health risks to the surrogate are further disregarded in the clause that enables her to have three surrogate births and three cycles of ova transfer (increased to 5 live births with no specification of the number of IVF cycles, in the 2010 version of the Bill) and, iv) in favouring a quick transfer of baby from surrogate to commissioning parents, the bill downplays the developmental needs of the baby (though it may be easing the bonding-related anxieties of commissioning parents as well as the commercial surrogate). The rights of the newborn baby are further undermined in terms of its survival, right to a safe home and the automatic right to know its identity (only if sought out and not before 18 years unless for medical purposes). Even the rights of the child to citizenship were not addressed until 2008 (see below).

The few instances in which the surrogacy guidelines (2005) have been invoked are particularly revealing of what and for whom recourse to the law is taken. Of the two cases known so far, both were in 2008 and concerned the custodial rights of the commissioning parents (in one case a Japanese father and in the other a German couple) and their difficulty in securing travel documents, visas and citizenship from their own countries for the surrogate children, Baby Manji in the first case and German twins in the other (PUCL correspondence 2008, Indian Express 2008, Bromfield 2010). [23] In both instances, the social parents were eventually able to adopt these children in their respective countries. The surrogacy bill was tightened, especially as a response to the experience of the German couple, permitting surrogacy arrangements to take place only if proof of citizenship for the child was presented by the intended parents. In both cases, the guidelines revealed lacunae regarding the ability of the surrogacy legislation to protect the rights of the new born baby to an assured and safe home (as identified by the 18th Law Commission Review in 2009). One of the few modifications in the 2010 version of the Bill is the mandatory requirement for foreign couples to produce a certificate from their countries ensuring the child will be considered a legal citizen of that country (SAMA 2011).

Other clauses in the ART Bill(s) reveal it as a document through which 'culture work' is carried out as I suggest in the following lines. In only

recognising gestational surrogacy[24] but not traditional surrogacy where the eggs of the surrogate (rather than those of a donor or of the commissioning woman) are used, the Bill reinforces biologically deterministic models of motherhood by emphasising that it is genetic substance of the commissioning couple rather than the gestation by the surrogate which defines motherhood.[25] However, the biogenetic model of kinship that is thus reinforced may be at odds with the ways in which surrogates themselves construct relatedness, as indicated in the following sections below.

The rules regarding the surrogate's marital status, as specified in the Indian ART bill, determine who can participate in surrogacy and who cannot, and become important in understanding how the bill works both to maintain as well as to shift widely prevalent ideas of appropriate parenthood. The Bill upholds hetero-normative ideals of parenthood in its reference to married couples, although there is an acknowledgement that women who are single can both commission and undertake surrogacy. Same-sex couples living in India or other places where such alliances are regarded as illegal are excluded from seeking surrogacy. The main criterion for a woman to legally undertake surrogacy is that she has to have already given birth to a healthy child. Given the Indian context where childbearing is mostly undertaken by women after marriage, in reality, only divorced or widowed women, rather than unmarried single women, would be considered as surrogates.[26]

Finally, any analysis of the impact of the surrogacy legislation on the ground would also need to be situated in terms of the historically informed ability of local people to seek recourse in the law, which is limited, as is their trust in the State. State legislation and policies to do with conception in India demonstrate a long history of, and stubborn focus on, drastic measures to limit the population birth rate (for example, through the two-child norm to gain political office, as well as the promotion of tubectomy despite the rhetoric of contraceptive choice, as acknowledged in the National Population Programme (2000; also Sama 2010). However, in contrast to state population policies thus far which have emphasised family planning programmes to restrict fertility, the law and policies to do with surrogacy promote and celebrate fertility, representing a watershed shift in State population perspectives. But in a context where the state and the law have been regarded suspiciously and circumvented, to what extent will the policies supposedly promoting surrogate welfare make a difference with regard to women's autonomy on the ground?[27]

To understand how the surrogacy regulation impinges upon the lives and bodies of surrogate women as well as the infertile women they live amongst, and the ways in which it reveals as well as shapes how procreative value is assigned and decision-making take place 'on the ground' we now turn to situate surrogacy in the context of the experiences of the poor infertile women who come from the same region of western India and cultural background as the surrogates' themselves.

Surrogate Decision-making in the context of Infertility 'At Home'

'With my first surrogacy (fee), I could get my husband's kidney operation done, admit my son in an English medium school, and buy a small flat…' (DG, 27-year-old mother of two, as quoted in the Sunday Hindustan Times, March 13, 2011).[28] In rural western India where women's role in reproduction is taken so much for granted that there is little overt value associated with it (Patel, 1994; Unnithan-Kumar, 2001), the arrival of paid surrogacy arrangements has the potential (as noted above) to lead to a significant reassessment of women's childbearing by the family, community and the State. Does the connection between surrogacy as a means to economic empowerment bestow greater reproductive autonomy and status to the women who act as surrogates? What does consent actually mean or represent in these conditions? And what does this tell us about the role of the bill in legitimising new reproductive arrangements between those related through surrogacy and those unable to participate in social reproduction. As discussed below, aside from the legislative domain, there are two more immediate sites where the dilemmas posed by the commercialisation of childbearing are mediated and reproductive autonomy and subordination experienced: the community (as the repository of ideologies of reproduction, where what Meyers (2001) calls 'matrigynist ideology' is most strongly prevalent, and the family (as the site where gendered difference is experienced and negotiated).[29]

Women in poor economic circumstances find surrogacy such an attractive option that they ironically have no choice. As one surrogate in an ethnographic study of the fertility clinics in Anand, Gujarat, told the researcher, 'it is our *majboori* (compulsion) to undertake surrogacy' (Pande, 2009a). The choice (or lack of) to undertake surrogacy in this sense reflects systemic inequities associated with poverty and structural violence, wherein large-scale economic and political inequities predispose the vulnerable to suffering (Farmer, 1997), where 'compulsion' makes visible the moral dilemma posed by the choice of surrogacy-or-poverty (Bailey 2011, 736).

The lack of choice exists in another sense: in rural western India, reproductive decision-making on when and how many children to have, when to have sexual intercourse and whether to use contraceptives, for example, are less the decision of the woman than of her husband and his family. This is not to imply that women have no decision-making capacity but rather that reproduction is considered more a matter for the patrilineal group and particular kinspersons within them rather than for any one individual (Unnithan-Kumar 2001). A married woman's reproduction and sexuality are closely monitored by her affinal family, so despite the collective decision-making entailed in matters of childbearing, she usually has the sole responsibility for ensuring that reproductive outcomes, conception and birth, are successful. In Rajasthan, the social cost of the inability to conceive at all

(due to infertility) or to conceive disabled or dysfunctional children, or even in some cases only girls, is great (E.g. Patel 2007)

Vimla and Zahida

Vimla, a poor and low caste resident of a large slum in Jaipur city, conceived twin girls shortly after her marriage and was unable to conceive for another 9 years when I first met her. 'People in my in-laws village and in the slum where I live call me *banjhdi* (barren)'. She told me that she fasted weekly and had visited a range of local healers: Matamai the female healer, a Hindu healer possessed by a Muslim spirit, and also the site where her uncle-in-law was buried as she believes her infertility is caused by his dissatisfied spirit (as he died childless) which 'tied her tubes'. She talks of her body becoming empty of blood (lost through menstruation/ failed childbirth), 'black' and weak (kumzor). She would only be better if she were able to produce another child and especially desired a son so that her husband's family line would continue.

Zahida, a Sunni Muslim living on the periphery of Jaipur city, was a frequent visitor to the health centre where I was attached. She had had a son in her first year after marriage and then did not conceive again for seven years. She was threatened with divorce (and the fall in financial and social status this entails) and had visited healers across castes in her attempts to get pregnant (Unnithan-Kumar, 2010). Women, such as Zahida, suffer economic hardship and social death as a consequence of being infertile. They also suffer economic hardship as a result of their infertility (also see Inhorn 1994). The quest for cures drives them to undertake expensive interventions at private clinics driving them further into debt.[30] Both Vimla and Zahida went on to have subsequent children through the medical interventions of the voluntary health centre which treated them for reproductive tract infections. Like a high percentage of women their inability to reproduce had been the result of reproductive tract infections (secondary sterility) and connected with their poverty and the lack of access to basic amenities such as water, food and timely care.[31] Their example is indicative of the anxiety even those women who have produced children have of becoming infertile. Their worry is well founded for two key reasons: i) due to the high incidence of reproductive tract infections which underlie sterility in the region, and ii) their poor economic conditions which prevent easy access to private sector infertility specialists.

Given the conditions that make childbearing imperative, and socially condoned autonomy limited, and under conditions where women's bodies are regarded (even by themselves) as in the service of the wider collective (Zahida and Vimla both talk about their spousal duties of childbearing), it is unsurprising that the surrogates in the region find themselves majboor or lacking choice to avail of the economic opportunities presented by surrogacy. The right to think about and use women's bodies for tangible benefits has a longer history in existing practices such as in dowry, where women who are

unable to generate a sustained or substantial flow of resources from their natal homes to the affinal home are subject to abuse (Sharma 1984). However, in the case of dowry payments (which flow from the girl's family to her husband's family), it is women's work value, including her reproductive labour that is ideologically dismissed in the face of the social status that the connection with her spouse's family will bring. While the lack of choice in surrogacy similarly reflects notions of a collective, kin-based ownership of women's bodies, a logic also demonstrated through dowry payments, the overt market transactions involved (which put a price to childbearing) nevertheless directly challenge the assumptions of women's reproductive labour as devalued.[32]

Surrogate arrangements, however, remain devalued by community members when measured in terms of the responsibilities associated with successful and appropriate childbearing (that is, within marriage). Adultery is a serious social offence across caste and class, especially for women, who are often subject to physical, sexual and domestic violence (PUCL reports following implementation of the Prevention of Domestic Violence Act 2005). While their immediate families support them, surrogates face ostracism and stigma from the wider caste community, often being called 'prostitutes' for bearing the child of a man other than their husband. This is the case even when no sexual intercourse is entailed in surrogacy (Pande 1998). A male gynaecologist working in the health centre for government employees in Jaipur told me he thought surrogacy was disgusting as it is adulterous to carry another man's (i.e., not the husband's) child to term (Doctor M, interview, March 2010).[33] Surrogates take on the shame of 'adultery' and hide their pregnancy from members of the community. Yet, despite facing moral disapprobation from the wider kin and community, surrogates themselves talk about their surrogacy as an act of 'sacrifice' to secure the welfare of their family. [34] Another striking feature of the way surrogates recover value from what they do is in their recourse to a language of selfessness and of viewing their 'babywork' as undertaken for securing the future of their own children. This is in contrast to the language of gifting per se (Pande 2010). In fact, dowry payments in themselves challenge ideas of the gift as altruistic. Gifts (or dan) including that of dowry (kanya-dan) procure the well-being and auspiciousness of the donor placing them in a higher social status than the receiver (Raheja 1988, Goody 1990, Unnithan-Kumar 1997). In addition, surrogate women in Pande's study talk of the value they derive from the fact that 'foreigners' who come to them for procreative assistance (also see interviews pasted on YouTube, May 2011). Tangible reference to this emerges when the surrogates Pande interviewed describe their contribution in terms of substance (blood, breast milk) and the effort/labour of gestation in creating the child, factors which they refer to as creating a relationship with the child which is equal to if not stronger than the genetic tie.[35] As Pande suggests, surrogates are recovering reproductive value in what they do through particular and selective renderings of kinship wherein babies are made for

others through a mixture of self and others' substance, and to whom one has obligations of caring and duty to a limited extent. This indicates not the disappearance of notions of parenthood and related responsibility, as Haker (2006) suggests for those participating in embryonic stem cell regeneration, but rather a selective reformulation of existing ideas of relatedness. It is in these accounts that we also see reproductive autonomy and agency expressed, not simply subordination.

The discussion so far has served to situate surrogacy experiences within specific ideological sites, such as of marriage and marriage payments and the social reproduction of the family as challenging state authority. We now move to examine what this situated-ness of surrogacy means for conceptualising reproductive autonomy.

Thinking through Surrogacy: reproductive autonomy, consent and choice

The advent of assisted reproductive technologies, Haker argues, has resulted in a shift in the concept of reproductive autonomy from being regarded as a negative right (in terms of women's rights to non-violation of their bodily integrity as experienced in the Indian sterilisation campaigns, for example) to being a positive right in terms of the right to access ARTs. Reproductive autonomy, as she suggests, 'is not synonymous with liberty in the sense of mere individual autonomy … rather it takes women seriously as moral agents who must decide what kind of life they want to live, together with others, in particular social contexts and given institutional constraints' (2006, p. 1). Ethically, it situates every woman as a moral agent, accountable for the decisions she makes.

Feminist and cross-cultural studies of autonomy (Mackenzie & Stoljar, 2000; Meyers 2001; Thachuk, 2004; Sherwin, 1998; Madhok, 2004; for example) have been especially important in challenging the assumption of autonomy as equated solely with the individual even as they have been pivotal in securing women's autonomy over their reproductive choices (including the right to oppose forced methods of curbing fertility, as well as the right to choose not to procreate; Meyers 2001). In developing the notion of 'relational autonomy', they bring recognition to the fact that individuals are situated within a wide number of relationships which influence, directly or indirectly, the capacity for decision-making. But as Meyers suggests, and the examples of infertile and surrogate women in the article demonstrate, the scope of socially condoned autonomy with regard to mothering is far less extensive than it initially appears to be. The significance of the concept of relational autonomy is that it enables an analysis of power as framing the contexts in which decisions are taken. The focus on power in reproductive decision-making is especially salient in India where patrilineal ideologies and institutions (sites of 'matrigynist idolatory', Meyers 2001:737) still determine procreative practices.

What is not being suggested here is that women cannot be individual decision makers with regard to reproduction in these contexts, but rather that they cannot emerge as autonomous in the manner conceptualised by feminists which is in terms of having a 'well coordinated repertoire(s) of agentic skills which they can call upon routinely to inform their decision about how best to go on' (Meyers 2001:742). In contexts where reproductive decisions regarding the timing and nature of sex, the number and spacing of children, the use and type of contraceptives, for example, are collectively, though not necessarily unanimously, determined by the family and community, consent, as an ethical principle that upholds individual autonomy, becomes less salient.

Reliance on an autonomy-based justification of informed consent as is prevalent in biomedical settings in the West is distorted, as Manson and O'Neill suggest. They argue instead for a model of consent to be relational, in other words, set in the context of the relationship between those who seek and those who give consent in the clinical context (Manson & O'Neill 2007). Their approach is instructive, based on the idea of consent as a product of 'communicative transactions' and the quality of information flow between the parties involved in giving and getting consent. Thus, it is not so much the specific detail of the consent instruments and procedures per se which make it ethically better, but rather a focus on what information is conveyed, by whom, about what and how (the communicative transaction), which makes consent ethically salient.

Manson and O'Neill's (ibid.) point about the quality of communication in relation to consent is critical when applied to the case of the Indian surrogates. In a context where women's childbearing is appropriated by the family as well as the state (Ram, 2004) and their sexual and reproductive consent is taken for granted, it is imperative that the regulations ensure detailed and explicit communication of information about surrogacy procedures. The existing bill does not take adequate measures beyond the standard protocols to ensure that the potential surrogate has full knowledge of the implications of her consent, leading some, such as Palattiyil et al (2010: 691), to suggest, there is little evidence that Indian surrogates' human rights and physical or psychological health are adequately protected.

Commercial surrogacy complicates practices of consent further, as it is suggested that a high payment to a surrogate is likely to compromise her capacity to give informed consent by encouraging her to minimise the risks involved in the procedures (Palattiyil et al 2010). This is one of the main reasons why, according to Palattiyil et al, the Indian legislation falls short of the International Federation of Social Work (IFSW) ethical standards, as it institutionalises commercial surrogacy by allowing payments.

The issue of payment is an arena of contestation between those who see the need for reproductive labour to be monetarily rewarded and valued in a capitalistic society and others who believe decisions about childbearing should remain in the domain of maternal altruism. It is also an issue of disagreement between feminists and surrogates across the globe. [36] The popular western

dichotomy made between gifts (not determined by the market) and commodities (to which market value is attached), is also being challenged by several social theorists (Strathern 2011, Spar 2006, Zelizer 2000) While I do not have the space to elaborate upon these positions, I note that Indian surrogates blur the boundaries between gifts and commodities through recourse to the ideology of dowry (see Pande 2011). My own ethnography on dowry payments also suggests that while viewed ideologically through the lens of the 'gift', in practice such transactions come to be seen as payments associated with a woman's labour, including her reproductive labour (Unnithan-Kumar 1997: 193, also Goody 1990).

Surrogacy, legislation and global stratifications

Surrogacy (traditional and gestational), like other forms of assisted procreation, is socially significant in that, parenthood emerges as fragmented[37] across persons who contribute biogenetically, socially and financially to the making of a child. As Almeling (2011) among others suggests, women can separate maternity into several parts: one woman can provide the egg, another can carry the embryo and a third can raise the child – all three can lay claim to motherhood. The fact that kinship connections with offspring are forged through means other than 'blood' has particularly destabilised notions of a kinship based in 'biology', as Ragoné (1994, 1999), Strathern (1992, 2002), Franklin (2005), Edwards et al. (1993), and others have so powerfully argued. In the case of surrogacy in particular, the anxieties to do with biological connectedness seem to resolve in the shift away from 'traditional' surrogacy arrangements (where the eggs of the surrogate are used) to the more popular practice of gestational surrogacy (where the surrogate gestates the fertilised embryo but does not contribute any of her own reproductive material). Gestational surrogacy is preferred by commissioning parents as well as surrogates in the USA, for instance, as it removes the surrogate as a contender for having any 'real' (i.e., genetic) ties with the baby she gestates.

The Indian ART Bill only permits gestational surrogacy arrangements, following the same model of relatedness as is prevalent in Northern Europe and America, with the intent to sever the possibilities of any long-term claims and relationships developing between the surrogate and the child she carries. But as gestation in surrogacy, as the accounts above suggest, establishes maternal connections through substances other than blood or reproductive tissue in Western India, gender ideologies in the region elevate gestation as a means through which women establish ties of relatedness with their offspring. In this context, men are given primacy in procreation, where they are regarded as creators of children with women contributing the womb 'vessel' to carry or nurture the baby (Unnithan-Kumar 2004) Here, gestation, unlike in Northern Europe and America is regarded as the primary means through which motherhood is conferred.

Even the process of 'giving away' offspring, as a surrogate does, is not alien to indigenous caste-based conceptions of appropriate parenting. Children are given away for adoption amongst close kin (such as the bua (FZ), mausi (MZ), nana-mama (mother's brothers') if the close relatives are infertile. [38] Daughters are given away at marriage through economic prestations (dowry or dahej) and ritual gifting (kanya dan) to people who become kin. Like daughters born to be 'given away' at marriage, surrogate babies are also given away. [39] In this context gestational surrogacy can be regarded as an expression of a more familiar form prevalent in existing kinship practice: surrogacy is appropriated into local kinship worlds at the same time that it is derided as an adulterous relationship, or undertaken 'without choice'.

Attention to notions of relationality and the morally appropriate processes (ritual gifting, for example) through which people marry and become parents in western India is central to an understanding of how 'regulatory' the ART Bill is in reality. In terms of its 'culture work', the Bill, as argued in the lines above, thus reaffirms and appropriates for national purposes two indigenous, caste-based notions of procreation: i) of women's role in conception as primarily defined by 'nurturing' and, ii) the idea that women's reproductive bodies serve collective interests (of the family, community, caste). On the other hand, in enabling payments to be received and in legalising surrogacy, the Bill contributes to challenging the ideological devaluation of women's childbearing (as 'natural', taken for granted and not being valued in monetary terms). We also see for the first time an alignment taking place between a state encouraging childbirth (in a context where it is more widely discouraged, as evident in its wider anti-natalist population policies) and the strongly natalist patrilineal ideologies still in place in much of rural India, where fertility is widely celebrated in the religious festivals such as Teej and Gangaur. Living in such contexts, Indian surrogates are in a similar position, as Teman has described in Israel, wherein surrogates have to reconcile their personal ideas regarding maternity within a wider context where, 'reproduction is celebrated as the (Jewish-Israeli) women's 'national mission'… a product of both social pressure and explicit government encouragement' (Teman, 2003 p. 80). [40]

However until the legislation has the means to redress the pressures which propel women to undertake surrogacy as a 'compulsion' (lack of choice), it is unlikely that the instrument of consent alone, however comprehensively formulated, will ensure surrogate welfare. Like Sunder Rajan (2007), I suggest that the ethical formulations that accompany global bio-capital in the South will always be violatory however much attention is paid to the ethical instruments themselves. I have looked at how these processes impact not only on the subjects of direct intervention (patients of clinical trials or surrogates) but also how the lives of people who share their local moral worlds are profoundly affected. Following Manson and O'Neill (2007) I suggest that it is not so much the detail of the instrument of consent

itself that is important but equally the context in which it is applied and made relevant that should be of concern.

The idea of exploitation which is systemic is of significance when we consider the commercial aspects of trans-national surrogacy for surrogates in India. The commodification of surrogacy, while of benefit to the surrogate, has also opened channels for their monetary exploitation and corruption. There has arisen a whole set of people – clinicians, nurses, middle-men, brokers, family members – who view the legalisation of surrogacy as a further opportunity to make money, an issue which is beyond the scope of this article. [41]The significance of this fact is reflected in emphasis of the ART bill on both the pressing need to regulate private fertility clinics and to encourage these clinics at the same time. State legislation, however, does not go far enough in enforcing checks on clinics, for instance, in examining their recruitment and selection procedures, the kinds of counselling provided, the quality of medical procedures carried out.[42] Amendments to the guidelines have mainly focused on ensuring commissioning couples have more documentation (e.g., proof of citizenship for the intended child) which, though necessary, does not address the issue of monetary exploitation.

In conclusion, whatever the legal arrangements, the global availability and movement of reproductive technologies which assist procreation have ensured that surrogacy arrangements will continue to take place, bypassing the state if necessary. [43] Arrangements between clinicians and surrogates were already in place several years before the ART bill in India was formulated – showing how the legislation is in response to, rather than pre-emptive of, trans-national surrogacy. The state needs to do more 'work' in regaining the trust of the people that it will uphold their welfare and move beyond the provision of informed consent which is inadequate given the compulsions and complexities of decision-making accompanying reproduction in India. To ban surrogacy in India runs the fear of pushing this practice 'underground' and further removed from any kind of legislation ensuring the welfare of those most vulnerable.[44] The 18th Law Commission set up in 2009 to review the ART bill in respect to surrogacy states clearly that the prohibition of surrogacy is undesirable. Recognising surrogacy as a 'supreme saviour' of the distresses faced by infertile couples, it advocates active legislative intervention to facilitate the correct use of new technologies (2009:6).[45]

As this article has shown, for the new legislation to fully act 'as defender of human liberty and an instrument of the distribution of positive entitlements' (18th Law Commission review 2009) the focus has to move beyond the standard bioethical instruments to consider the languages, economies, kinship and moralities which frame issues of reproductive choice and consent on-the-ground. Of further consideration is the extent to which the state and legislation are popularly perceived and trusted to work for the welfare of those they seek to regulate.

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Biographical Notes

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Notes

[1] See Smerdon (2008) for a history of the formulation of the guidelines between 2000 when the first deliberations took place, 2002 when the draft guidelines were released, 2005 when the national guidelines to regulate ART clinics came into force to the more comprehensive rules and regulations of the 2008 bill, further slightly modified in the 2010 version.

[2] A legally enshrined and contractually enforced ethics, Sunder Rajan argues stems from the desire of state and corporations to 'build up capacity', to become global experimental sites, wherein populations are used primarily as (clinical) experimental subjects with little attention to their own therapeutic needs …'the form this ethics takes, quite literally the informed consent that volunteers sign – does not mitigate the fundamental structural violence of clinical trials conducted in the third world'(2007: 75).

[3] A concept subject to substantive critique by feminist scholars and anthropologists (for non western perspectives see, for example, SAMA 2010, Menon 2006, Madhok 2004, Petchesky 1998)

[4] The automatic access to healthcare for surrogates is qualified in the 2010 draft Bill where quality medical care is contingent on their proving that their symptoms stem from their surrogacy.
[5] Even though conditions of secondary sterility are easily treatable through the existing public health infrastructure these services are virtually non-existent in the public health sector in India (Qadeer, 2009) where the focus has historically been on controlling the fertility of poor women rather than on fertility promotion.
[6] Wider issues linked to the commodification of reproduction warrant a discussion beyond the scope of the present article.
[7] Bailey (2011), for example, makes a similar point although not directly in relation to the Bill. Such processes point to the ways in which 'new legislation can be oppressive for a significant population depending on the politics of its drafters' (Qadeer 2010: 209).
[8] Collier and Ong define global assemblages as the abstract, mobile and dynamic circulation of particular forms of governance, technoscience, ethics, for example, that circulate across countries, people and cultures taking on specific forms as local ensembles, and which define new material, collective and discursive relationships…encouraging ethical reflection (2005: 4).
[9] Two national organisations based in Delhi: SAMA and the Centre for Health and Social Justice provided key material and insights, as did the centre for Medical Ethics in Mumbai. In Rajasthan, members of the PUCL and legal aid organisations, as well as members of two health based NGOs shared insights and access to up to date legislative responses (for example on the Baby Manji case).
[10] This is even the case in states such as Tamil Nadu which are supposed to have better public services as Ram's excellent ethnographic observations on how class and gender biases in clinical contexts works, highlights (Ram 2010).
[11] Qadeer (2009) makes a powerful case about the ease and yet absence of public health based infertility services for the poor.
[12] Smerdon (2008), Pande (2009) among others. Smerdon observes that by 2008 IVF and other fertility clinics have been established in rural as well as urban areas in most states of the country.
[13] These critiques of the NRHM were the focus of a strategic, high level, national meeting of the People's Health Movement, Delhi, February 2011.
[14] Overall, infertile couples travelling to India typically expect to pay £8,000–13,000 per birth inclusive (Bromfield 2010). Of this amount, approximately £4,000–£5,000 goes to the surrogate.
[15] There has, nevertheless, been an increasing problem noted with the provision of ART services to gay couples and single men with some providers openly denying them services (Smerdon 2008).
[16] Part I of the 2008 Bill (pp. 1–38) sets out the definitions and provisions in nine chapters on subjects ranging from the registration and duties of clinics to the regulation of research, offences and penalties. Chapter 7 is devoted to 'the rights and duties of patients, donors, surrogates and children' and will be the main section from which this present paper draws. In addition, Part 2 (pp. 39–43) of the Bill describes in greater detail the rules as set out in Part 1, and Part 3 (pp. 44–135) provides samples of the schedules, forms and contracts pertaining to the

parties involved in the processes of assisted reproduction, including forms for the agreement for surrogacy (p. 91), consent for donor eggs (p. 95) and information on the surrogate (p. 104). The ART regulation Bill of 2010 covers only part I of the 2008 Bill.

[17] It defines a surrogate mother as, 'a woman who agrees to have an embryo generated from the sperm of a man who is not her husband and the oocyte of another woman, implanted in her to carry the pregnancy to full term and deliver the child to its biological parent(s)' (pp. 4–5, Chapter 1, Preliminaries).

[18] In the 2010 version of the Bill, this has been changed to 5 live births, to include those of the surrogate.

[19] The ART Bill is progressive, especially when perceived in the context of the ban on surrogacy operative in a number of countries such as Australia, China, France, Italy, Germany, Denmark, Mexico, Spain, Switzerland and some states in the USA (Pande 2009b). By contrast, Israel was the first country where surrogacy was publicly regulated in 1996 (Kahn 2000; Teman 2003) and as such provides an interesting comparison to India, as discussed in the paper.

[20] The 2010 version of the Bill stipulates that the payment to the surrogate be made in 5 instalments rather than 3 (2008 version) with the bulk of the payment in the final transaction following the delivery of the child, further disabling the poor household and devaluing the labour of the surrogate (SAMA 2011).

[21] As evidenced by Pande during her fieldwork in Gujarat (2010).

[22] Acknowledged by clinicians as an indicator of their care (e.g. Smerdon 2008).

[23] According to the 18th Law Commission review, in the absence of any law to govern surrogacy the 2005 guidelines applied at the time; 2009: 21

[24] Gestational surrogacy refers to the context where the surrogate does not provide reproductive tissue (her own eggs) and where emphasis is placed on her role in gestating the embryo.

[25] Helena Ragoné charts a similar shift in surrogacy practices in the USA, where the moral anxieties to develop kinship ties based in genetics combine with insurance claim anxieties to distance surrogates from the possibilities of 'bonding' (e.g., emotionally, financially) with the children they carry to term.

[26] This is in contrast to Israel where the law specifically demands that surrogates are single and unmarried women except under 'severe circumstances' (Kahn 2000, p. 143).

[27] Another way of putting it would be to think of surrogacy legislation in terms of the limits of the State to exercise biopower as witnessed in the recent challenges it has faced to regulate sex selective abortion despite a history of legislation to do with the Pre-Conception and Prenatal Diagnostic Testing Acts (PNDT Act 1994, PC-PNDT Act 2002) which were promulgated to deter sex determination and related abortion.

[28] Further media reports (on the cases of DG, GB; as reported in the Hindustan Times, 2011 with my anonymisation) reveal similar trajectories: DG started out as an egg donor, donating six times which earned her £4,400. Her first surrogacy paid for her husband's kidney operation and enabled her to buy a small flat in Ahmedabad. She is a surrogate for the second time, now for a Japanese couple. She gets £4750 to be a surrogate, £2000 for childcare for 2 months and gifts. Her sister GB, 23 years old, is also a surrogate mother, earning money enabling her to

go home to Nepal. These surrogate accounts point both to the fact of an increasing market in reproduction as also the need to investigate how parenthood is caught up in market values and processes (Spar 2006) in order to regulate it.

[29] A third important site, beyond the scope of this article, is the clinical context where class and caste distinctions as well as medical authority determine the boundaries of autonomy (see especially Ram 2010; Sama 2010, Burke 2010).

[30] Zahida's expenses, for example, came out of existing household resources which were sold (a goat and a TV).

[31] Key causes for secondary infertility similar to those identified in the public health literature (Oomen 2001, Mukherjee and Nadimpally 2006).

[32] And in this sense become similar to situations where a brideprice in cash is transacted in an overt calculation of women's productive and reproductive value (Unnithan-Kumar 1997).

[33] In Israel too, as Kahn documents (2000), the stress on the surrogate being unmarried is to prevent an illicit sexual union taking place, as intercourse is regarded as bringing about the union between the husband's sperm and the womb of the carrying mother.

[34]Pande (2009b) and as implied in D. Gurung's newspaper interview as quoted above.

[35] Raveena, carrying a baby for a South Korean couple residing in California, is quoted as saying 'After all, they just give the eggs, but the blood, all the sweat, all the effort is mine. Of course it is going after me' (Pande 2009b, p. 384). Likening surrogates to their own daughters being given away at marriage and therefore paraya dhan (someone else's property), Hetal is quoted as saying 'right from the day she is born we start preparing to give her away. We think she was never ours but still we care for her when she is with us. It will be exactly the same. We know the baby is not ours; they are investing so much money … it is their property. But I will love her like my own…' (Pande 2009b, p.387).

[36]Jill Hawkins, Britain's most prolific surrogate mother, who has borne eight surrogate children in 19 years, captures this feeling when she says, 'it is not a shameful thing to desperately want a child and pay someone to help' (Burke 2010).

[37]Edwards, Franklin, Hirsch, Price and Strathern (1993); Ragoné (1994), among others.

[38]Adoption from outside this context, as entailed in IVF procedures for example, have to be carried out 'in secret' as Bharadwaj observes (2003).

[39] Pande's ethnography on Gujarati surrogate perspectives demonstrates this clearly (2009b).

[40] In her study of the agency of unmarried women surrogates in Israel, Teman argues that it is through the use of medicalised metaphors of reproduction, through which women's bodies are rendered 'artificial', that they are able to distinguish between their own childbearing and that of others and so 'retain their cultural role and national and personal identities when they take part in processes which do not result in their own motherhood' (Teman 2003, p. 81).

[41] The power of clinics is especially palpable in the Indian context, where the private health sector is largely unregulated and associated with major financial turnovers. The access to funds has enabled the private sector clinics to equip

themselves with the latest cutting-edge technologies, making them far more competitive in the global context compared to the Indian public health provision.
[42] For instance, it has especially failed to have any specific clauses that control middle-men in the trade.
[43]As indeed other alliances between clinicians and their clients, such as in sex selective abortion, has shown.
[44]Here I differ from Smerdon's analysis which suggests that a ban on surrogacy practices is the only viable option.
[45]The review led to modifications in the 2008 Bill, as stipulated in the 2010 Bill. Accepting the complexity of surrogacy legislation it advocated for life insurance for surrogates and the provision of financial support for the baby in the event of the death of the commissioning couple. It also stressed that the husband and the family of the surrogate be involved in the consent procedures. These additions as they appear in the 2010 Bill are further contested by feminist and health scholars and activists (e.g. Sama 2011).

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