

Results and Discussion

This ethnographic study aimed to unravel experiences of surrogate mothers in Anand - Gujrat, the influence of participation in surrogacy on the women's lives and families, construction of maternal identity in the context of surrogacy, and the psychological agency of the surrogate mothers. The findings of the study are organised into the following sections:

- Characteristics, Knowledge and Motivations of the Participants
- The Surrogacy Process
- Surrogacy Journey: A Roller Coaster Ride
- Formation of the Maternal Identity during Surrogacy
- Psychological Agency of the Women in the Context of Surrogacy
- Surrogacy Outcomes and Future Plans of the Women

Characteristics, Knowledge and Motivations of the Participants

A comprehensive understanding of the surrogate mothers' background was crucial to contextualise their experiences. Such information was gathered through a brief questionnaire prior to in-depth interviews with the women. Figures 13, 14 and 15 portray demographic, reproductive and socio-economic indicators of the women, their social profile and geographical spread by the place of residence.

Figure 13 indicates that the women participating in the surrogacy had crossed their prime reproductive age with a mean age at 31 years. Women had married at a young age (mean 19 years) and there was a considerable age gap between them and their spouse (mean age 35 years). Contrary to the age limit of 35 years for surrogate mothers set out in the Surrogacy (Regulation) Bill, 2016 released by the Ministry of Health and Family Welfare, India, as well as older versions of the ICMR guidelines, 34 percent participants of this study were 35 years and older.

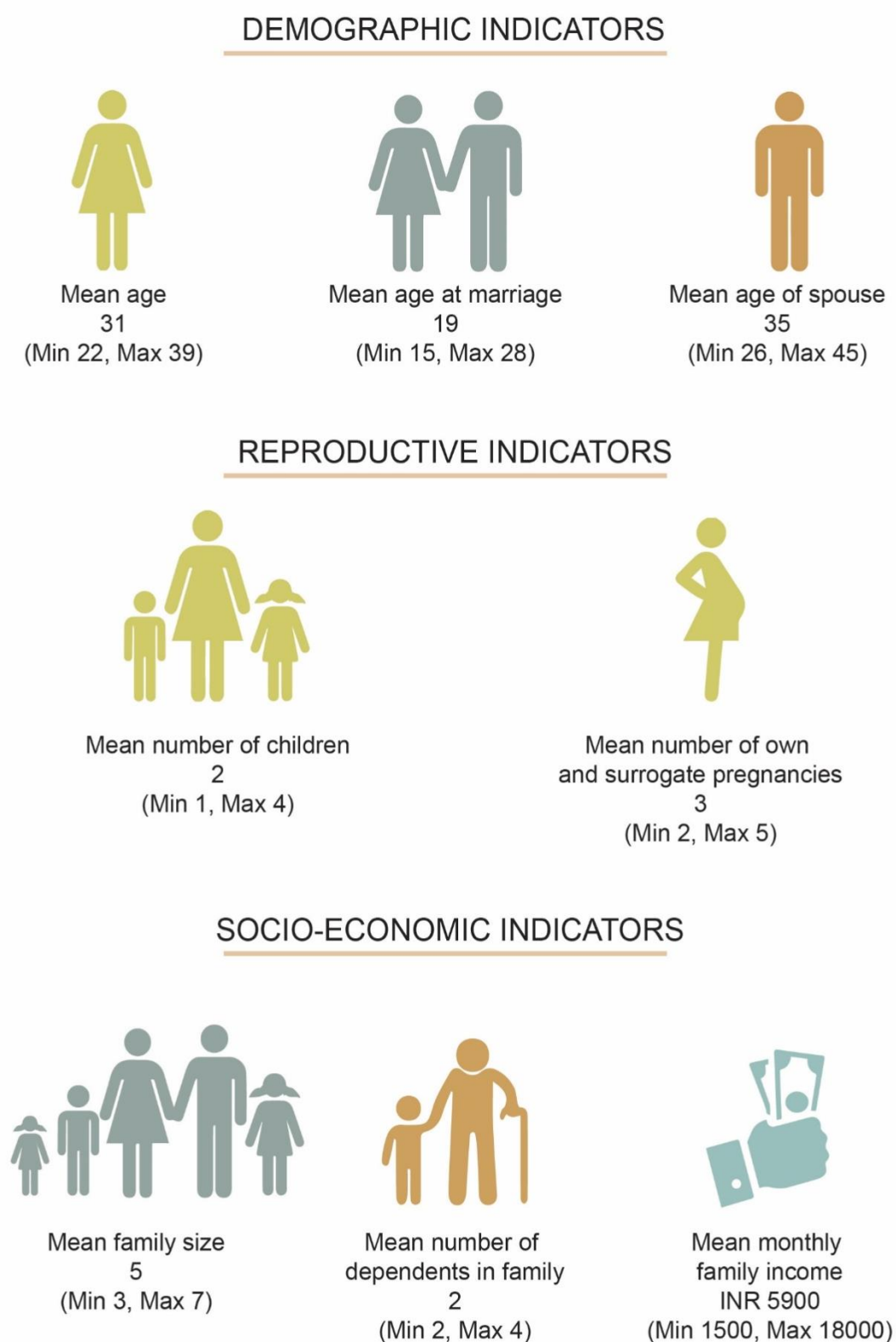
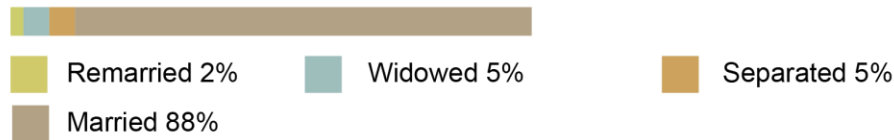


Figure 13. Demographic, reproductive and economic profile of the women.

Familial Profile of the Surrogate Mothers



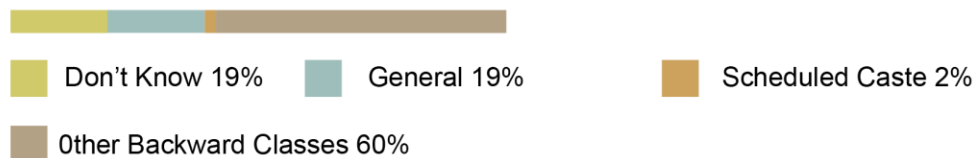
Marital Profile of the Surrogate Mothers



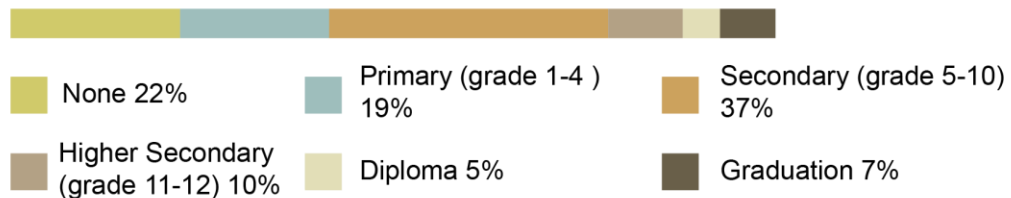
Religious Profile of the Surrogate Mothers



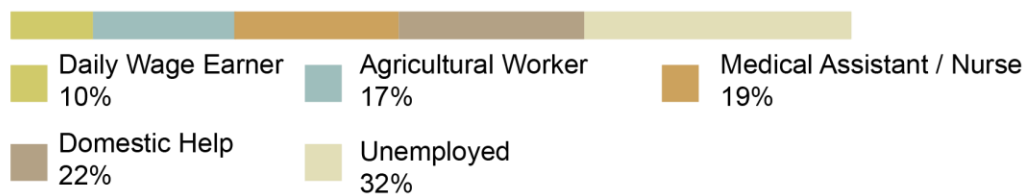
Caste Profile of the Surrogate Mothers



Educational Profile of the Surrogate Mothers



Employment Profile of the Surrogate Mothers



Employment Profile of the Spouses

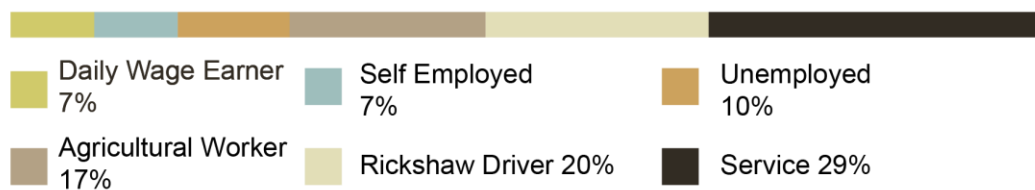


Figure 14. Social profile of the women and their spouses.

On an average, women had carried three pregnancies to term including their own and the surrogate pregnancies. The highest number of pregnancies carried to term was five for four of the women. For more than half (54%) of the women their eldest child was 11 years or older. Narratives of women indicated that as their own children grew up, women felt the financial pressure to support quality education of their children. This promoted their participation in surrogacy at a higher reproductive age. This reproductive profile of women entering surrogacy arrangements needs careful scrutiny to determine the health risks involved.

Majority of the women were currently married (88%) with a minor representation of separated (5%), widowed (5%) and remarried (2%) women. More than half of the women (64%) lived in nuclear households, followed by 24 percent living with extended family and 12 percent living in a joint family. The average size of the household was five, generally with two dependent members, mostly children, and in eight cases parents-in-law of the women. Representation of Hindu religion was highest among the participants (66%) followed by women with Christian (29%) and Muslim (5%) religions. Overwhelming 62 percent women belonged to scheduled castes and other backwards classes. Educational attainment among women was low with 22 percent women with no literacy, 19 percent women with primary education, 37 percent with secondary and 10 percent with higher secondary schooling. Five percent women had completed a diploma and seven percent reported completing graduate studies. Prior to participation in surrogacy, 32 percent women were unemployed and 59 percent women engaged in agricultural work or worked as domestic helps or did odd jobs. Only 19 percent women reported working in the organised sector and were poorly paid (mean income 3100, median 3000). The highest monthly wage reported amongst employed women was INR. 5200.

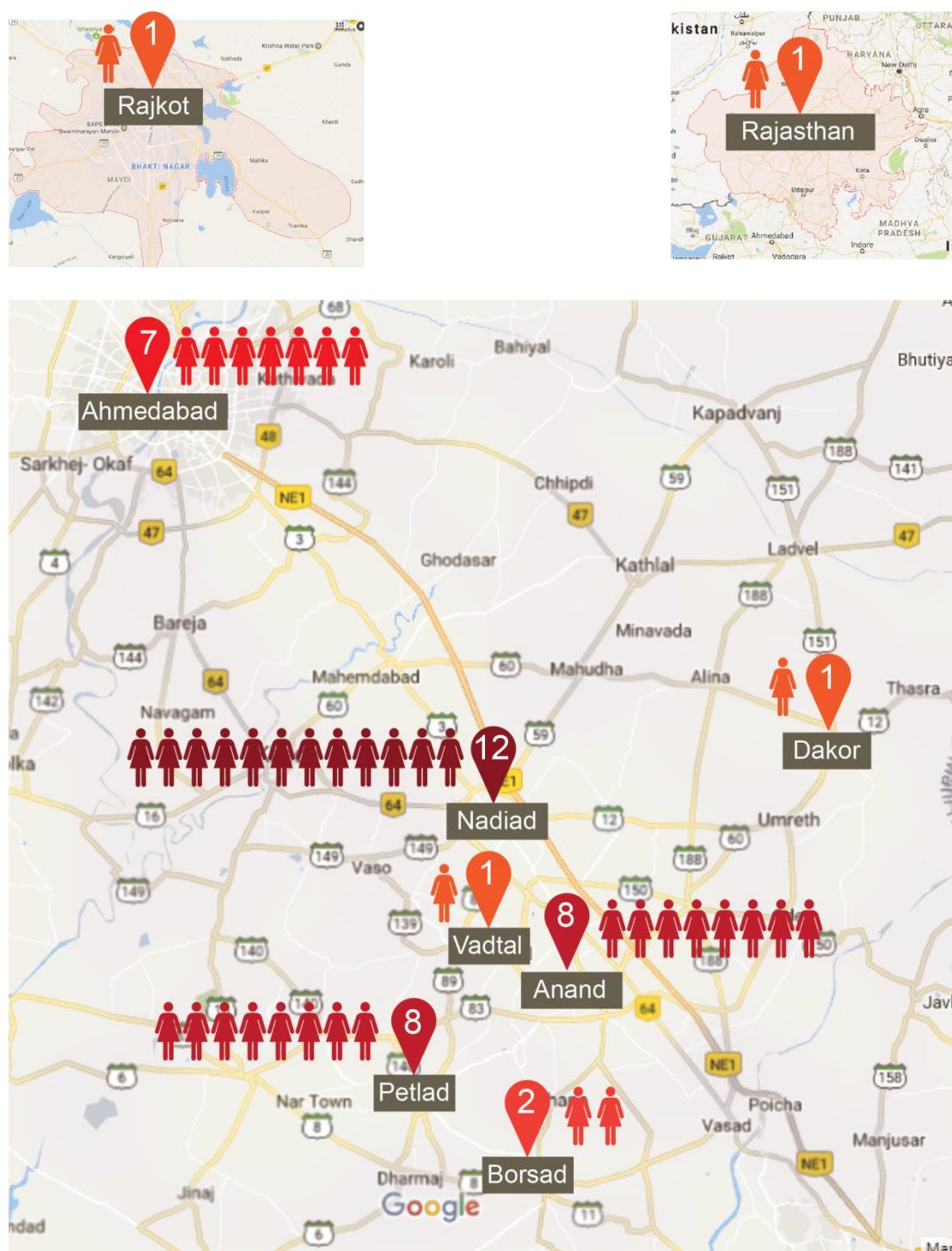


Figure 15. Geographical spread of women by their place of residence.

Spouses of 29 percent women earned a living by doing low-paying jobs in organised sector with job profiles of a librarian, lab technician, computer operator, peon, drivers etc. About 20 percent drove a rickshaw, 24 percent were daily wage earners or agricultural labourers, 7 percent were self-employed and ran small poultry

businesses or general stores, and 10 percent were unemployed. Average monthly income for a five-member family with 2 dependents was only INR 5,900. This socio-economic profile of women indicated a macro context of poverty with poor educational attainments and limited livelihood options for men and women largely from the marginalised sections of the society. Economic necessities forced these women based in Anand and nearby regions like Nadiyad, Petlad, Borsad, Dacor and the metro city of Ahmedabad to participate in surrogacy. One of the women hailed from Rajkot and another from neighbouring state Rajasthan (Figure 15).

The overall profile of the women and their spouses indicated that the macro-context of poverty, poor educational attainments and limited livelihood opportunities constrained individual choices and life trajectories. The women during personal interviews described surrogacy as a '*majburi*' in the literal sense 'compulsion,' stating that they would not have participated in surrogacy if there were other profitable livelihood options available to them; especially because surrogacy was physically daunting work. The systemic failure experienced as a compulsion to participate in surrogacy by the women could be referred as structural coercion. Women who lack access to health care services in the private hospitals are the ones who are forced to sell their reproductive potential at these facilities (Forde, 2016; Qadeer, 2010). The average monthly family income of INR 5900 for women living in a five member family (roughly INR 39 per day per person) was very close to the official poverty threshold set at INR 32 in rural areas and INR 47 in urban areas in 2012 by the Rangarajan Committee (Government of India, 2014). Fifty eight percent women studied reported monthly family incomes that fell below the official poverty line in India. This income was critically lower compared to the global poverty line of USD

1.25 per person per day set by the World Bank in 2008 (The World Bank, 2015). A large majority of women studied (87%) fell below this global poverty benchmark.

These findings corroborated with other studies involving Indian surrogate mothers in Gujarat (Pande, 2009a) and Mumbai (Forde, 2016) but were in contrast with the empirical evidence presented by Deomampo (2013) wherein the surrogate mothers in Mumbai “depicted a solidly middleclass lifestyle” and were far from being economically desperate though experienced financial instability. Probably, living in the economic hub Mumbai provided ample livelihood opportunities to the women and their spouses. This difference indicates the diverse life contexts of the surrogate mothers in India and aptly highlights why representation of Indian women as a homogeneous category is problematic (Chaudhary, 2012). It is thus crucial to understand the experiences of surrogate mothers in India with keen attention to the local contexts in which women live.

Source of knowledge about surrogacy. Table 5 portrays the source of knowledge about surrogacy for women and their spouses. In 83 percent of instances, surrogacy agents proposed participation in surrogacy directly to the women, and in 17 percent of instances, they contacted spouses of women. Largely, people known to women and men acted as surrogacy agents (76%) and linked them to the ART clinic as prospective surrogate mother. These surrogacy agents included close family members, relatives, friends, neighbours, and colleagues. In other cases (17%) surrogacy agents were barely known to the women and were co-passengers while travelling or were indirect contacts of people known to women. One of the women was directly contacted by commissioning parents and another reported lack of involvement of any surrogacy agent where her spouse had learnt about surrogacy through a local newspaper. Whether introduced to surrogacy by familiar or unfamiliar

people, women reported carefully ascertaining the authenticity of information received prior to participation in surrogacy. The surrogacy agents, largely former surrogate mothers, egg donors or staff at the ART clinic, played a crucial role in recruiting women for surrogacy.

Table 5.

Sources of Knowledge for Participation in Surrogacy

Knowledge Source	Women	Men	Total
Neighbour	8	0	8
Acquaintance	7	0	7
Friend	4	2	6
Sister	3	3	6
Other relatives	5	0	5
Brother-in-law's wife	3	0	3
Brother	0	1	1
Brother's wife	1	0	1
Husband's sister	1	0	1
Colleague	1	0	1
Commissioning parents	1	0	1
News paper	0	1	1
Total	34	07	41

Women were acquainted with surrogacy agents through their informal networks. Managal, a 35 years old first-time surrogate mother explained, “if I do it and get money, (I am) likely to discuss it with other women. Then that woman says, ‘take me along as well. Even my family will become happy. Even I will go.’”

Hu kareene javu etale mane paisa male etale beeja ben ne waat karwani j che. Pachi ae ben na kahe ke ‘mare hi lai jaje. Maru pan ghar sukhi thashe. Hu hi javu em.

The newly acquired affluence by the agents through their own participation in surrogacy kindled interest and desire amongst other women to overcome their own limiting life circumstances. There were consistent patterns in the narratives of women that described their initial contact with these surrogacy agents and the nature of interactions that followed. The agents revealed their own experiences of surrogacy and encouraged other women for participation.

Agents typically shared with the women that money is paid in exchange for handing away the baby to intended parents who hold all the parental rights over the child born through surrogacy (51%). They explained to the women that the child is conceived through medication and thus surrogacy was asexual (27%) and a moral form of work (20%). Over half of the surrogate mothers revealed that in the initial interactions surrogacy agents focused on the vulnerability experienced by women (51%) like lack of housing ownership and stay at rental homes, limited income to support education of children, health ailments of family members, alcohol addiction and or unemployment of the spouse, debt, lack of access to profitable livelihood options, and inability to accumulate wealth despite persistent hard work. The agents then presented surrogacy as a lucrative solution to these limiting life circumstances which could ensure large sums of money in relatively shorter duration and eventually secure future of their family (49%). Women also revealed the active involvement of agents in gaining approval of their spouses for surrogacy (29%). Women and their spouses were persuaded to at least visit the ART clinic once and explore the possibility of participation in surrogacy with medical practitioners (51%).

Motivations for participation in surrogacy. At the macro level, the larger socio-economic context was the major driving force for women's participation in surrogacy. Poor educational attainment, limited livelihood options and resulting low

family income were the primary push forces which appeared in the narratives of almost all the women. Surbhi (34 years) a nursing graduate and a first-time surrogate mother despite her educational attainments was stuck in a low paying job and resorted to surrogacy to ease off financial stress in the family. She shared, “my husband and me both are employed. The job is not good; it’s not a government job, private jobs don’t fetch much salary. Educating two children gets very difficult at times...therefore I came into this.”

Hu ne husband banne job kare che. Job etale sari nathi. Government nathee j, private job ma etali baddhi salary na hoy. Be balako ne bhanawana, amuk var ema bahu takleefpade...etale ema hu aai chu.

Whereas, women like Nikita (30 years) with no formal education shared that their poor educational attainments forced them to do menial low paying jobs. At the time of interview Nikita had undergone fourth embryo transfer hoping to attain a surrogate pregnancy after repeated failures. She shared, “Now that I am uneducated, I don’t get a proper job. Its difficult to survive on agricultural labour for long, or meet expenses.”

Hawe bhaneli nathi etale kaam toa aatalu baddhu khaas aapn ne male nahi. Khetar ni majuri karine aapan ne diwaso etala baddha jay nahi ane aapdo kharcho puro thay nahi.

Ranjana’s motive was identical to other women who entered surrogacy in the absence of a home or a land ownership. “We don’t possess anything, neither a home nor a piece of land. (I) must do something for my children,” said Ranjana.

Ke mari pase kasu che nahi ke, ghar nahi, jameen nahi. Chokrao mate kasu karu pade ne.

The World Bank report (2012) identified control over assests and resources as an important indicator of the wellbeing of women. The surrogate mothers studied were

clearly marginalised in absence of land and/or housing ownership which could be seen as structural coercion (Forde, 2016; Qadeer, 2010) for participation in surrogacy.

Women were also driven by their immediate familial needs and a strong desire for stability and a secure future for their family and children but lacked avenues to ensure it. They were keen to cope with family crisis situations, both immediate and anticipated like illness, disability, or alcoholism of the spouse, debts, and money to pay a dowry for their daughters and college education for their children, especially sons. These motives were evident in statements like the one by Ramila (26 years), “if one is unhappy, one has to come (in surrogacy). If one is struggling (unhappy) must not one enter (surrogacy)? (laughed in embarrassment). My husband is bedridden for long. We have mortgaged our home and have borrowed money.”

Hawe dukh hoy toa aavu pade ne. Dukh pade toa aavu pade ne? (laughed in embarrassment). Mara gharwala ni bimari chalu ne chalu j che. Ane ghar geerwi ame mukyu che, devu che.

Under these limiting circumstances, surrogacy appeared as the only lucrative option available which promised women a large sum of money in a relatively short duration of a year. Grace (32 years) a teacher in a government run school explained, “because (one) does not get as much money in these many months. We are doing a job even then we don’t get it. Who will pay you 3.5 lakhs in 10 months? Will anyone pay? No one will pay.”

Kyoki itane mahine main itane paise nahi milate. Ham log job karte hai phir bhi nahin milate. Das mahine main saade teen laakh rupaye kaun dega tumhe? Koi dega? Koi nahi dega.

Apart from the obvious monetary gains, women believed that their participation in surrogacy will enhance their social and familial status in the long run

in two ways. Firstly, women believed that investing in quality education for their children will help them break the cycle of poverty and educated children will be financially prepared to take care of their old dependent parents in future. Minakshi (36 years) a former domestic help with no formal education and a second-time surrogate mother shared,

Children must feel that our mother did well for us. They will say, ‘We had nothing but she managed to do quite a lot.’ Once the son grows up, he will (earn and) feed us. If we care for him now, he will care for us in our old age. They should not feel that our parents didn’t do anything for us. What will happen if he doesn’t care for us (feed us) when we grow old? If we don’t care for him, he will not care for us (keep us).

Chokarao ne lage ne ke mara mummy ne haru karyu amara khatar. ‘Kasu nahi hatu toa aawu haru karyu mummy ne’ evu kahe ne chokara. Moto thai ne chokaro aapan ne khwadawshe ne. Aapade atyare enu kare toa aapan ne mota thai ne khawadawshe. Evu na chokarao ne lagu joiae ke mare mummy papa ne kassu karyu nahi amara khatar. Aju moto thai ne rovalo na aale aapan ne toa pachi su thay? Aapade eni khatar na kariae toa ae aapan ne na rakhe.

Minakshi's narrative is a vivid indicator of the social order based on a morality of duties and obligations towards others, closely linked with the ‘Hindu’ sense of self. According to Chakkarath (2005), the ultimate goal of a *Hindu* self is to attain salvation or *moksha* (indifference) through practice of *dharma* - a disciplined life where the individual fulfills duties and responsibilities and adheres to morals, social values and norms. Several other narratives indicated that the women prioritised needs of their children. Fulfilling needs of children was viewed as a moral obligation of

parents so as to in turn receive reciprocal care from children, especially sons, during old age.

Secondly, a few women (10%) imagined that their contribution in alleviating family crisis situations and new found affluence will raise their familial and social status. They hoped for an elevated status and respect through sacrifices made and money earned through surrogacy. Such aspiration for social status was clearly evident in the narrative of a first time surrogate mother Kalika (35 years) an agricultural labourer having attained primary education.

This business of mine is good. Even if I come twice my reputation will increase in future. (People will say) his wife went and did everything well, that is (she) raised credit of the household. She made a nice home and saved money in the name of children. I love wearing jewellery. I thought, my husband never wore it then how can I wear it? I thought, if I do this business, I will first buy my husband a gold band and a chain. Then he will say, that 'I could never buy it for her, but she did this business and managed to buy me gold.' That is how I will gain respect; (he will say) 'because of her I am wearing gold today.' That's what I desire.

Maro aa dhando saro che. Me be wakhat aaish ne toa pan mari ijjat wadhshe kale. Ke bhai ni baydi ne jai ne baddhu saru baddhu karyu. Etle su ke emna ghar ni wadhari caidit (credit). Ene ghar saru banayvu, chokara na name paisa mukya. Mane amuk amuk dagino perwano mane shokh che. Pachi me evu kidhu ke main toa mare toa ghar wala ne nahi peri toa hun kevi rite peru? Pan hun kidhu ke aa dhando karish ne toa hun pahila mara gharwala ne doro ane weeti peraish. Pachi maro gharwalo kесе ke me toa koi diwas nahi ene perai pan ene aa dhando kari ne mane doro ane weeti lai aapi. Ane

aama thee aagad mari ijjat wadhshe. Ke 'aaje ena karta hu doro ne weeti peru chu.' Mari tamanna aawi che."

Though Kalika began by sharing her desire to buy jewellery for herself, she quickly changed her narrative and stated that she did not desire much for her own and would instead like to buy jewellery for her husband. Kalika imagined that doing so will gain her respect from her husband and will improve her social standing. Clearly, the 'self-sacrificing' tendency to serve the duties of an ideal wife and a mother was geared towards future power gains. Kalika thought that surrogacy offered her an avenue to exceed her economic contribution in the family as compared to her husband. She also imagined that it will invariably offer her a superior position in the family through the respect that she would earn in the eyes of her husband, children, and in society.

These behavioural manifestations of prioritising needs of children in expectation of reciprocal care in the old age expressed by Minakshi and living up the social ideals to gain a power position in the family narrated by Kalika closely match the observations of Ganesh (1999) and Menon (2004) about psychological agency of women in India. Ganesh (1999) proposed that in the absence of a national social security system, family and kinship networks form the primary sources of support for women, who thus negotiate and adjust in pursuit of their goals. Married women actively seek assimilation in their conjugal families by living up to the social role ideals of a wife and a mother by the virtues of self-control, self-improvement, and duty and service to others which in future may bring them in positions of power and ensure security (Menon, 2004).

Figure 16 presents a word frequency chart of the most prominent motivations for participation in surrogacy which women shared during in-depth interviews. A larger cell size represents greater frequency for the word enclosed in the cell. The

participation in surrogacy. Women experienced burden of responsibilities (*jawabdaari*) to meet the needs (*jarurat*) of the family and mitigate challenges posed by poverty (*garabee*), inflation (*mohongwari*), daily expenses (*kharcha*), loans (*karja*), financial loss (*nuksaan*), and an alcoholic (*daru*) spouse. Women revealed that in the absence of land ownership (*jameen*) and limited opportunities to earn a livelihood (*dhand*) they felt compelled (*majburi*) to participate in surrogacy. In the absence of savings women worried over dowry for their daughters. Women lived in poverty and were troubled by financial loans and mortgages. Additional recurrent words that did not feature in the chart of most frequently cited words included poor (*gareeb*), wedding (*lagan*) and mortgage (*girwee*).

Contrary to a common narrative of '*majburi*' or compulsion, a few women (3) especially second-time surrogate mothers shared being content with their lives and reported undertaking surrogacy to make the most out of their reproductive potential before they attained menopause. Women also aspired to acquire wealth in the form of savings (*moodhi*) and material assets including jewellery (*dagina*), automobile, and a computer for the family. Dhara (25 years) a home maker had completed her secondary education. Her father had assured her a share in ancestral property and recommended not to participate in surrogacy. Dhara with a strong desire for a stable life nevertheless entered surrogacy and bought a home through the money she earned. Her foreign intended parents paid her well – surplus amount in cash and kind beyond the terms specified in the surrogacy contract, maintained contact with her post surrogacy and sent her money and gifts for her family on every birthday of the surrogate child. They even promised a handsome payment to Dhara for the fifth grand birthday celebration they planned to do at the ART clinic in India and advised Dhara against a second surrogacy. Content with her first surrogacy experience and reluctant to depend on her

father or the intended parents for monetary support, Dhara took up second surrogacy against the will of her reluctant spouse worried for her health and safety. She planned to save all her earnings for the college education of her son. In her sixth month of second surrogacy, Dhara shared, “we have bought everything. All my needs are met. We used money from first surrogacy to build a home and invested some in a fixed deposit. I don’t need to do this at all.”

Amare toa baddhu j lai lidhu che, jarurato toa baddhi j che mari pase. Pahela toa ame ghar banai lidhu ane fix ma mukela j che. Etale mane toa kai j jarur nathi.

Apart from the ambitious motives of the women to circumvent economic hardships, their narratives also revealed unrealistic perspectives about the life-changing potential of surrogacy. Women imagined that the approximate amount of INR 3.5 lakhs for the surrogacy would be an end to all their problems, only to realise later that though a large sum, it was still limited to take care of all their economic burdens and aspirations. A few women (10) underwent a second round of surrogacy when they realised that the money they earned through their first surrogacy fell short to meet their needs and aspiration. Hiteshi (35 years) a widow and a former domestic help shared her desire for extra payment from the intended parents so that she could purchase a home in an urban setting. Hiteshi’s husband died soon after her first surrogacy and her mother insisted that Hiteshi should live at the maternal home along with her brother and his wife. Hiteshi however was reluctant to permanently move in the maternal village as she was not skilled in the agricultural labour – the only viable source of income for her at the village. Hiteshi with bare minimum primary education hoped that in an urban setting she could continue her earnings as a domestic help post surrogacy, but was disheartened to know that houses were much more expensive in

urban regions than what she imagined. She said, “After my first surrogacy, I fell short of money to buy a home. I have saved 1.75 lakhs and will get 4.25 lakhs from this surrogacy but I am hoping if intended parents favour me I can get a home. It’s impossible to get a home under 9 lakhs here.”

*Pahali war me jyare hu banyee hate ne tyare mane ghar mate paisa ocha
padiya hata. Toa atyare 1.75 lakh padiya che mara jode ane hawe aa 4.25
laakh aawashe pan hawe aasha karu chu ke partiwala saame joae toa mane
ghar mali jay. Ahiya nav laakh thee ocha ma ghar na male.*

Such narratives indicated unrealistic perspectives of women about the transformative potential of surrogacy and continued patronage from the commissioning parents which could leave them feeling unfulfilled at the end of the surrogacy endeavour and may affect their mental health and well-being.

Overall, a strong desire of women to tap the potential of surrogacy to overcome limiting life circumstances and to transform lives of their children was vivid in their narratives. Beyond the overarching economic necessity, women’s aspirations were not only limited to immediate financial gains but also depicted careful planning for a secure future and an elevated socio-economic status in the family and society.

Key Takeaways

Characteristics of the Participants and Motivations for Surrogacy

- Surrogate mothers had crossed prime reproductive age with mean age of 31 years and an age range of 22 to 39 years. Thirty-four percent of the surrogate mothers studied had crossed an upper age limit of 35 years for participation in surrogacy as specified in the draft Surrogacy (Regulation) Bill, 2016. Average number of pregnancies carried to term in the life-time was three. Maximum number of pregnancies carried to term was five for four of the women. This reproductive profile of women entering surrogacy arrangements needs careful scrutiny to determine the risks to their health.
- Systemic failures in the form of macro-context of poverty, poor educational attainments and limited livelihood opportunities promoted their participation in surrogacy. Women described their surrogacy endeavour as a '*majburi*' or compulsion.
- At the time of participation in surrogacy, 58 percent women studied fell below official poverty line of India set by the Rangarajan Committee and 87 percent fell below global poverty benchmark of USD 1.25 per person per day set by the World Bank for the years 2008-2014.
- Former surrogate mothers, egg donors, nurses and surrogacy hostel wardens recruited women for surrogacy through personal contacts. For 76 percent of women agent recruiting them for surrogacy was a person known to them.

- Surrogacy agents focused on the vulnerability experienced by women like lack of housing ownership, limited income, and alcohol addiction and/or unemployment of the spouse, debt, limited livelihood options in 51% cases and offered surrogacy as the only way out of the poverty.
- Women reported their aspirations for their children and a strong desire to educate them and bring stability to their lives as primary motivations for participation in surrogacy.
- Apart from obvious monetary gains, women believed that participation in surrogacy will enhance their familial and social status in the long run. Educated children were seen as an asset to break the cycle of poverty and to care for aging parents. Women hoped for an elevated status and respect through sacrifices made and money earned through surrogacy.
- A few women expressed unrealistic perspective about the transformative potential of surrogacy hoping that it will resolve all the challenges they faced and expected patronage from commissioning parents post surrogacy.

The Surrogacy Process

The surrogacy process lasted for anywhere between 1– 12 months depending on the number of hormonal treatment cycles women underwent before attaining a surrogate pregnancy, whether they carried the pregnancy to full term, and the time commissioning parents took to take charge of the baby after birth. The process involved a fixed chronology of events with a few exit points. The specific events during surrogacy could be organised into three distinct phases including a pre-pregnancy phase, during pregnancy phase and post-delivery phase.

Pre-pregnancy phase.

First contact with the ART clinic. Once women learnt about surrogacy, they preferred to ascertain its authenticity and lack of sexual involvement which helped them view this novel procedure as a morally permissible form of work (*saru kaam*). Few women (20%) first visited the ART clinic without their spouse, either alone or with the surrogacy agent. Another 76 percent women discussed participation in surrogacy with their spouse and they jointly visited the clinic. One initiated surrogacy without the knowledge of her spouse and revealed it only after undergoing embryo transfer. In another instance, a husband made all the preliminary enquiries and later convinced his wife for participation. Mutual consent was mandatory for participation in surrogacy. In the initial visit to the ART clinic, women and their spouses had informal conversations with the clinic staff and the surrogate mothers undergoing treatment to gain an orientation to the nature of surrogacy work. Overall, women shared spending considerable time in convincing spouse for participation in surrogacy. The amount of time that couples took to finalise their participation ranged from a few months to a couple of years. Couples with young infants and those lacking

alternative child care support during women's institutionalisation for surrogacy usually delayed the participation.



Figure 17. Surrogacy process in the pre-pregnancy phase.

Counselling and intake. Medical practitioners routinely explored motivations of women for participation in surrogacy. The women and their spouses were jointly

briefed about surrogacy process and were requested to sign a consent form declaring their willingness to participate in surrogacy. Narratives of women from the in-depth interviews along with the observations of five routine counselling and intake sessions revealed the key themes that medical practitioners shared with the couples. The data gathered through the interviews and the observations were in congruence and complemented each-other.

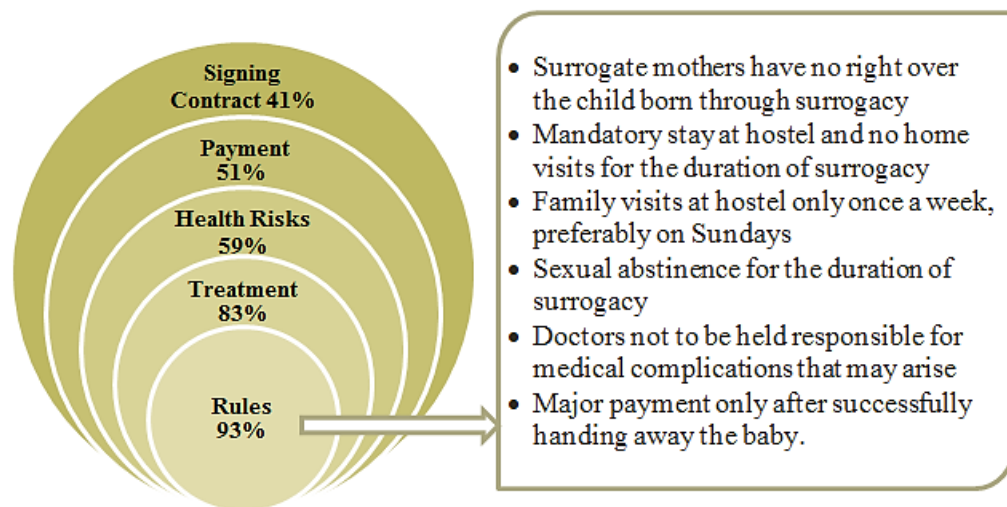


Figure 18. Women's recall of contents of the counselling session.

Figure 18 displays women's recall of the key concepts that medical practitioners covered during the initial and the only counselling session. The counselling session typically covered rules for participation in surrogacy, information about the treatment and health risks, amount and mode of payment for the surrogacy services and the surrogacy contract to be signed by the couple. Majority of the women (93%) recalled that the medical practitioners focused on the 'rules' that surrogate mothers must adhere to during their participation in surrogacy. Medical practitioners emphasised that the surrogate mothers did not have any rights over the child born through surrogacy and must stay at the surrogate hostel for the entire duration of surrogacy. Women were told that even in the case of family adversities home visits would be prohibited for the surrogate mothers but the family members could visit

them at the surrogate hostel once a week, preferably on a Sunday. Women were told to maintain sexual abstinence from the start of the hormonal treatment for surrogacy until the time of successfully handing away the baby. Sukanya (26 years), a second-time surrogate mother recalled her initial counselling session and shared,

The doctor explains us, ‘On the day of embryo transfer if anything happens at your home, say even if your father-in-law dies, you must come for the transfer. Whatever intended parents say you have to do that, if they ask you to take care you should. You shouldn’t roam around. You must be neat and tidy. When the commissioning parents visit they should not get disgusted if you don’t take bath and are not neat and tidy.

Ben aapan ne samjhawe... ‘je diwase transfer hoy te diwase ghare kai thayu, samjho ke sasro off thai gayo toa pan transfer karwa toa aawuj padshe evu kidhu... ane partiwala je kahe ne evu karvu pade em. Etle partiwala ke ne ke jo tamare saachwanu, aaram karwanu, doad doad nahi karwanu, chal chal nahi karwanu ane vyawastheet rehwanu. Pachi partiwala aawe tyare aapade nahayiae dhoiae nahi, vayasteeth na rahiye toa ae loko ne chitari na chadhe

Sukanya’s recall of the contents of the counselling session indicates the control medical practitioners and intended parents exerted on the surrogate mothers after women and their spouses consented participation in surrogacy. The rules that imposed life style restrictions on the women and their spouses severely curtailed their personal freedom. The narrative also indicated the biased notions of the medical practitioners towards the women from the low socio-economic as unhygienic.

The counselling sessions observed corroborated women’s narratives and mainly focused on conveying what Berk (2015) referred to as ‘life style rules and behavioural restrictions’. These restrictions stemmed from the poor success rate of

IVF-ET (Colin, 2009; Malhotra et al. 2013) in an effort to maximise attainment of surrogate pregnancies and thereafter live births. Medical practitioners practiced such control by instilling amongst surrogate mothers a fear of pregnancy loss which would put at stake their aspirations for a stable future.

Women were briefed about multiple health risks involved in surrogacy including but not limited to the high blood pressure, excessive bleeding, miscarriage, hysterectomy, caesarean section, and in unfortunate circumstances even death; though it was highlighted that death during surrogacy was highly unlikely. Medical practitioners insisted that they could not be held responsible for any of the health complications developed during surrogacy and no lawsuit could be filed against them. The sole responsibility for any adverse outcomes of participation in surrogacy was proclaimed to be of women. Yashsree (26 years) a first-time surrogate mother in her seventh month of surrogate pregnancy, narrated her experience of counselling as,

Doctor said, ‘this (death) has never happened with me, but if you have poor luck and something happens to you, then it won’t be our fault. Therefore, it’s your will; your life is in your own control. If God has planned well (for you), you will return well (alive and healthy). Even if some problem occurs, it is your responsibility; we don’t have any role to play in that. Then don’t say, I came at your (clinic) and this happened or that happened, and then you start talking of filing a lawsuit. All that would be wrong’.

Bole mere saath toa aisa kabhi hua nahi lekin agar aapki kismat jor nahi kar gai ane aapko kuch ho gaya usame sab hamara toa nahi hoga gunha. Is liye aapki iccha, aapki jaan aapke haath me hain. Bhagwaan ne jo accha likha hoga toa accha hi jaoge aap. Agar kuch problem bhee hotee hai toa wo aapke hee mathe, fir usme hamara haath nahi hain. Fir aisa mat bolna ke aapke

waha aae toa hamko aisa ho gaya ane waisa ho gaya ane aap case karane ki baatain karo. Ye sab galat hoga.

It was clear from the narrative of Yashshree and other surrogate mothers that medical practitioners denied any responsibility for medical complications or even death of the women during surrogacy. Medical practitioners justified likelihood of the death of the surrogate mothers as ‘women’s fate’ or ‘God’s will’. Further, women and their family members were also advised against seeking legal justice for any grievances. Women did not get any copy of the surrogacy contract for own reference. Whether the clause prohibiting surrogate mothers and their relatives from filing lawsuits was documented in the surrogacy contract could not be ascertained. Any medical negligence which may compromise health or even life of the surrogate mothers may go unnoticed with these limitations imposed on them.

Palattiyil, Blyth, Sidhva & Balakrishnan (2010) have argued that surrogacy contracts often enlist responsibilities of surrogate mothers but remain silent about their rights and surrogate mothers in India may not be adequately protected against gross violations of their human rights. The data indicated that even the counselling sessions focused on responsibilities of the surrogate mothers without any mention of the rights women had during the surrogacy process. The express denial of grievance redressal for women and their family members in the context of surrogacy was the most exploitative and alarming element which requires urgent scrutiny.

Other than the rules for participation in surrogacy, 83 percent women reported that the counselling session briefed them about medical procedures involved. Women knew that surrogacy involved heavy medication and bed rest; but failed to understand exactly what certain medical procedures like embryo transfer entailed and experienced anxiety. A first-time surrogate mother Heena (36 years) shared that the

medical practitioners assumed the surrogacy agent had briefed her regarding the medical procedures involved and did not cover procedural details during counselling. In a rather unusual incident, Peehu (25 years) a first-time surrogate mother coaxed into surrogacy by her husband ran away in the middle of the preliminary physical examination out of fear. She had undergone tubal sterilisation and was anxious that the practitioner will cut open the sutures to get her pregnant. The agent and the fellow surrogate mothers helped her make up her mind for participation in surrogacy. Peehu's experience, though rare and far from the normative surrogacy experience shared by other surrogate mothers, raises questions about the execution of surrogacy programmes in India in the absence of standardised treatment and counselling protocols and a robust monitoring system. The experiences of Heena and Peehu indicated a lack of preparedness of women for the novel medical procedures and their anxious state of mind until the procedures were performed. Insensitivity of the medical practitioners towards anxiety experienced by surrogate mothers, the absence of any supportive counselling for them and transferring responsibility of educating the prospective surrogate mothers to the surrogacy agents were especially problematic.

Practitioners rarely discussed psychological and legal implications of surrogate motherhood. Deomampo (2013) and van den Akker (2003) have reported that surrogate mothers knew little about legal, psychological and social impact of surrogacy on their lives and relied on the clinics for information. Poor educational attainments and infrastructure constraints curtail Indian surrogate mothers' access to reliable information making them dependent on the practitioners.

Deonandan, Green, and Van Beinum (2012) suggested that, when transnational surrogacy involves a destination region with a colonial history, the authority figure of a doctor is modelled on an image of western power and may lead

to subtle forms of coercion especially when surrogate mothers are socially disadvantaged. Such coercion was evident in the authoritative ethos of the counselling sessions wherein medical practitioners were insensitive to the needs of the surrogate mothers, laid down restrictive rules for surrogate mothers without any scope for negotiation and did not discuss their rights during surrogacy. Observations of the counselling episodes indicated that participation of the prospective surrogate mother and her spouse in the session was limited to providing factual information that the medical practitioners asked for. Practitioners did not encourage their participation in the counselling session and did not explore their opinions or challenges they faced for participation in surrogacy. It appeared that as an authority sanctioning the payment for surrogacy, medical practitioners exerted power on them and expected them to follow the norms set out at the clinic unquestioningly.

Observations of the counselling sessions and the narratives of women from the in-depth interviews indicated that women along with their spouses finalised their decision to participate in surrogacy by signing the consent on the same day. It saved them an additional visit to the clinic for the signing of the consent and thereby additional travel expenses. Agents and fellow surrogate mothers often encouraged new women to participate in surrogacy and not to worry about possible complications by portraying medical practitioner in a heroic light. Experienced surrogate mothers often narrated one incidence wherein a 'dead' surrogate mother was brought back to life by the medical practitioner almost after an hour. Women were told that in a life-threatening situation, medical practitioners save the adult patient (surrogate mother) first and then the foetus. Hiteshi recalled being briefed at the clinic, "We don't let any such thing happen to you and even if it does, we save the adult life first."

Ame evu kasu thava nahi deiye tamne ane kadaj evu bani shake toa ame moto jeev pahala bachai laiye che.

Qadeer (2010^b) highlighted that in a doctor-patient relationship, Indian patients are less likely to play the role of an informed partner and are dependent on the doctors for decisions. The data indicated that the surrogate mothers as the ‘non-patient treatment seekers’ faced the similar challenge. Medical practitioners considered intended parents as their primary patients and consulted them for any treatment decisions while surrogate mothers provided their body as a site for medical intervention. Surrogate mothers revealed complete faith in the medical practitioners’ decisions and did not question them. Also at play was a power difference wherein surrogate mothers experienced hesitation to seek clarification of their doubts to ‘ever busy’ and ‘highly qualified’ medical practitioners.

Only 51 percent surrogate mothers recalled the medical practitioners sharing payment details and 41 percent reported being briefed about the surrogacy agreement to be signed with the commissioning parents. Sargam (28 years) a second-time surrogate mother recalled, “madam explained, ‘you will get monthly salary. We will make an agreement of 2.40. Only if intended parents are happy they may pay extra. In the case of miscarriage, you may get 10-15 thousand rupees, not more. You don’t get full payment.”

Madam ne evu samjhaywu ke dar mahine tamne pagar malshe. Ne be ne challis nu agreement. Pachi partywala kadaj khush thai ne aape toa wadhare male. Vachhe kai thay toa 10 ke 15 hajar rupiya aape che. Wadhare na aape. Puru payment na male.

This and plenty of similar narratives indicated that the women were at a losing end regarding payment for their surrogacy services despite enormous risks to their

health and lives. Over 85 percent of the total payment for surrogacy was paid to the women only after successfully handing away the baby to the intended parents. The success rates for surrogacy continue to be low (Colin, 2009; Malhotra et al. 2013) and health complications and late-term miscarriages are common despite utmost care and medication taken by the surrogate mother. After undergoing extensive hormonal and medical treatment, adherence to nutritional and lifestyle restrictions and separation from family during institutionalisation a late miscarriage left women with barely any monetary gains.

On a positive note, the experience of Mangal (35 years) a first-time surrogate mother indicated that the medical practitioners ascertained the absence of coercion for Mangal's participation in surrogacy. At the same time, they obtained Mangal's informed consent through her thumb impression on the consent form for participation in surrogacy. This raises serious questions about the validity of the informed consent sought from the women with no literacy. With no formal education, Mangal could not read the contents of the consent form. She gave her thumb impression on the consent form purely on the basis of trust. She shared that medical practitioners explained her 'everything' and then she gave her thumb impression on the papers presented to her.

Women (29%) also shared they were determined to participate in surrogacy even before formal counselling session was held, perceived minimal threats to health during surrogacy and were confident of the medical practitioner's ability to protect them against any health complications. When asked whether they reconsidered decision to participate in surrogacy post counselling session, they reported that they did deliberate much over the health complications and took the risk to secure future of their own children. Once the prospective surrogate mother and her spouse signed consent to participation in surrogacy, medical practitioners began hormonal treatment

of the women to ‘prepare’ her uterus for the implantation of embryo. The treatment involved oral, vaginal, as well as injectable medication. During this period women returned home and visited the clinic at regular intervals as per the treatment protocol.

Meeting the commissioning parents. After the hormonal treatment women and their spouses were typically introduced to the commissioning parents.

Table 5: *Nationality of the Commissioning Parents*

Surrogacy Cycles	Nationality				Total
	Indian	NRI	Foreigner	Not Known	
First Surrogacy	13	14	12	2	41
Second Surrogacy	3	4	8	0	15
Third Surrogacy	0	0	1	0	1
Total	16	18	21	2	57

Note. NRI = Non Resident Indians. N = 57 surrogacy cycles 41 women underwent

In all, 41 surrogate mothers interviewed (26 first-timers and 15 repeaters) underwent a total of 57 surrogacy cycles (23 completed cycles with at least 1 live birth and 34 ongoing cycles with 26 confirmed pregnancies and 8 completed embryo transfers awaiting pregnancy confirmation). Table 2 displays the nationality of the commissioning parents involved in each of these 57 surrogacy cycles women underwent. It is evident from the Table 2 that for more than half (61%) of the surrogacy cycles intended parents were Indians or Indian origin people. Two surrogate mothers did not know the nationality of their commissioning parents.

Figure 19 indicates status of contact between the surrogate mothers and their commissioning parents by the nationality of the later for each of the 57 surrogacy cycles. In 61 percent of all the 57 cycles, surrogate mothers had met commissioning parents at least once, mostly at the time of embryo transfer, after confirmation of the pregnancy or at the time of ultrasound examination in the fourth month of gestation. In the remaining 39 percent surrogacy cycles, surrogate mothers had never met the

commissioning parents prior to the birth of the surrogate child. It appeared that commissioning parents with foreign nationality were less likely to maintain contact with the surrogate mothers prior to the birth of the surrogate child. Geographical distance and linguistic barriers were the likely barriers preventing such contact.

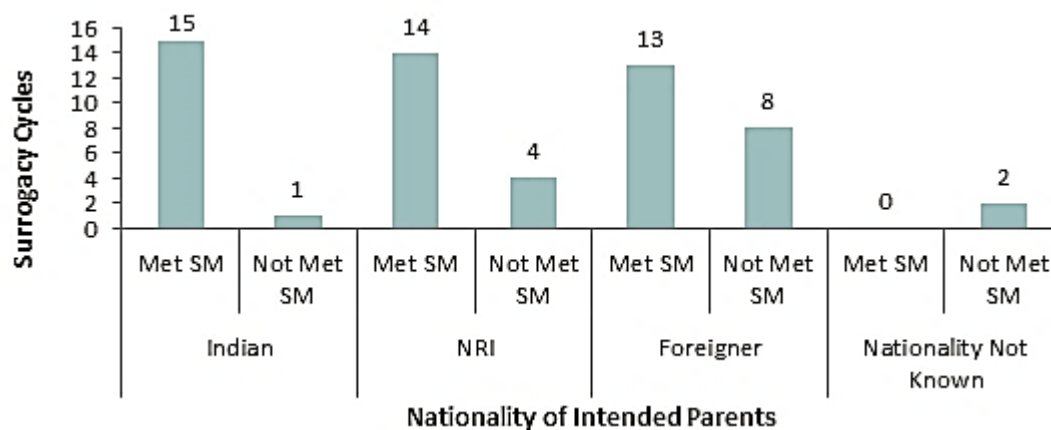


Figure 19. Status of surrogate mothers' contact with commissioning parents.

Observations of five introductory episodes between the commissioning parents and their surrogate mothers revealed that commissioning parents were equally novel to the situation and experienced a certain degree of awkwardness not knowing how to strike a conversation with their prospective surrogate mother. The medical practitioners intervened and suggested some general questions that the commissioning parents could ask the surrogate mother or completely took over the conversation. The questions revolved around personal characteristics of the prospective surrogate mother like her age and parity, information about her children and family, reasons for her participation in surrogacy, child care arrangements during institutionalisation. The interactions at times also revealed religious preferences of the commissioning parents. Medical practitioners played an additional role of an interpreter between foreign commissioning parents and the surrogate mothers. Observations also revealed that the role of prospective surrogate mothers was very limited in the interactions. The brief interaction ended with clicking of a photograph of the commissioning parents with the

prospective surrogate mother and her family. A surrogacy agreement was signed by the commissioning parents after such meetings. Consequently, these initial meetings were typical and were limited to the exchange of niceties. Medical practitioners routinely objectified surrogate mother in their dialogue when they kept insisting on the ‘quality of the endometrium’ of the prospective surrogate mothers and their personal characteristics to establish their worth for surrogacy. The subtle power differences where interests of the commissioning parents prevailed as a paying party were observed too. In one of the sessions intended mother insisted for a transfer of five embryos in the womb of the prospective surrogate mother and the medical practitioner was accommodative of her demand. This evidence supports the concern raised by Deonandan, Green, and Van Beinum (2012) that when medical decisions are made weighing monetary costs against the health of the surrogate mothers, conflict of interests are highly likely. As medical practitioners become a common party representing both the commissioning parents and the surrogate mothers, in matters of conflict, interests of intended parents as a paying party are likely to prevail. The absence of an independent advocate jeopardised the well-being of the surrogate mothers. The data from in-depth interviews of the surrogate mothers supported the observational findings. Veena (33 years) a prospective surrogate mother having undergone seven embryo transfer cycles with various commissioning parents but had failed to conceive so far revealed, “it’s the same discussion with everyone like, how many children do you have? Why are you doing this (surrogacy)? Who will care for your children? Will you stay here for nine months? Etc.”

Etle baddha ni saathe aawee j charchao thay ke tamara baalko ketala? Sa mate tame aa karo cho? Tamara baalk ne kon sachawase? Pachi tame nav mahina ahiya aagad rehsho? Eveej.

A couple of women also shared that their commissioning parents discussed religious preferences during the introductory meeting. Hiteshi (35 years) a second-time surrogate mother shared that her intended parents confirmed whether she was a Hindu Brahmin and a pure vegetarian during the initial meeting. Corea (1985), Vora (2009, 2010) and other feminist scholars have highlighted that historically procreation was considered a right of privileged white women and women from a 'less worthy' race were deemed fit to play the role of breeders for wealthy westerners. In the Indian socio-cultural milieu, certain castes are considered 'pure' or 'better' compared to the others. Commissioning parents in their desire to maintain 'purity' of their off-spring may demand a surrogate mother from similar if not equally higher socio-religious standing. Hiteshi's experience revealed such eugenic notions deeply entrenched in the Indian social set-up where her intended parents considered a '*Brahmin*' woman as a 'more worthy' person to carry their foetus to full term.

In one rare case, eugenic notions also surfaced in the narrative of a first-time surrogate mother Jagruti (38 years). When asked about the thoughts that crossed her mind when she met intended parents for the first time, Jagruti expressed dissatisfaction about the 'dark skinned' intended father for whom she undertook surrogacy. Jagruti associated white skin of the intended parents with affluence and resulting profit for the surrogate mothers in the context of surrogacy. Her biased notion affected her perception about the intended father. In general, narratives of women indicated that they construed provision of surrogacy services to foreign nationals as a more profitable venture compared to provision of services to the Indian nationals. A couple of surrogate mothers explained that for foreign nationals surrogacy in India was a cheaper option and they were in a better position to pay extra money to the surrogate mothers compared to their Indian counterparts. One of the

surrogate mothers explained that by the time Indian couples experiencing infertility resorted to surrogacy they had already exhausted their major savings in ART treatment and could rarely afford to pay extra money that exceeded the compensation for surrogacy services specified in the surrogacy contract. In essence, even if women were forced into surrogacy due to limiting life experiences, they viewed surrogacy as an income generation opportunity and aimed to reap maximum profit from it.

In cases where frozen embryo samples were used for embryo transfer, the commissioning parents skipped this initial visit and the surrogate mothers only hoped to meet them at the time of delivery and handing away the baby, and expressed anxiety for not knowing their commissioning parents.

Medical regimen. After the surrogacy agreement was signed by the prospective surrogate mothers and the commissioning parents, medical practitioners performed embryo transfer under suitable medical conditions. The procedure involved artificially placing the embryo/s in the uterus of the surrogate mother. Women were unaware of the exact procedures and equipment used for it and reported experiencing anxiety prior to execution of the procedure.

A first-time surrogate mother Heena (36 years) narrated her extreme experience of embryo transfer in a great detail during her interview. She shared that the surrogacy agent who introduced her to surrogacy never explained procedural details of embryo transfer. When she reached the clinic for the transfer at the scheduled time, medical assistants asked her to undress and shaved her pubic hair without briefing her. Unfortunately, the medical practitioner was delayed that day and the medical assistants switched off the lights and left Heena alone in the embryo transfer room until the medical practitioner arrived. Heena spent nearly 20 minutes alone in the dark room, lying down on the treatment table, in a semi-nude state,

unable to anticipate the next course of action. Heena shared that in those twenty minutes she experienced extreme anxiety and palpitations thinking that the intended father will impregnate her. Heena expressed anger towards the surrogacy agent for lack of her preparedness for the embryo transfer. Standardised counselling procedures and sensitisation of the medical staff may help prevent such incidences.

Typically, after the embryo transfer, women were immediately moved to a ward where they spent their day resting in a bed to enhance chances of pregnancy. Women were advised to strictly follow bed rest for the next two days and limit their mobility until two pregnancy confirmation tests were performed on the day 17 and day 21 post embryo transfer. Women experienced a great anxiety anticipating the results of the pregnancy test. One of the nurses from the clinic visited surrogacy hostels and casually announced the pregnancy test results by loudly calling out names of the women who had attained a positive pregnancy confirmation report. The women who failed to conceive often reported a sense of loss, disappointment, and failure but did not receive any counselling support. They returned home and visited in the following month for a fresh hormonal treatment cycle.

A mean number of hormonal treatment cycles that women underwent to attain surrogate pregnancy was three, with maximum seven treatment cycles reported. Women shared that, in the case of repetitive failures, medical practitioner provided curative treatment free of cost to facilitate the success of subsequent embryo transfer. Women were allowed to undergo up to 10 treatment cycles and failure to conceive even in the tenth attempt ended in closure of the surrogacy endeavour. A couple of women narrated a recent episode during casual conversations, wherein a woman was unwilling to discontinue the hormonal treatment cycles even after the tenth consecutive embryo transfer failure. The medical practitioner then marked final

closure of her failed surrogacy endeavour by performing a *Hindu* ritual of felicitation-handing the woman a coconut and a shawl to recognise her contributions. The episode indicted that it may be hard for some women to cope with the sense of loss after repeated failure of embryo transfer. Economic desperation may push women to undergo repeated embryo transfer trials and women may struggle over the decision to discontinue repeated attempts. In absence of a central monitoring mechanism, women may maintain secrecy about their repeated embryo transfer failures at one clinic and begin fresh trials at other ART clinics. Counselling support may be crucial to attain a healthy sense of closure over a failed surrogacy endeavour.

During pregnancy phase. On the attainment of the surrogate pregnancy, women continued their stay at one of the surrogate hostels managed by the clinic or at the extended living facility created at the clinic. Women were expected to follow a set routine along with the fellow surrogate mothers and were supervised by the matrons at the surrogacy hostel.

Cultural indoctrination. Participant observation at the surrogate hostels revealed that hostel matrons and experienced fellow surrogate mothers guided newcomers about routine medical procedures. The daily informal casual talks revolved around the importance of meticulously following medical routine, careful restrictions over diet and movement, constant risk of miscarriage and associated financial loss, stories about women's experiences with commissioning parties, and heroic instances where medical practitioners successfully handled surrogacy cases with medical complications. These informal casual conversations weaved together a unique context-specific culture with specified rules of conduct at the surrogate hostels that indoctrinated newcomers in no time. Even narratives of women captured during in-depth interviews corroborated these observations.

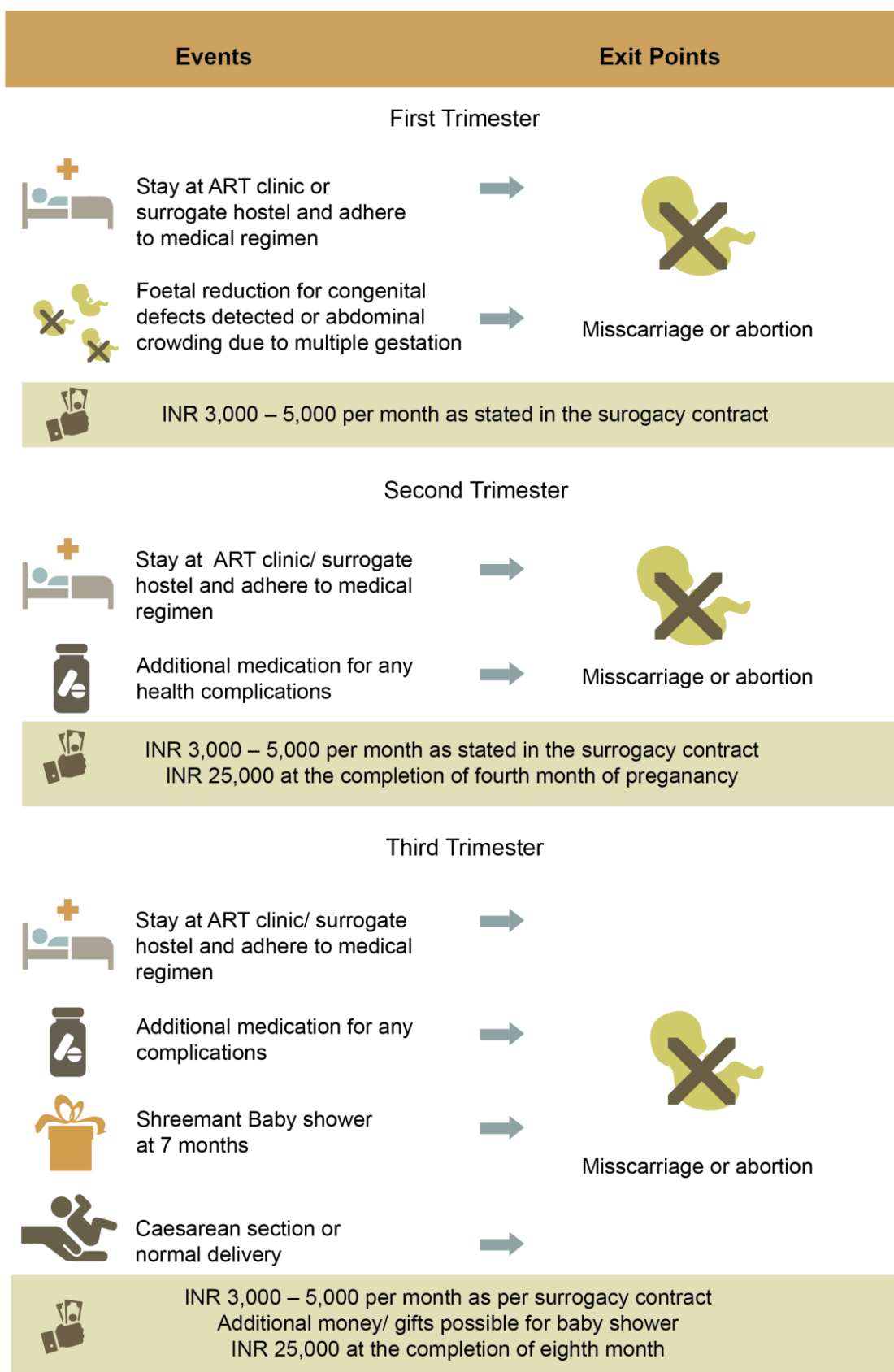


Figure 20. Surrogacy process post confirmation of the pregnancy.

A first-time surrogate mother shared that the hostel matron monitored the visits of the commissioning parents at the hostel to meet their pregnant surrogate mother and ensured that the surrogate mothers were 'presentable'. Women shared approaching fellow surrogate mothers for advice and reported that their behaviour and adherence to the medical regimen was monitored by the fellow surrogates. Experienced surrogate mothers often justified the set code of conduct at the surrogate hostels by viewing medical practitioner as an intermediary between surrogate mothers and their commissioning parents. These casual conversations helped newcomers to adjust and cope with the new routine.

The data indicated that women largely relied on these informal networks to gather information and gauge what to expect in their surrogacy endeavour. It also indicated inhibitions of women in approaching medical practitioners who were in authoritative position and were perceived too 'busy' to approach for any clarifications or support. Narratives of women and routine observations of women's interactions were indicative of the power difference women perceived between the medical practitioners and the self.

Women hesitated to approach medical practitioners, feared being judged and thereby relied on the informal networks for information. Women's dependence on informal networks also fuelled several misconceptions. Some prominent misconceptions included,

- Eating bananas and drinking has a cooling effect on the uterus and helps embryo implantation resulting in successful ET. Women should consume only bananas and milk post ET until pregnancy is confirmed.
- A head bath during surrogate pregnancy leads to miscarriage and must be avoided

- Bananas, milk, and medication results in firm ‘sticking’ of embryo in the womb. Foetus therefore does not progress down in the cervix at the time of delivery. Therefore caesarean section delivery is mandatory.
- Procedure of extracting embryonic fluid (Prenatal Genetic Diagnosis) is performed to reduce ‘excess water’ from the womb (amniotic sack). Eating bread helps to absorb all the excess water and thus helps one avoid medical procedure of water extraction
- Intercourse during surrogate pregnancy breaks foetal limbs and therefore intercourse is prohibited for surrogate mothers.

Regular educational counselling may help prevent such misconceptions.

Daily routine. Mornings at the surrogacy hostels routinely began with tea and breakfast and women took turns for bathing in the few bathrooms available. Minor scuffles over waiting for their turn to bathe were common. A mid-morning snack involved a fresh fruit, distributed daily by a vendor associated with the clinic. On alternate mornings, external trainers visited the hostel and trained interested women in skills like operating computers, embroidery, tailoring, and *mehndi* (making henna patterns). Other women chose to help the in-house cook in cleaning vegetables.

Women chose their lunch and dinner services among those provided in-house and by a few external contractors who provided packaged meals. Many preferred externally packaged meal services and often mentioned their dissatisfaction with the quality of food available. The post-lunch period was often spent watching popular series or movies on a common television followed by a late afternoon siesta. Women mostly rested in bed all day long, formed distinct groups and enjoyed leisure time together. Interspersed throughout the day was a medical regimen that involved heavy oral medication and injectable medicines administered by the hostel matron, a nursing

professional. The evening tea with dry snacks was eagerly awaited. Women were taken to the clinic for regular medical check-ups and were dropped back to the surrogate hostel by autos once every week in the late afternoons. In the evenings, women relaxed within the hostel premises and spent the evening chatting with the fellow surrogates; rarely a few women sought special permission to venture out for a short walk nearby. Late evenings were spent watching TV series, followed by an early dinner and sleep.

Visits by family members were recommended only on Sundays, but considerable flexibility was observed at the surrogate hostels. The presence of family members and children for a few hours of the day was common and in most cases, fellow surrogates were accommodative of the family members' presence in the shared rooms. At the same time, participant observations revealed that keeping children at the surrogacy hostel was strongly discouraged by the matrons to ensure minimum disruption of the daily routine and to avoid disturbance to the surrogate women who may be resting. Women reported that any digression from this set routine was unusual. Occasionally, a drunken spouse of some surrogate mother visited the surrogate hostel demanding money from her. When women resisted such demands their spouses resorted to verbal and/or physical abuse. At such times fellow surrogate mothers and the hostel matrons intervened to resolve the matter.

In the case of any congenital anomalies or abdominal crowding due to multiple gestations detected during a routine check-up, a procedure of foetal reduction was conducted with the consent of the commissioning parents. The procedure was carried out in the first trimester by a visiting specialist. The specialist used ultrasound as a guide and inserted a needle through surrogate mother's abdomen and into the uterus to the foetus to be terminated. The specialist then injected potassium chloride

solution in the heart of the foetus until it stopped beating. The procedure required temporary transfer of the surrogate mother to the ART clinic for a couple of days. One of the potential threats of the procedure involved miscarriage of the remaining foetuses. In the context of payment structure for surrogate mothers in India, where major portion of the money was paid to the woman at the end of surrogacy, the practice of foetal reduction further marginalised rights of the surrogate mothers. If the foetal reduction resulted in the miscarriage of remaining foetuses, the surrogate mother faced significant financial loss despite undergoing rigorous medical regimen for surrogacy. Observations of three foetal reduction episodes revealed that the procedure was quite painful for the women. In other unfortunate circumstances of spontaneous abortions and medical termination of pregnancy for health reasons, women were treated at the clinic and then discharged. Women returned home and resumed a fresh treatment cycle at their will.

Participant observations at the hostels revealed that a '*Shreemant*' or a baby shower was the most awaited moment of joy for the surrogate mothers. The Hindu religious ritual was performed for small groups of women who embarked on the seventh month of pregnancy. Women enjoyed a sumptuous meal along with sweets and gifts on this day. The advance preparations were full of excitement wherein the hostel matrons got sarees, imitation jewellery and footwear for the surrogates to choose as attire for the '*shreemant*'. The event brought in a lot of excitement in otherwise dull routine at the surrogate hostels. A few women had great experiences wherein in other than the attires purchased at the hostel, commissioning parents sent additional clothes and gifts for their surrogates and return gifts for fellow surrogate matters. Women also appreciated the blessings they believed they received during the ritual. The celebration was sponsored by commissioning parents and occasionally, e-

mails seeking permission for '*Shreemant*' did not fetch any response. At times they refused to pay for the expenses pointing out that the women did not follow Hinduism. Women who did not get an opportunity to celebrate '*Shreemant*' were disheartened and expressed anger towards their commissioning parents.

As the months passed by women eagerly looked forward to a smooth and safe delivery and going back to their homes and family. At these advanced stages of pregnancy women especially with multiple gestations experienced discomfort and were often moved to the ART clinic for close monitoring of their health. At times, women also requested the medical practitioners to perform an early caesarean section as they could no longer bear the discomforts of multiple gestations. If the foetus had gained the prerequisite weight for birth, the medical practitioners adhered to such requests subject to the consent of the commissioning parents.

Post-delivery phase. Figure 21 depicts main events and payment structure for the surrogate mothers post-delivery. Women hoped to see the infant born and most (36) of them expressed a sense of attachment with it. However, the infant was immediately shifted to a neonatal care unit situated in another hospital nearby. Women, especially when under the effect of anaesthesia post caesarean section delivery rarely got a chance to see the infant.

Women shared that immediately after the delivery, they were told gender of the new-born and could catch a glimpse before the new-born was segregated from them and moved into a neonatal care unit of another hospital nearby. Women were expected to provide breast milk upon request of the commissioning parents. Direct breastfeeding was discouraged and women used breast pumps to extract milk and handed it over to commissioning parents. In rare cases, commissioning parents encouraged surrogate mothers to breastfeed the baby and one woman also reported the

commissioning mother undergoing hormonal treatment for secretion of the milk.

Women were paid additional money for the provision of breast milk.

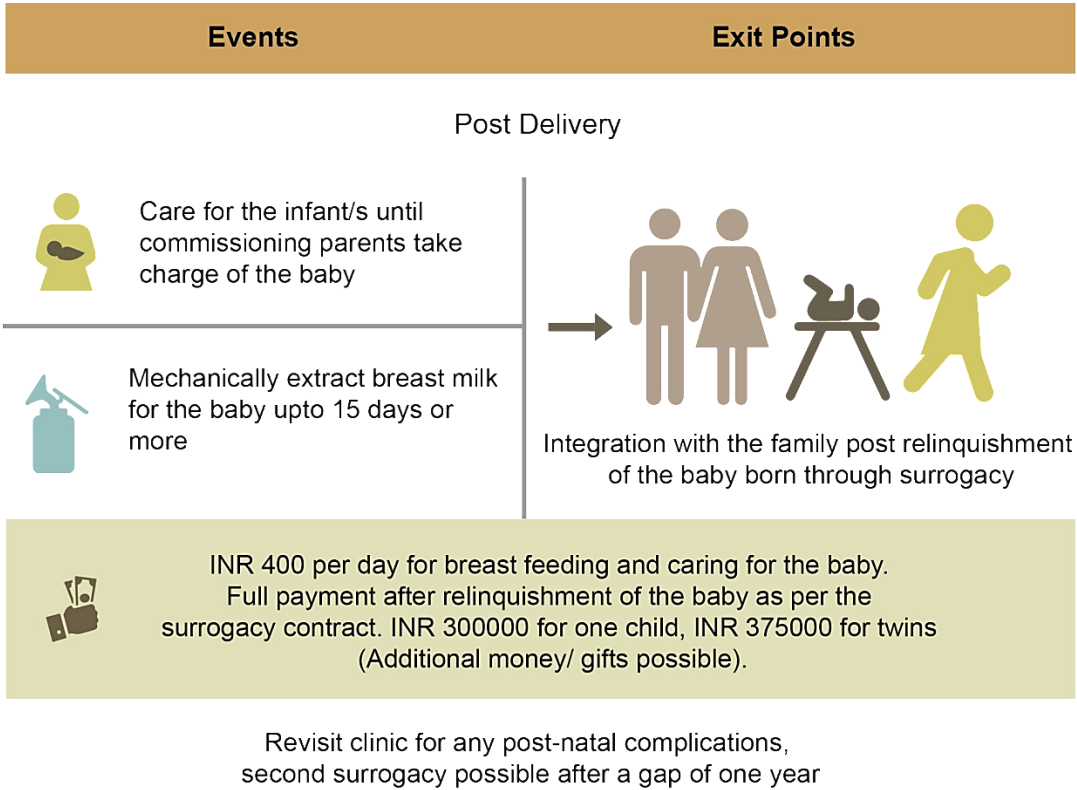


Figure 21. Surrogacy process post-delivery.

The practice of segregating infant from the surrogate mother immediately after the birth and discouraging them from directly breast-feeding the infants can be equated with what Berk (2015) referred to as ‘risk management,’ especially management of ‘attachment’ that the surrogate mothers may experience with the infant through surrogacy contracts observed in the U.S. In the Indian setting, a similar role was performed by the medical practitioners and surrogacy agents who from the beginning of the treatment reiterated to the surrogate mothers that the child was ‘not their own.’ At times, when commissioning parents were foreign nationals, surrogate mothers were requested to take care of the infant by the time commissioning parents arrived and took complete charge of the baby. Women were paid separately for their services as a nanny. A major sum of compensation for the surrogacy services was

paid to the surrogate mothers only after successfully handing away the baby to the commissioning parents. Women were provided post-partum care at the clinic for up to six months post-delivery on need basis.

Overall, medical practitioners considered commissioning parents as their primary patients despite the surrogate pregnancy being housed in the body of the surrogate mother who was subjected to extensive medical treatment. They excluded the surrogate mothers from any treatment dialogue all through the surrogate pregnancy and consulted only commissioning parents for any crucial decisions like number of embryos to be placed in the surrogate's womb, method of embryo transfer and for PGD. Observations of the introductory meetings between the surrogate mother and the commissioning parents, regular ultra-sounds and foetal reduction procedures indicated that medical practitioners engaged only commissioning parents in any dialogue pertaining to the pregnancy or the foetus/es. The ultra-sound room was set up such that the surrogate mother could not see the screen and thereby the images of the foetus/es she was carrying. The screen was only visible to the medical practitioners performing the examination and the visiting commissioning parent/s. Post-delivery women were deprived of the contact with the foetus they gestated for nine months. Women were expected to provide breast milk for the new-born but were not allowed to directly breastfeed. In essence, throughout surrogacy the role of a surrogate mother was reduced to a 'mere provider of a womb', as a means to an end resulting in the objectification of women.

Women reported specific challenges that they faced during the pre-pregnancy, during pregnancy, and post-delivery phases. These challenges along with the facilitators that eased the surrogacy journey for women are described in detail in the next sub-section.

Key Takeaways**The Surrogacy Process and the Experiences of the Women**

- The surrogacy process geared towards enhancing success rates systematically objectified women entering surrogacy and marginalised their rights.
- One time counselling session for the intake of women in surrogacy had an authoritative ethos. Medical practitioners laid down lifestyle and behavioural restrictions for surrogate mothers without any scope for negotiation, emphasised responsibilities of the women, and did not discuss rights of surrogate mothers during surrogacy.
- Medical practitioners did not encourage participation of the prospective surrogate mother and her spouse in the counselling session and did not explore their opinions or challenges they faced for participation in surrogacy. Further, women and their family members were also advised against seeking redressal for any grievances or seeking legal justice.
- Surrogacy agents and medical practitioners instilled among surrogate mothers a fear of pregnancy loss which would put at stake their aspirations for a stable future. The sole responsibility for any adverse outcomes of participation in surrogacy was proclaimed to be of women.
- Women experienced hesitation to approach medical practitioners, feared being judged and thereby relied on informal networks for information. Information acquired from the informal networks though was not always factually accurate.

- The study indicated lack of preparedness of women when they embarked on the surrogacy journey. Knowledge of women regarding procedural details was glaringly limited and they failed to anticipate impact of institutionalisation on their mental health.
- Over 85 percent of the total payment for surrogacy was paid to the women only after successfully handing away the baby to the commissioning parents. A late miscarriage left women with barely any financial gains. Fear of financial loss compelled women to obsessively adhere to the restrictions imposed.
- Surrogate mothers were distanced from the foetus they gestated by referring to commissioning parents as patient while surrogate mothers' body remained the site of intervention, constant reminders that the 'baby' was not their own, segregating infant from the surrogate mother immediately after the birth and discouraging them from directly breast-feeding.
- The role of surrogate mother was reduced to a 'mere provider of womb', as a means to an end resulting in the objectification of women. Overcoming a purely contractual and 'functional' nature of surrogacy relationship to form a 'personal' relationship with the commissioning parents could be viewed as an attempt of the surrogate mothers to subvert objectification to some extent.

Surrogacy Journey: A Roller Coaster Ride.

The novelty of the surrogacy process, the stigma associated with it, the medical regimen, and the restrictions imposed during participation in surrogacy posed varied challenges for the women. At the same time, familial support, financial gains and personal satisfactions during surrogacy helped women navigate the novel and rough terrain of surrogacy. The unique experiences during the surrogacy endeavour evoked a variety of intense emotions and feelings among women making the surrogacy journey akin to a roller coaster ride for them. Women's experiences were mediated by several people with whom women interacted within varying contexts (Figure 22).

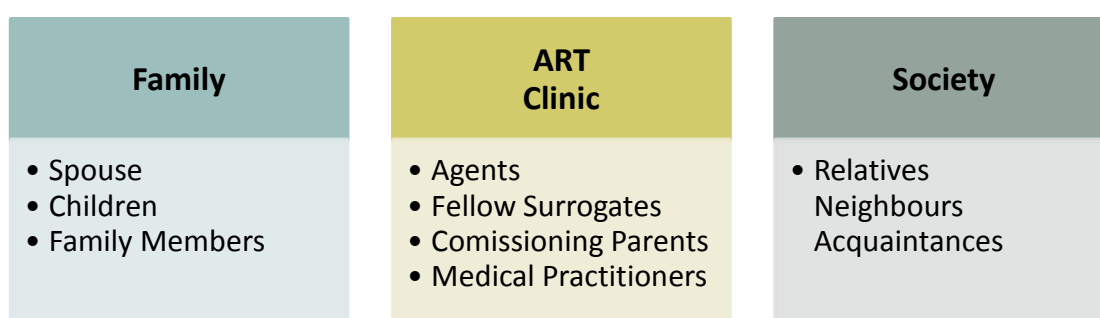


Figure 22. Contexts and actors mediating experiences of the women.

The narratives of women were analysed to discern their intra-personal and inter-personal experiences in the contexts family, the ART clinic and the larger society. A large portion of women's narratives were laden with emotional states and feelings. A detailed description of these context specific experiences and emotions is organised in the following sub-sections:

- Barriers women experienced in the context of family and society
- Barriers women experienced in the context of ART clinic
- Facilitators women experienced during surrogacy

The sub-sections are interspersed with illustrative quotes and brief case studies to demonstrate the ‘common’ and ‘routine’ as well as ‘unique’ and ‘extreme’ experiences of the women. While it is important to highlight the broad range of women’s experiences, the unique and extreme cases need to be interpreted as rare occurrences, in a departure from the generalised, standard and routine surrogacy experience. At the same time, unique and extreme cases reveal explicit elements of the exploitative contexts which are significant from the policy perspective.

Barriers women experienced in the context of family and society. The barriers or challenges women experienced in the context of family and society included concerns over childcare arrangements and parenting during institutionalisation for surrogacy, conflicts with spouse and other family members, conjugal as well as natal, and concerns over stigma for participation in surrogacy.

Childcare arrangements and parenting. When women embarked on the surrogacy journey their minds were set on securing a good future for their children using the money they earned through surrogacy. The primacy women gave to fulfilling the needs of their children was also evident in the concerns they expressed about childcare during their institutionalisation for surrogacy (46%).

Women were discouraged from bringing their own children at the surrogate hostels to facilitate complete rest for women and increase the chances of success of the surrogacy arrangement. Spouses of the women considered childcare as a primary responsibility of women and resisted their participation in surrogacy in the absence of satisfactory alternative childcare arrangements. In the absence of any support system to care for the very young children, 24 percent women reported delaying their participation in surrogacy and waited for a couple of years until their children grew up and could be left in the care of extended family members. For example, Sargam (28

years) a second-time surrogate mother shared, “initially, my husband refused. He said, staying there for nine months, son is young, who will care for him? A couple of years passed. Initially we were indecisive. Then when my son completed 3 years I came here in the hospital.”

Etale mara husband pahale naa j paadta hata. Ene evu kidhu ke nav mahina tyaanj rehwaanu. Ane chokaro nanno hato ene kon saachwe? Varas be varas neekadee gaya. Etle pahle ame toa ha – na kartahata. Pachi maro chokaro tran varas nu thayo ne tyare hu ahiya aawee hospital ma.

Women with older children chose to keep them at residential hostels or the eldest daughter managed the household and cared for younger siblings in the absence of the mother.

During institutionalisation women worried that extended family members may not care well for their children and that there may be adverse effects of maternal absence on the schooling and studies of their children. Nipa (35 years) a first-time surrogate mother who entered surrogacy without the knowledge of her husband had left her children in the care of her natal family. She shared intense feelings of guilt for not being able to look after her own children during surrogacy and shared, “I feel overwhelmed, that children are with my sister-in-law. Often over phone, my children cry; my sister-in-law may or may not be treating them well. Then I feel, because of me my children are suffering, it’s my fault that I gave them birth.”

Chokara atyare bhabhi jode che. Ane phone upar ghani waar chokara radata hoy mara, bhabhi hari rite raakhe na raakhe. Pachi eva vichar aawe che ke mara je ae che te mara chokarao ne bhogwa pade che em, dukh. Ae mari bhool ne ke me emane janam aapyo.

Other women (12%) also expressed guilt that while they engaged in extensive care work for someone else's child, their own children were deprived of the much-deserved maternal care. Sukanya (26 years) a second time surrogate mother expressed guilt over a minor injury her son suffered in her absence. She shared, "I experience tension that I am keeping someone else's child in my womb, ensuring its optimal health, such an extensive care for it. God is hurting my child. Won't I worry? Poor (child) without mother. No one cares like a mother does, not even a father."

Mare tension kevu aave ke ahiya hu beeja nu balak mara pet ma raakhyu eni tandurustee aapade raakhiye, eni ketlee baddhi kaaljee aapde raakhiye.

Bhagwaan aapda j baalk ne nuksan pohchave em. Evi chinta toa rehwanee j ne? Bicharane ma wagar... ma jevu toa koi raakhe j nahi. Baap hi na rakhe.

Concerns over safety of daughters during institutionalisation for surrogacy were evident from expressions of 12 percent women like, "(I) will not come again. My daughter is growing up, who will care (for her)? My husband drinks alcohol and roams around. And if (one) doesn't have daughter and has two sons then it's okay."

Beeji waar nahi aawanu. Chokari moti thay, kon sachawe? Mara gharwala daaru pee ne farya kare. Ane chokari na hoy ane be chokara hoy toa chale.

Few women (7%) also regretted not knowing about adequate pre-natal care during their own pregnancies. Kalika (35 years) a first time surrogate mother shared, "(I) feel sad, that I did not do any of this for my own son but (I am doing it) for someone else's child."

Dukh thay ne. Ke me mara chokara maate aavu nahi karyu pan paarkana chokraa mate.

A few women (7%) deliberated about revealing their participation in surrogacy to their children, especially women who had adolescent or young adult sons

and daughters. Hiteshi (35 years) a former domestic help and a second-time surrogate mother had lost her husband soon after her first surrogacy. She had two children, an elder daughter (17 years) and a younger son (13 years). Hiteshi gave her children a book about surrogacy available at the clinic to read. Rukshar (36 years) had two children, a son (17 years) she enrolled in an engineering college through the money she earned in her first surrogacy and a daughter (16 years) she intended to get married within a couple of years. Rukshar's son was living at a private hostel for students in Anand and Rukshar told him about her second surrogacy so that he could visit her at the surrogate hostel whenever he was in any need for money. Other women who had younger children decided against revealing their participation in surrogacy to their children. Heena (36 years) a first-time surrogate mother with two children shared her feelings of embarrassment when her son asked her about her baby bump. She said, "my younger 7-year-old son visits. This time he asked me, 'Mummy, why your tummy is bulging?' His father said, it's because of gas (laughs). I was embarrassed that my son is asking this. Then I told (my husband) not to bring him here."

Maro nanno babo 7 waras na aave. Mane aa wakhte aayo toa mane ke mummy taro pet kem fooli gayu che? Toa ena papa ke emne gas thai gayu che ne etale (laughs). Pachi hu sharmai gai ke maaru baalk aaj mane aa prashna kare che. Pan pachi me evu kidhu ke have tame na lawo ene.

Women were especially concerned that their own children were likely to share their observations of the surrogate hostels with others and therefore restricted their visits to the hostels.

Overall, women were concerned about impact of the surrogacy episode on the day-to-day lives of their children and experienced anxiety about the well-being of their children during their participation in surrogacy. Raval (2009) in an ethnographic

study of Gujarati women had revealed that women exercised psychological agency to resolve intrapersonal and interpersonal conflicts when the wellbeing of others, especially children and grandchildren was in question rather than needs of the self. They resolved these conflicts such that the benefits for their children were optimised. Raval speculated that internalisation of others' needs perhaps came to be experienced as personal needs. Similar trends were visible in the data gathered for this study, wherein almost all the women justified their participation in surrogacy – a stigmatised form of work – to ensure wellbeing of their children. Even challenges and conflicts women faced after participation in surrogacy revolved around the needs of their children. For example, women expressed concerns about well-being of their children, considered needs of the children while deliberating whether to participate in surrogacy again or not, and considered age and needs of the children when they contemplated revealing participation in surrogacy to their children.

Conflicts with spouse and other family members. Conflicts over decision to participate in surrogacy were reported by 17 percent women. Three women reported physical abuse by their spouses; one experienced it during decision making prior to participation in surrogacy and the other two during institutionalisation when their drunken spouses visited the surrogacy hostel, demanded money and abused them over refusal. In such cases the hostel matron intervened and protected surrogate mothers against violence from their spouses. One of the women also experienced mental pressure from her spouse to quit surrogacy while she was waiting for her pregnancy confirmation report post embryo transfer. Nipa (35 years) a first-time surrogate mother got embryo transfer done without the knowledge of her spouse, who had temporarily migrated to another village as an agricultural labourer, and informed him only when he got suspicious. Unconvinced of the authenticity of the surrogacy and

suspicious of the involvement of other men in impregnating Nipa, he kept a tight vigil on her. Nipa narrated her experience as follows,

He quarrelled with me and was about to hit me in rage. He quarrelled with Madam asking her to send me back. She said, 'Commissioning parents spent so much money on her. You repay all the expenses made and then take her back.' He had no money. For next 15 days he did not work and kept a vigil on me. He visited to check on me in the mornings, at nights and midnights. He was suspicious someone will enter my room and sleep with me and all that.

Pachi jhagada thaya mari upar, mane ekdam marwa ubha thai gaya hata.

Emne madam jode jhagdo karyo ke ene pachi mokalee doa. Toa ke 'Party ne eni paachad ketalo kharcho karyo. Ae baddho kharcho tame bhogi lo ane lai jav'. Aatlo rupayo eni jode nato. Pachi 15 diwas kamavu nahi, mara pachad na pachad rahyo. Diwase jowa aawe ratre pachi ardhi ratre jowa aawe. Ene whyam ke koi aawashe ane room ma jashe, eni jode hushe, evu baddhu.

Nipa's narrative indicates the control that spouses may exert on the surrogate mothers during surrogacy and the nature and extent of psychological abuse women may face. This case also emphasised the importance of spousal awareness for the participation of women in surrogacy. In the absence of a robust social security system and inadequate regulation of surrogacy services, participation in surrogacy without the knowledge of spouse or other family members may prove to be risky.

The case study of Sheetal (Box 1) is tragic and signifies an extreme example of monetary exploitation of women by their spouse. Nipa's and Sheetal's experiences highlighted importance of counselling prospective surrogate mothers about the impact it may have on their family life and need for post-surrogacy counselling and guidance on financial management for the surrogate mothers.

Box 1: Case study of Sheetal

Sheetal (26 years) a third-time surrogate mother had chosen her life partner and married him without approval of her family severing all contacts with them. A mother of one had participated in surrogacy with a dream of buying an own house but failed to achieve it as she spent all the money earned through both the surrogacies for clearing her husband's debts. She revealed, *"When I was living here for nine months, he indulged in gambling and liquor and was indebted. When I returned, and broached the topic of buying a home he kept refusing. Gradually, I realised that he was indebted. Every evening someone or the other visited our home (to ask for money). All the money earned was spent in repaying loans incurred and I could not buy a home. We fought a lot but what could I do? I had done a love marriage; I don't have anyone (any support). My parents have severed all ties with me. Therefore, I had to bear it all in silence. Second-time, he sent me for surrogacy saying 'You go. I won't do any such thing this time.' Then I returned for second surrogacy. But he was indebted again. My husband was a gambler, his gambling had no limits. Again, all the money earned was spent in repaying loans and I could not buy a home. Now I have come for surrogacy for the third time on my own. This time (doctor) took in writing from him that he has no rights over the money I earn through surrogacy. Because we took this in writing, knowing that he will not get any money, he deserted me and left. He belongs to Nepal, he went there. I asked him for divorce because of his behaviour. He suggested me to accompany him but I refused because he duped me twice. Now I have kept my son in a paid day-care facility."*

A follow-up observation with Sheetal after delivery revealed that the Doctor concerned over Sheetal's husband duping her again strongly recommended that Sheetal should invest the money in buying a home in her own name. Doctor offered to furnish it with basic amenities and promised her a job at the clinic as a nanny. Sheetal insisted for a cheque payment stating she would need money for daily expenses and schooling of her child. In the Doctor's cabin, in a heated state of mind, Sheetal almost snatched her cheque from the hands of a nurse and stormed out. Sheetal had contacted her husband and was considering reconciliation and migration to Nepal. Matron warned her against falling prey to his proposal. Opinion of fellow surrogate mothers was divided on whether Sheetal should invest the money in buying a home as or encash the money. Sheetal was exasperated and refused to discuss anymore.

Sheetal's experience revealed possibility of the exploitation of women in the context of family. Her experience also indicated that the women may not be always fully prepared for the financial management in the post-surrogacy phase. Surrogate mothers at the clinic introduced me with one more woman whose husband took away all the money she earned through her first surrogacy, took over the family home with all its belongings, deserted her and remarried another woman. Her experience was traumatic and she refused to discuss the women with extreme experiences may not come forward to participate in study and share their views. This challenge was addressed through purposeful sampling of critical cases. A couple of women also expressed anxiety about infidelity by their spouse during their long absence from the family for surrogacy.

Women's experiences of conflict and abuse in the familial context were not limited to their spouses, but some of them (17%) also reported interpersonal conflicts with other family members. One woman reported resistance for participation in surrogacy by family members, a couple of women reported inadequate support from the extended family members who introduced women in surrogacy and 12 percent women reported family members and relatives demanding a share in the money women earned through surrogacy as reasons for conflict.

Women expressed feelings of betrayal and dejection when family members initiated them into surrogacy but did not maintain follow-up contact during institutionalisation at the surrogate hostel. They contended that these 'relatives turned surrogacy agents' would visit them only at the time of delivery to collect their own commission of INR 15,000 from the clinic for introducing them into surrogacy. Unfulfilled expectations of sustained support throughout surrogacy left women seething. Such transformations in personal relationships during surrogacy may have

mental health implications for women and on-going counselling support can be helpful.

Coercion from significant others for a share in the money earned through surrogacy was reported by 12 percent women. Sometimes it took the form of subtle expectations of financial aid expressed by family members and in a rare case involved threat from the family members for money. The narratives below are presented in the order of increasing degrees of coercion from the significant others experienced by these five women.

Sukanya (26 years) a second-time surrogate mother revealed that her natal family members had severed all ties with her because she had eloped and married the man she loved against their will. Sukanya's sister-in-law (husband's sister) had married Sukanya's brother and therefore was a member of Sukanya's natal family. Her sister-in-law provoked Sukanya's natal family to ask for a share in the money she earned. Sukanya shared,

This time, I told my mother and came (for surrogacy); she said, 'Okay, do help me' (laughed). That's what she said, even she asked for money; it's a period of money! My sister-in-law knew of my surrogacy and told my sister that I did it but did not offer monetary support to my natal family. They therefore raised an objection. But I told them, I got married with my own money. I will fulfil needs of the people with whom I will live my life. Then none of them could say anything and kept quiet."

Aa wakhte aai ne toa mummy ne pan kahi didhu. Toa ke haru beta mane pan madad karje (laughs). Evu kidhu ene, ene hee paisa ni mangani kari etale aa toa paisa no jamano che nai! Mara nanand janta hata, ene mara ben ne kidhu ke me aavu karayvu ane pachi ae loko ne paisa nu samadhan nahi

karyu. Te loko virodh uthayelo. Pan me toa kahi didhelu, ke jo lagan me karyu toa hu je karyu te mara paisa nu. Mare aakhi jindagi jya rhewanu e loko nu j bhalu karu ne? Toa pachi kasu boliya nahi. Chup thai gaya.

Minakshi (36 years) a second time surrogate mother shared, “If I get into surrogacy do any of his sisters help him with the chores? Nobody does. Now they visit to ask for money. But I don’t give them any. My husband too says, ‘my wife takes so many injections, why should we give money to her.’”

Aapde jai e toa ghar wala nu karwa koi nanand aawe? Koi na aawe. Hawe paisa joyta hot toa aave mangva. Pan hu toa aaltee j nahi ne. Mara pati pan kahe ke ‘mari baydee aatla baddha soya khay ane paisa aane aapwana?’

Ranjana (30 years) a first-time surrogate mother had an alcoholic unemployed husband. Her brother had supported her with home rent and food grain and expected that she will return the favour using surrogacy earnings. Ranjana shared,

Whatever (he) asks I must give because my brother has spent money for me. I lived in a rental house. My brother paid the rent and bought yearlong supply of grains for me. Therefore, I should give whatever my brother asks. He said, ‘after buying your home if anything is left then you give me.’ I must understand and give. My brother has only one daughter. I will invest 50,000 as a fix deposit in the name of his daughter.

Mangshe te aalwuj pashe ne, kem ke bhai ne aapadee pachad kharcho karyo che. Hu pahle bhade rahtee hati ane maro bhai mara ghar nu bhadu bharto ane mane waras nu anaj bahri aalto. Pachi bhai mange te aapwu padshe. Ene kidhu ke taaru ghar lai le ane pachi kai wadhe toa mane aalje. Mara bhai ni ek j chokaree che. Etale ena chokaree na name 50,000 fix kari deish.

Sukanya and Minakshi were successful in keeping at bay relatives who were seeking money from them. However, not all women could take such a firm stance against their family members seeking monetary support from them after learning of their surrogacy endeavour. The narrative of Ranjana and the case study of Hiteshi presented in the Box 2 indicated that the women experienced an obligation to help their natal family members at times to return the favours they had sought in the past. Apart from the obligation experienced to share the profits from surrogacy with their brothers what was common among Ranjana and Hiteshi was that both lacked any support from their husband; Ranjana's husband was an alcoholic and she was contemplating a divorce and Hiteshi was recently widowed. With no source of regular income, lack of support from conjugal family, and absence of any social security system both Ranjana and Hiteshi anticipated reliance on their natal families in future; making it difficult for them to resist even subtle demands for money posed by their brothers. Both the cases thus indicate complexities of the self which is enmeshed with the contextual circumstances. All the three cases of Sukanya, Ranjana and Hiteshi also indicate that expectations of monetary support were not limited to the conjugal families of women but were also put forth by natal family members.

Box 2: Case study of Hiteshi

Hiteshi (35 years) a second-time surrogate mother, had planned to buy a house from the money she earned through her first surrogacy. However, she lost her husband soon after. Her earnings through first surrogacy fell short to buy a home and she reluctantly decided to live with her natal family along with her son. Her brother then insisted that Hiteshi should buy an auto-rickshaw for him and he would earn and pay her Rs. 200 daily from his earnings. With much reluctance, she finally gave in to the pressure and bought an auto rickshaw for her brother. A few months later following some differences of opinion amongst Hiteshi and her sister-in-law (brother's wife) her brother reduced the amount of daily payment he made to Hiteshi to Rs. 150. When questioned about reduction in the payment he returned the keys of auto rickshaw to Hiteshi refusing to drive it any more. Finally, Hiteshi ended up selling newly bought rickshaw and incurred a loss of Rs. 42,000. Hiteshi then decided to repeat surrogacy to earn more money to buy a home. She barely knew agricultural work, the only means of income generation at her natal village. She was determined to live in an urban location for easy access to viable employment opportunities – to work as a cook in the urban households. After her preliminary property search she realised that the money she earned through surrogacy was inadequate for buying a house in a town. Being a widow without any regular source for income, banks refused to lend her a housing loan. Hiteshi then reluctantly asked her brother to raise a small amount as a loan and support her to purchase a home. In return she offered him and his family cohabitation in the home she intended to purchase. But her brother declined the offer and Hiteshi was left contemplating her way out of the situation.

Lastly, Suman's narrative not only revealed the grave exploitation within the context of family, but also the implication of such exploitation for the mental health of women. Suman (32 years) a mother of three sons, had a husband with a disability which limited his participation in the workforce. Suman, a first-time surrogate mother, was led to participate in surrogacy on persistent insistence by her in-laws. In the seventh month of her surrogate pregnancy she shared,

My sister-in-law's alcoholic son often comes here drunk and asks for money. I told, 'I don't have any money', he therefore threatened me saying, 'I will abort it, my mother helped you to get it, and I will get it aborted.' When I get my payment of 25,000 rupees, I will give him 10,000 for getting me here. My family members are such that they can kill for money.

Mara nanand no chokaro ghadee ghadee paisa mangto ne daru pee ne, ahiya be tran wakhat pee ne aai gayo. Mane ke kee 'mane paisa joie'. Hu kidhu 'nahi paisa'. Toa ke 'tamaru kadhahi nakhish. je mara mummy ne karaywu che ne tamaru ae hu kadhahi nakhish.' Pachi 25 hajar no cheque aawashe ne toa ema thee ene das hajar aapee deish, ae loko laya etale. Mara ghar wala loko ne paisa mate maari naakhe.

In summary, conflicts with spouse and family during surrogacy were not limited to the conjugal families of women but were also prevalent with the natal families; further these conflicts also affected the women's mental health in terms of experiencing stress, anger, and feelings of dejection.

Stigma. Women and their spouses anticipated stigma for participation in surrogacy and most of them chose to keep surrogacy a secret endeavour. The stigma was associated with gender role norms. Prolonged or frequent absence of women from the household and involvement of the women in paid work were looked down by the members of women's immediate social networks. Isha (30 years) a first-time surrogate mother shared, "We kept it secret because people will question my husband saying, and 'don't you have any manners that you sent your wife to earn.' There is nothing wrong in this but people don't agree. In Ahmedabad women rarely do this. They are unaware of surrogacy."

Chupaweene aaya etale tyagadi ke gharwala ne j bole ke tame ke 'tame loko ne tewan nathi ke tame loko baydao ne aa rite kamawa moklo cho?' Ema kai kharab nathi pan koi manta nahi ne aawu. Ahmedabad ma khaas kari ne koi ladies nahi koi karta. Etlu jaanta bhee nahi ke aawu thay che.

Minakshi shared that her husband faced stigma for 'living on the earnings of the wife.' In her words, "(we) suffered a lot at that time. Everyone said to my husband, 'you live on your wife's earnings.'

Tyare toa bahu tras thayu baka. Baddha gharwala ne evu kahe ke baaydi ni kamanee par jeewo em.

Women anticipated that people would misconstrue surrogacy as selling own child or equate it to prostitution. Some exemplar narratives included, Yashshree (26 years) a first-time surrogate mother shared, "they will think child can't be born like this, his wife must have some extra marital affair. They will think wrong things about me which means I will lose my reputation. Along with me my husband and my children will be ashamed too."

Woh toa yahi sochenge na ke baccha aisa thodi na hota hai, iski aurat ka kahi bahar kuch chalta hoga, toa wo kuch undha sochenge na mere bare main. Matalab meri hi bejatee hogi na. Aur mere saath saath mere bacche log ki mere ghar wale ki... sabka sar neeche.

A couple of women also expressed fear that their children may face stigma and revealing their participation in surrogacy may create hurdles in getting their daughters married. Kavita (28 years) a twice surrogate mother shared, "in future, our children may face problems. Once they grow up they may feel that mother sold a child and using that money we are enjoying our life. When we live in society we are bound to have problems in future."

Bhawishya ma aapda baalk ne problem thay ne. Motu thai ne aam lage ne ke ta mummy chokaro wechi ne aaywee, aa paisa thee ame leher karo cho. Ane bhawishya ma aapda samaj ma aapde rahiae toa problem thay.

As surrogacy progressed, women experienced great difficulties in justifying their prolonged absences from the family. They failed to visit their extended families when invited to attend social gatherings, festivities, weddings, or during crisis situations like a death in the family. Women then avoided attending phone calls of the relatives and answering queries about their whereabouts.

In summary, concern over the wellbeing of their children was the primary barrier women reported in the context of family. Data indicated that conflicts with spouse and family during surrogacy were not limited to the conjugal families of women but were also prevalent with the natal families and affected their mental health. It appeared that micro-context of women especially; stability of their marital relationship was a crucial determinant of a positive surrogacy outcome. Women anticipated and experienced stigma due to traditional gender role ideologies.

Barriers women experienced in the context of the ART clinic. The primary barriers women experienced in the context of ART clinic mainly stemmed from the women's alienation from their family during institutionalisation for surrogacy, stringent medical regimen, extensive care work, and disagreements of women with the fellow surrogate mothers, medical professionals, and the commissioning parents.

Alienation from the family during institutionalisation. Women acknowledged that institutionalisation during surrogacy helped them maintain secrecy about their surrogacy endeavour and avoid stigma. At the same time, almost all the women also reported alienation from their family during the institutionalisation as a primary hurdle they experienced in their surrogacy journey. Most of the women had

never lived on their own without the company of their family members prior to participation in surrogacy. Separation from the family members itself was a novel experience for the women and was detested by most with a couple of exceptions. Women reported feeling homesick and eagerly looked forward to returning home post surrogacy. Restrictions over mobility further accentuated the boredom and saturation that women experienced during their stay at the surrogate hostels. Dhara (25 years) a second-time surrogate mother described it as,

We must stay inside; they don't allow us to venture out. Really. We don't get to venture out. Only if our spouse is visiting we can go out. Otherwise it is not allowed at all. That is because some women are not supposed to be let out, some women are not good. Some go back home."

Aapade andar ne andar padi rehwanu, aapn ne baahar nahi nikdawa de ae toa. Toa. Aapade kai baahar jawa male nahi. Toa. Aapda gharwala aave na toa j baahar jaway. Nahi toa bilkul baahar na jaway. Kem ke amuk bayda ne nahi javu devu hoy ne. Amuk bayda sara nahi hoy ne. Amuk ghare jata rahe.

Isha (30 years) a first-time surrogate mother and a former home maker with two children narrated her experience of institutionalisation as confinement and proposed that the mandatory stay at the surrogacy hostel should be reduced to four months. In her words,

Everything is fine, but (my) mind fails to accept it here. There is so much difference between (living) here and (living) at home. At own home, time flies but here the day doesn't get over, time is still. How much can (one) sleep in a day? That's why it is difficult to spend time here. It will be good if (they) change the system and allow staying at home for four months and then bring us here then it will be good. It would be okay to visit every fortnight for an

hour to take injections. It feels like one is confined in the hostel. It feels like when will nine months get over and when will (I) go home.

Baddhu saaru che pan mann nathi maantu ahiyagadi. Etle ahiya ma ane ghar ma bahu farak ne. Aapda ghare toa diwas jato rahe toa khabar nahi pade pan ahiya toa diwas j nathee jato, time j nahi jato. Suta aakhho diwas ketlu suwanu? Etle time nathi jato ahiya. Chaar mahina ghare rahwa de ne toa saaru. Pandhar diwas ma khali kallak mate aave injection lehwa toa pan chale. Hostel maa jane purayu hou evu laage che. Kyare nav mahina paar pade ane ghare jata rahie evu lage.

In addition to feelings of confinement as experienced by Isha, other women expressed feelings of being stuck unless they delivered the surrogate child.

Yashashree (26 years) a first time surrogate mother shared, “my mind is saturated/ full looking at all of this. It feels like I can see only this and nothing beyond this. It feels like I have come way too far, how I can return now unless I don’t give away this (baby). Now I cannot step back.”

Ye sab ko dekh ke man bhar sa gaya hai. Jane bas yahi itana hi dikhata hai, iske aage kuch dikhai hi nahi deta. Esa lage ke mai bahot door aa chuki hun, ab peeche kaise jaau, jab tak ye de nahi saktee mai peeche ja nahi sakati.

When asked, ‘what could women do if they felt like discontinuing their surrogacy?’ a former home maker and a first-time surrogate mother Pooja (39 years) lowered her voice to almost an inaudible level and shared,

That’s not permitted. One must keep it! Those who don’t want to keep it keep moving around, so that the report (pregnancy) fails. They don’t rest, don’t take medicines, and do all such things. But once pregnancy is confirmed then there is no way out (laughs).

Evu na chale. Toa pachi toa rakhwuj pade ne! Ane jene na rakhvu hoy ne, amuk farya kare. Etale report na aawe. Rest na kare, dawa na khae, evu baddhu kare. Pan ek waar rahi gayo toa rahi j jay, pachi kai chutko j nahi.

This revelation by Pooja is worrisome as it indicated that women may not fully understand the possible adverse impact of surrogacy on their lives prior to participation in surrogacy. However, after entering a surrogacy contract may not have any means for retreat. Discussions about surrogacy and the proposed surrogacy regulation bill have remained silent about the surrogate mother's right to medical termination of pregnancy.

Women found restrictions over daily chores and movement and sexual abstinence stifling. They also reported dissatisfaction with the food available at the surrogacy hostel and longed for home cooked meals. Sharing of limited resources like space, television, and bathrooms at the hostel at times resulted in disagreements. These limitations contributed to women's feelings of dissatisfaction towards institutionalisation. Women failed to anticipate extent of alienation they would experience during institutionalisation prior to their participation in surrogacy.

Qadeer and John (2009) and Tieu (2009) have stated that it might be difficult to understand fully what the experience of surrogacy would entail prior to participation. Deonandan, Green, and van Beinum (2012) have expressed concerns that changes in the daily routine and diet and disruption of normal familial roles and responsibilities may be difficult to predict and may adversely affect psychological health of surrogate mothers. The data correspond with these concerns expressed.

The data gathered in this study indicated lack of preparedness of women when they embarked on the surrogacy journey. Knowledge of women regarding procedural details of surrogacy was glairingly limited and largely women failed to anticipate

impact of institutionalisation on their mental health, neither were they briefed about it. Educational counselling of prospective surrogate mothers may help them better understand requirements of the surrogacy programme and its influence on their life.

Medical regimen and effects on the health of the women. Surrogacy involved extensive medical treatment that required timely intake of oral and vaginal medication as well as injectable hormones. Women often reported being aware that they were required to take medication during surrogacy but failed to accurately estimate extent of medication. Ritu (26 years) a first-time surrogate revealed after her delivery,

There is lot of difference in own delivery and this. In my own, I never experienced any pain or took medication. I thought this would be same like my own delivery. But this is difficult in comparison. Towards the end in the eighth month I got too restless.

Ghar nee delivery ane aa delivery ma bahu fark pade. Gharnee delivery wakhte mane aavu kai thayu nahi ke aaigadi dukhe ane dawa golio galu. Aa mane evu j laagtu hatu ke gharnee delivery jevu j hashe aam. Pan aa toa ena thee aghari che. Ema chella aathwa mahina ma toa me khoob j hairaan thai.

Women indicated that experience of taking numerous injections was one of the most difficult parts of the medical treatment for surrogacy. An illustrative quote of a second-time surrogate mother indicated the extent of pain and discomfort that women experienced because of injections. Sukanya (26 years) a second time surrogate mother shared, “Oh no, too many injections! I had severe inflammation here (points to hips) because I took injections. It is so painful! After my first experience, I was not feeling like to repeat (surrogacy).”

Naa baba, bahu soya toa... mane toa ahiya dhajjiya ne dhajjiya thai gayla (points to hips), injection khada hata ne ae. Baddhu evu dukhe ne! Ae pahlee war aai ne fare beeji waar aawanu man nahee thatu hatu mane.

Hiteshi's narrative indicated the exasperation that women experienced with the extent of medication required in the surrogacy treatment. Hiteshi (35 years) a second-time surrogate mother recalled,

That time was such that (I felt) this is my job only meant for consuming medication. And in that, there are some heavy medications which cause itching sensation all over the body, there is burning sensation in chest and stomach, all such things happen, one feels dizzy and all that. In the summers, it is more problematic.

Ae samay aevo hato ke bas aa mari nokari che dawa golio galwa maate ni j che. Ane ema evi amuk golio awee jay ne bhare to khaaj aawe sharir ma, pachi aam chati ma lahi bare, pet ma lahi bare, evu baddhu thay, chakkar aawe evu baddhu thay. Unhalo hot ne toa pachi wadhare tras.

Many women (66%) reported that heavy medication and limited mobility adversely affected their health. A few women also linked the adverse health outcomes with the poor-quality gametes/diseased embryos transferred in their womb for surrogacy. Typically cited health problems included nausea and a loss of appetite, general weakness and a feeling of loss of vitality, body ache and minor discomforts like gas, acidity, itching, and a burning sensation in body due to heavy medication, and in some cases, high BP and bleeding. Lila (29 years) a first-time surrogate mother in her first trimester shared health issues she experienced as, "(I) can eat only small portions of food. There is persistent pain all over the body. (I) get sensations as if insects are biting (me). Body keeps aching and I am unable to sleep. In this (one)

suffers. (I) get headache because menstrual cycle is suppressed. (They) give medicines but how many medicines (one) can consume?”

Thoduk aatlu k j khaway. Pachi aa sharir toa aam aakhu dukh j kare. Aam kitanu kem kadta hoy evu thay. Sharir dukhiya kare ungh na aawe. Pan aama takleef thay. Mathu bahu dukhe masik rokay etle. Dava toa aape pan ketali dava khawani?

Few women (10%) also expressed other challenges like weight loss, stretch marks, hyperpigmentation, and dark circles under the eyes during surrogacy. In addition, (27%) of the second time surrogate mothers reported post-surrogacy health challenges they faced after returning home. Bhagwati (35 years) a second-time surrogate mother shared that she could not bear heat after returning home from her first surrogacy. She also experienced loss of appetite, weight loss and general weakness for almost a year post surrogacy. On the contrary a couple of women reported improvements in health after they began medical treatment for the surrogacy and shared gaining some weight.

Extensive care work in the context of failures, loss and pain. With limited success rates of surrogacy treatment, failed embryo transfers were far too common. Of the 41 women interviewed 20 women had experienced at least one failed embryo transfer (Figure 23) in the current surrogacy cycle. Repeated failure was a difficult experience for the most. Women revealed a deep sense of failure when they received a negative pregnancy report especially after staying away from home for over 15 -21 days and consuming medication and taking several injections. Experienced fellow surrogate mothers consoled these women and encouraged them to return for a repeat embryo transfer. Women feared undergoing several embryo transfers and shared difficulty in maintaining secrecy about their participation in surrogacy.

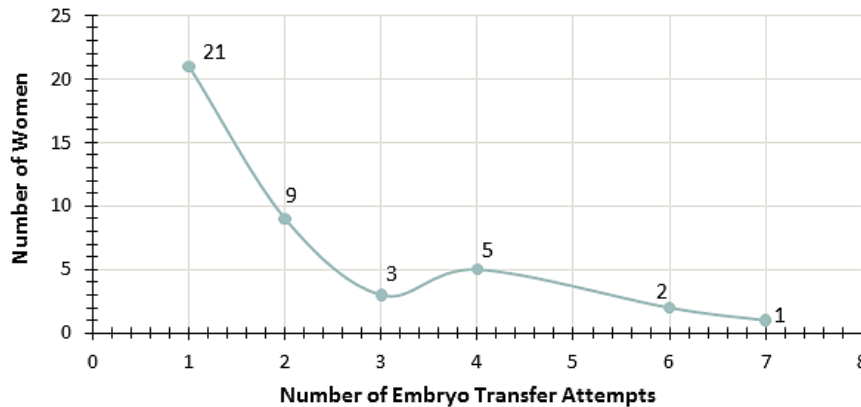


Figure 23. The number of embryo transfer attempts women underwent.

Figure 23 indicates that half (51%) of the participants of this study had attained surrogate pregnancy in the first attempt of embryo transfer. It appeared that the frequency of women attaining a surrogate pregnancy declined with increased number of embryo transfer attempts. This indicates a possibility that with increasing number of failed embryo transfer attempts, chances of attaining a surrogate pregnancy may diminish. Systematic collection of data for embryo transfers and associated outcomes along with variables like age and parity which have been previously linked with its success rate is a crucial area for research. Such an evidence will help to generate conclusive evidence to set upper limit for the maximum number of trials any woman can undergo to attain a surrogate pregnancy.

Participant observation presented in the Box 3 unravels an incidence where a surrogate mother Radha was told about her negative pregnancy report. She experienced a range of feelings including disbelief, a sense of failure, anger, and anxiety about the failed pregnancy report. The episode poignantly highlighted the need for involvement of the trained professionals to disclose the pregnancy test results to the surrogate mothers in person, offer them psychological support for coping and to bust the prevalent myths.

Box 3: Disclosure of Pregnancy Reports**Location:** Surrogate hostel.

A nurse had visited and announced the names of the women who had a positive pregnancy report, the list did not include Radha's name. Tears welled up in Radha's eyes and she started packing her belongings. Other surrogate mothers mid-way through their surrogate pregnancies started assuring her;

"Don't cry. Only people who are lucky get (positive) report in the first round (of embryo transfer). You should come again. Do come."

"Rone ka nahi. Pahli baar me toa khali nasib walo ka hi report aata hai. Fir se aana aap. Wapas aana."

Radha could not control her tears and explained,

"I took so much precaution, took so much care. Then how could the report fail? I am telling the truth; it moved inside my belly from here to here (gestures by moving her hand across her belly horizontally from left to right). I could feel it so much. I was sure I had conceived the baby. How is it possible? How could I not get the report?"

"Maine toa kitna Shambhala tha, kitna care liya tha. Fir bhi kaise nahi aaya report? Aur mai sach bol rahi hun, mere pet me naa yaha se yaha wo ghumta tha (makes gesture by moving her hand across her belly horizontally from left to right). Mujhe kitna feeling ho raha tha. Muze toa yakin tha ki baccha rah gaya hai. Aisa kaise ho sakata hai? Report kaise nahi aaya?"

She started throwing things in her bag with a frown on her face (appeared frustrated and had stopped crying by now). A fellow surrogate mother Dhara explaining her,

"One gets such feelings because of medication. It feels like something is moving in the belly, chest feels heavy. All this is a result of medication we take."

"Aree aisa feeling toa dawa ki wajah se hota hai. Aisa lagata hai ki pet me kuch ghum raha hai, chaati bhi bhaari ho jaati hai. Ye sab ham dawa lete hai naa uska asar hota hai."

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Radha responded,

“But I did not experience any heaviness in the chest at all. It was moving so much in my belly. What’s the use of taking so much care? I had taken so much care.”

“Par mujhe chaati me bharipan toa bilkul nahi ho raha tha. Pet me toa itana ghum raha tha! Kya faayda itni saari care le ke. Maine toa kitna khayaal rakha tha.”

Dhara then started telling me about the precautions Radha took.

“Do you know how much she cared for self? She was eating only bananas and milk. After doing all this and taking medicines, tablets and injections now (she) must go home. After going through so much of pain if report is not positive then won’t one feel sad?”

“Isne toa itna khayaal rakha tha pata hai? Yeh toa sirf doodh aur kele kha rahi. Aur Itnaa sab kar ke dawa goli injection khake ab ghar chale jaane ka. Aaatlu dukh waithi ne report naa aave toa dukh toa thaay j ne?”

Two years of failed embryo transfer trials had left Veena (33 years) wondering about the possible reason for her failure to conceive. She repeatedly fell sick with fever, had suffered great deal of weight loss, weakness and painful bruises due to repeated injections and was annoyed and frustrated with these adverse health outcomes. She took couple of months off after every failed attempt to recover her body before mustering courage for the next trial. Her experience is indicative of the adverse impact of undergoing repeated and prolonged embryo transfer treatment cycles on the physical and mental health of surrogate mothers. Women who faced repeated embryo transfer failures demonstrated a resolve to attain a surrogate pregnancy despite the hardships they faced. Financial desperation of the women may impede their decision to discontinue surrogacy treatment despite the hardships they experience. Agents, as well as experienced surrogate mothers encouraged women to

repeat embryo transfer cycles until they attained success. There was no professional guidance provided to the women regarding when they should discontinue their trials in case of repeated failures and the issue needs to be addressed.

When women attained a surrogate pregnancy, they were made aware of the need to take rest and extensive care during surrogacy for successful attainment of a live birth. Surabhi (34 years) a first-time surrogate mother participating in surrogacy revealed how medical practitioners emphasised extensive care. She shared, “here, doctor has told to take rest, not to use stairs, and not to sleep with husband etc. I am tensed that report will fail. (I) completed seven months, now only two months are remaining. (I) feel anxious that now if it fails, I will not get anything. I won’t get money; they give a small amount.”

Ahiya doctor ne kidhu aaram j karwaanu. Dadara nahi utarwana, gharwala jode nahi huwanu evu baddhu. Chinta toa thay j ne ke report bagadee jay. Saat mahina kaadhya, have be mahina rahya toa chinta thay j ne, bagadi jay toa kasu hee na male. Paisa hee na male, thoda k aaape.

Women shared that even matron of the surrogacy hostel advised them to take adequate care. Narrative of Surabhi and many similar narratives indicated a culture of fear of loss propagated by the service providers to ensure that surrogate mothers adhered to extensive care work. As women were paid a major sum of money only after handing away the surrogate child, fear of financial loss compelled women to obsessively adhere to the restrictions imposed.

Early and late term miscarriages and health complications during pregnancy were common and caused great anxiety for women due to uncertainty of outcomes. Vishakha, a second-time surrogate mother compared the surrogate foetus with a glass vessel. She said, “There is tension. After doing all of this and ensuring care if there is

a miscarriage then it's problematic for us. There is anxiety. This is like a glass vessel. It can result in a miscarriage anytime.”

Tension toa thay j ne? Aatlu baddhu kariae saachwanu toa hee miss thawanu toa aapda mate problem ae toa beekh lage j ne. Aa toa kaach na vasan jewu game tyare miss thai jay.

Almost all surrogate mothers shared experiencing fear of miscarriage. Their narratives suggested that they experienced considerable anxiety about miscarriage which affected their day-to-day living at the surrogacy hostel and highlighted the need for continued counselling support during surrogacy.

Multifetal pregnancies were a common occurrence because of the norm to implant multiple embryos in the surrogate mother's womb. Women were required to undergo a painful procedure of foetal reduction to reduce the number of foetuses to a twin or singleton pregnancy for mitigating complications associated with multifetal pregnancies. Box 4 describes one routine episode of foetal reduction observed. Misha (35 years) hailed from Rajasthan and worked as a migrant labourer in Delhi. She was directly approached by her commissioning mother –the resident of a bungalow next to the construction site where she worked. Misha who had undergone five deliveries of her own and had three surviving children came to Anand for surrogacy with her commissioning mother. She conceived triplets and underwent foetal reduction to retain twins. The episode revealed cultural norms for son preference wherein the commissioning mother insisted on the survival of the male foetus. The incidence also indicated that for medical practitioners foetal reduction was a routine procedure, though it could be overwhelming for the commissioning parents as well as surrogate mothers. The medical specialist described in detail execution of the foetal reduction to the commissioning mother without addressing her feelings and emotional status.

Box 4: Foetal Reduction Episode**Location:** Sonography room**Participants:** Medical specialist, nurse, surrogate mother Misha, commissioning mother**Commissioning Mother:** Is it a girl or a boy, can one identify?*Ladaka hai ya ladki hai pata chalta hai?***Medical Specialist:** I can identify but I can't tell you.*Pata toa chalta hai par ham bata nahi sakte.***Commissioning Mother:** My mother-in-law says it is better if I can get a son, that's why if you could say something.*Nahi, woh toa meri sasu maa hai naa, wo bolti hai ki ab ladka ho jaae toa accha.**Isliye aap kuch bol sako toa.***Medical Specialist:** Law prohibits us from telling you. Otherwise, we are not your enemy.*Law hai ki ham aapko nahi bol sakte. Aise toa koi ham aapke dushman thodehi na hai.***Commissioning Mother:** Doctor please, if you could intimate me a little, now that you must reduce one of them. Otherwise retain all three of them (foetuses).*Doctor bas, thoda aap idea de sakte toa. Ab ek toa kum karna hai nahi toa sare ke sare teen rakho.***Medical Specialist:** Whatever we do here we do it after thinking it through.*Ham yah sab jo karte hai soach samajh kar hi kartain hai.*

Medical specialist informed Misha that he was about to insert the needle in her belly which would be little painful for her in the beginning. He asked her to stay still and not move at all. He then inserted a thin long needle directly in her belly. A painful expression covered her face.

Medical Specialist (informed commissioning mother): Of the three foetuses one will now stop growing further so that the remaining two can grow properly.

I insert needle in the baby only once so that other babies are not hurt. I don't insert it, take it out, and again reinsert. Can you see this needle, inside the baby?

*Hum ek baar hi bacche ko needle maarte hai taaki dusre babies ko takleef na ho. ye nahi ke ek baar dala, nikala, fir dala. Aap dekh sakte ho ye needle deekh rahi hai, bacche k andar?**(Continued on the next page)*

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(The specialist pointed towards the needle on the screen of sonography machine).

Medical Specialist: Fluid is inserted in the heart of the baby and heart has stopped beating. The procedure is performed and everything is all right.

You must keep a fast today. Sin of killing the baby would not be on me, it would be yours!

"Aapko aaj upwaas rakhana padega. Baby ko maarne ka paap hamko toa nahi lagega na, aapko lagega!"

Commissioning Mother: That's true.

Woh baat to hai.

Medical Specialist: I was just joking.

Mai toa sirf majhaak kar raha tha.

Misha was then shifted to adjoining room and put on intravenous fluids and medication. Nurse told commissioning mother to provide her food. Misha began weeping.

Nurse (to Misha): What happened is it paining? (Misha nodded).

Kya hua, dukhata hai?

Commissioning Mother: Did you apply something (aesthetic) before inserting the needle?

Usko kuch lagaya tha aapne sui daalne k pahle ya fir aise hi daal di?

Nurse: For everyone it is inserted like this. For some it's painful for others it is not. Do you want a CD of this procedure?

Aise hi dalte hai sabko. Kisi ko dukhata hai kisi ko nahi dukhata. Aapko CD chahiye?

Commissioning Mother: What's the use of keeping a CD of such work?

Aise kaam ka CD kya lene ka.

(Commissioning mother left the room).

Follow-up interactions with Misha revealed that within a week's time post this foetal-reduction episode she suffered miscarriage of the remaining two fetuses. In an impromptu conversation I had with her on the day she suffered miscarriage of the third foetus Misha revealed,

Come. Today there is one more story for you. One more foetus came out today. When I went to urinate this morning, the foetus slipped out. I did not even urinate and came out. After seeing this big foetus slip out, won't I get scared? I was paralysed with fear. But there was no one nearby. Then I came here on my own. I took a plastic bag and I went in the bathroom with a rag. I picked up the foetus with the rag, put it in the bag, tied a knot and brought it here. After coming back, I just lay down. Later sister (nurse) came and I told her, she then told the doctor (about miscarriage).

Aao. Aaj aap ke liye aur ek kahani ho gai hai. Aaj aur ek baccha bahar nikal aaya. Sabah mai peshab karne gai toa baccha bahar gir gaya. Fir maine peshab bhi nahi ki aise hi bahar aa gai. Fir itana bada baccha baahar aa gaya ye dekh ke apane toa ghabara hi jaenge na! Mere haath per se toa jaan hee nikal gai thee. Par waha acajou baaju koi tha hi nahi. Fir mai hi akeli aai yaha. Plastic ki thaili li aur fir bathroom me gai ek kapada leke. Maine bacche ko kapade se uthaya aur thaili me dala aur gaath maar ke yaha le aai. Fir toa mai aake let hi gai. Baad me sister aai toa maine ise bola, unhone doctor ko bola.

Misha despite undergoing arduous medical regimen did not gain much at the end of the failed surrogacy and was deprived of the much deserved mental support. For the busy medical practitioners, early term miscarriages were a mere routine, and the commissioning mother was grieving her own loss and was in the need for psychological support. The incidence highlighted the lack of professional standards of care, especially from the mental health perspective, in the context of surrogacy in India. Foetal reduction has associated risks of miscarriage of the remaining foetuses, preterm labour, and infection to the woman (WebMD, 2016). These adverse outcomes

compromise the health of the surrogate mothers and make them especially vulnerable to financial loss in the context of current surrogacy payment structure wherein over 80 percent of the money is paid to the women only after achieving a live birth. In case of miscarriage women were barely paid INR 10,000 – 15,000. The loss was often propagated as the ‘ill fate’ of the surrogate mothers, rather than as a result of the multiple implantations of embryos. Despite these adverse health and economic outcomes of foetal reduction for the surrogate mothers, they did not have any say in determining the number of embryos implanted in their womb. The decision was controlled by the medical practitioners and the commissioning parents whose efforts were focused on enhancing the ‘success rate’ of the surrogacy arrangement while the surrogate mothers bore the consequences of this decision.

Loss in the form of a late term miscarriage was especially tragic for the surrogate mothers. Managl (35 years) a first-time surrogate mother who experienced a miscarriage at the end of second trimester was devastated to think of the financial loss. In the small recovery room with two beds for the surrogate mothers experiencing health complications, Mangal discussed the possibility of maximising financial gain post miscarriage with a fellow surrogate mother Jagruti. Jagruti too was undergoing a difficult surrogate pregnancy and was unhappy with her surrogacy experience. She had conceived triplets, was recovering from persistent vomiting and diarrhoea and was supposed to undergo foetal reduction. Excerpt of the interaction between Mangal, Jagruti presented in the Box 5 is disturbing for multiple reasons. It indicates the monetary vulnerability of Indian surrogate mothers in the current payment structure, demonstrates control exerted by the medical practitioners through surrogacy contracts, and questions the bodily integrity of women in the context of surrogacy where women are willing to cut open their bodies for money.

Box 5: Pregnancy Loss and Vulnerability

Mangal: Today I must undergo curating. I bled last four days just like menstruation. My case failed in the sixth month! Now if Madam is understanding and gives me something it will help. I have a loan to repay, that's why I came here.

Hawe toa saru che pahle karta, aaje toa krietan karwanu che. Mane bleeding thayu chaar diwas masik jevu. Chatta mahinama case bagadi gai! Madam kai samjhi ne aapshe toa saru.

Jagruti (in a charged-up voice continues her dialogue animatedly): Oh dear, I know, I have seen. In my presence case of a woman failed towards the end, poor thing was not paid anything. She cried so much, but she did not get anything. These people don't pay anything.

Are mane khabar che ben, hu joylu che ne! Mara same ek ben hata emni case chelle bagadi gai. Ene bechari ne kai nahi aapyu. Ketali radi ae ben, pan emane kasu hi na malyu. Aa loko kai nahi aape.

Jagruti: Mangal ben you do one thing; you tell madam to perform a caesarean section and take the babies out. If your body is cut open, then you would get paid for that. At the least INR 50,000 can be demanded for a caesarean! If they do curetting, you will not get any money.

Mangal ben tame ek kaam karo, tame ne madam ne kaho ke sizar kari ne baalko lewa. Sharir chirai jay ne toa eni mate tamne paisa malshe. Kam se kam 50,000 toa mangi j shakay ne sizar na! Krietan kare toa paisa na male tamne...

Mangal: Yes, I will speak with Madam. I will tell her that she must do a Caesar. Now if she understands and pays it will be good. Case failed in the sixth month..."

Ha hu waat karish ne madam jode. Emne kaish ke madam sizar kari doa. Have madam kai samzi ne aapshe toa saru. Chatta mahina ma aawi ne case bagadi gai."

(Following week, Jagruti ben informed me that Mangal underwent curetting and was paid INR 10,000. Jagruti shared that Mangal had an argument with the clinic staff regarding the payment. However, it did not help her get more money and she was told that she was not eligible for second surrogacy attempt as she was over 35 years).

Late term miscarriage compromised economic interests of women who after undergoing extensive medical ordeals and pain barely received any money – the

primary motivating factor for them to enter surrogacy in the context of poverty. The medical practitioners justified the meagre payments based on the surrogacy contract signed, and dismissed the opposition raised by the women. Lastly, Jagruti's advice to Mangal to propose a caesarean section to the doctor to earn INR 50,000 brings to surface difficult questions of bodily integrity and body as a commodity which can be sold to earn money. The episode highlights extreme economic vulnerability of women forcing them to take drastic measures to break the cycle of poverty.

The worries of surrogate mothers were not only limited to the possibility of miscarriage and associated financial loss but a couple of them also revealed anxiety about death during caesarean section or a death due to late term medical complications. Grace (32 years) a first-time surrogate mother confided, "I am very worried about the caesarean section (to be carried out) after two months. What will be done? What will happen? What if I die?"

Sijhar ke baare me doa mahine ke baad mere ko bahut chinta lagee rahtee hai. Toa kya karenge? Kya ho jaega? Mar bhi jaau toa?

Grace revealed that she planned to share her fear with the medical practitioner during her next regular check-up. In the following week when asked whether she discussed her fears with the medical practitioner, Grace refused stating she did not get a chance to discuss it but was feeling comfortable by then. A few days later, fellow surrogate mothers shared that Grace had left the hostel premises without seeking permission of the medical practitioner and went and lived with her children and family. Her agent had managed to bring her back almost after a week and since then Grace was put up at the clinic for greater surveillance. Worries over death during caesarean section delivery could possibly have led Grace to escape the hostel

premises. Overall, participation in surrogacy had major implications for the mental health of women which passed unnoticed.

Limiting experiences with commissioning parents. Figure 24 presents data for the 41 surrogate mothers' perceived quality of the relationship with their commissioning parents for the total of 57 surrogacy cycles they underwent. The quality of the surrogate mother – commissioning parents relationship was determined by categorising the narratives of women describing their relationship with the commissioning parents as 'positive', 'negative', and 'neutral'. The data are presented by the nationality of the commissioning parents categorised as 'Indian', 'NRI', and 'foreigner'. For two of the surrogacy cycles, data on the nationality of commissioning parents was not available. Figure 24 indicates that women's positive experiences with the commissioning parents outnumbered negative experiences with them. However, the negative experiences even when rare have significant implications for policy and are thus analysed and presented here in detail. These experiences therefore should not be generalised as the 'common' surrogacy experience.

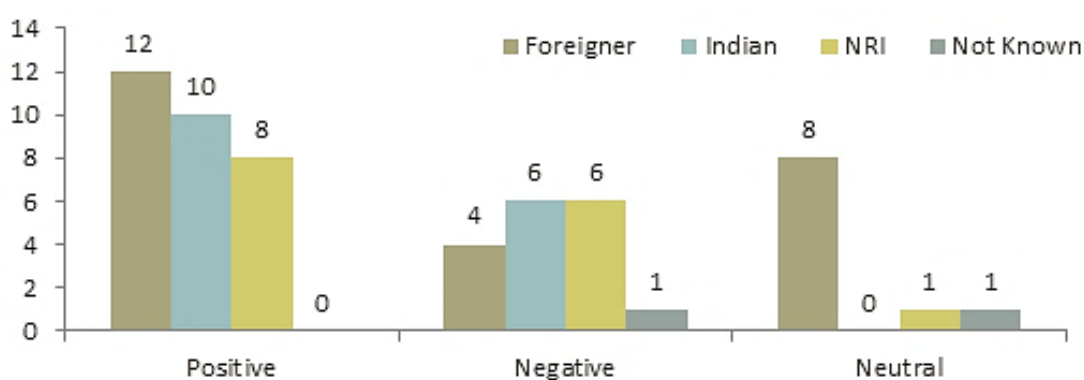


Figure 24. Quality of women's relationship with their commissioning parents

Note. n=57 surrogacy cycles 41 surrogate mothers underwent. NRI=Non Resident Indian

In all, women reported dissatisfaction with their commissioning parents for 30 percent surrogacy cycles and shared varied reasons. Inadequate or absolute no contact

with the commissioning parents during gestation was a primary dissatisfaction reported by 14 percent women – with one Indian, four NRI and three foreign commissioning parents. Women expected commissioning parents to maintain contact over phone, enquire about their health and look after their needs during pregnancy and visit them in person when possible. Geographical distance and /or language barrier restricted opportunities for interaction between foreign and NRI commissioning parents and their surrogate mothers. In case of foreign commissioning parents, women expected that the foreign commissioning parents be in touch with the medical practitioners or hostel matron regarding the health and any specific needs of their surrogate mother. Suman (32 years) a first-time surrogate mother for foreign commissioning parents despite linguistic barriers longed for meaningful interactions with them. She expressed, “(I) feel sad that these people don’t even bother to call. It’s okay even if they don’t send anything (gifts) but it would be great if they call and enquire about health. Then even I can tell them that the child is healthy, alert.”

“Dukh thay ke ae loko phone hi nahi karta. Bhale hi kai na moklawe pan phone kari ne khabar puchata hoy toa bahu saaru. Toa aapde hi jode phone kariae, ke ha balak tandurust che, hoshiyar che, aapde hi kahiae.”

‘Shreemant’ or a baby shower was a much-awaited ritual celebrated in the seventh month of pregnancy but was subject to approval and additional financial support from the commissioning parents. When commissioning parents refused to send extra money for the celebration or turned a blind eye to the e-mail correspondence from the clinic, women were deprived of the opportunity to celebrate. Two women expressed resentment towards commissioning parents, one foreign and one NRI, for not supporting this auspicious ritual.

In two of the rare cases surrogate mothers reported what Berk (2015) referred to as ‘womb envy’ resulting from the feelings of guilt and inadequacy amongst commissioning mothers experiencing infertility. These women reported that both the commissioning mother and the surrogate mother underwent embryo transfer and the commissioning mother failed to conceive but the surrogate mothers did. In these circumstances commissioning mothers were unhappy about their own failure to conceive. Franklin (2006) argued that IVF, which was originally designed to address biological inability to conceive, leaves users with a compounded feeling of failure due to its low success rates - a ‘paradox of IVF’. She claimed that, what people gain in IVF at best is a more nuanced understanding of the reason for their failure to conceive. Experience of failure to conceive recreated during surrogacy could have lead to dissatisfaction amongst the commissioning mothers. The two instances of ‘womb envy’ even though rare are important to highlight for the mental health implications it has for both the surrogate mother and the commissioning mother. Sensitising both the commissioning mothers and the surrogate mothers towards the needs of each other could possibly reduce such bitter experiences.

Three women reported dissatisfaction with the excessive involvement and at times control exerted by the commissioning parents at various points during surrogacy. Nipa (35 years), a first-time surrogate mother reported that her commissioning parents were too cautious while hiring her as a surrogate mother. Knowing that Nipa’s ailing husband had died a year ago, the commissioning parents were concerned about Nipa being a carrier of infectious diseases. Despite assurance offered by the medical practitioner that Nipa tested negative for any such disease, commissioning parents availed seven samples of her blood to be tested at independent

blood testing labs for own assurance and demanded that the embryo-transfer be done in their presence.

Misha, who underwent foetal reduction and subsequently suffered miscarriage of twin foetuses, had experienced extreme control exerted by her commissioning mother almost amounting to the violation of Misha's human rights. Her experience is indicative of the lax supervision and management of the surrogacy programmes in the country in general. Misha revealed that her commissioning mother duped her to settle for much lesser payment (INR 1.5 lakh) compared to the standard payment surrogate mothers received in Anand. She then restricted Misha's interaction with other surrogate mothers at the clinic, and confiscated Misha's mobile phone to limit her contact with her family. Misha revealed,

She accuses me saying, 'You must not have taken medicines properly that's why this (miscarriage) happens.' Even my phone is with her. For a week, I have not spoken with any family members. But she didn't ask even once if I want to talk to someone from my family. She anticipates that I will tell them how ill I am. I am ill, but she does not stay with me here, says, 'Even I will fall sick if I stay here.' These are rich people, why will they stay here?

Mujhe bhi boltee hai ke, 'tumne dawa barabar nahi lee hogi isi liye aisa hota hai.' Mera phone bhi unhi ke paas hai. Ek hafta ho gaya maine ghar pe kisi se baat nahi ki. Par wo ek bhee baar nahi kehatee ke kya tumhe ghar pe baat karni hai? Unhe yah lagta hai ke kahi main ghar par yah nahi bol dun ke main itani bimar hun. Mai yaha itani bimar hun par wo yaha mere saath nahi rahte. Kahte hain, 'yaha rah ke main bhee bimar ho jaungi.' Wo ameer log hain. Yaha thodi rahenge?

Misha's experience indicated that when commissioning parents were directly involved in recruiting surrogate mothers, commissioning parents may exert greater control over the surrogate, can divulge the facts for own advantage and severely curtail the freedom of surrogate mothers.

Another woman Minakshi (36 years), a second time surrogate mother, compared her experiences with the two foreign commissioning mothers, an Afro-American woman during her first and a London based woman in her second surrogacy whom she had never met. In her first surrogacy, Minakshi experienced extensive involvement of the Afro-American commissioning mother whereas in the second surrogacy the commissioning mother maintained no contact. Her narrative clearly indicated discomfort with constant presence from the Afro-American commissioning mother despite her humane and caring approach during first surrogacy. However, in the hindsight Minakshi felt that compared to the detachment of the commissioning mother that she experienced in her second surrogacy, excessive positive contact was preferable. Minakshi, narrated her experience with the commissioning party in the first surrogacy as follows,

She stayed with me for 5 months. She would get snacks and milk, sit beside me, and feed me; until and unless I ate food she would not leave. Then on the days when I wished that she should not come, she would certainly visit. I would pretend to sleep, if I saw her I would not wake up. Then she would just settle there, sit and chew gum. She would bring 2 kg big apples. If she kept sitting beside me all day long wouldn't I have headaches? I could not move, I could not walk, and I just had to lie down motionless. I could not understand what she spoke, how could I talk to her? All day long she would keep saying

‘My baby, my baby. My baby good boy’. I would say, ‘you keep mumbling but at least let me sleep.’

Paanch mahina mari jode rahya. Sev khamani, khaman, doodh lai ne aawte. Aapada jode bese ane aapan ne khwadawe ane aapde khaaye na ne taa lagi ne jay j nahi bol! Pachi koi diwas aapde wicharie ke aaje ae naa aay toa saaru, toa ae barabar aai j jay ae diwase. Me toa unghi j javu baa. Ene jovu toa uthu j nahi. Pachi ae toa besi j jay ane besi ne chingam khay. Aakho diwas mari jode house ma besi rehatee. Apple toa aatla motaa lai ne aawe, aam be kilo ne be kilo. Maru toa maathu j chadhi jatu, besi rahe Jodi ne Jodi aakkho diwas toa maro mathu na chadhi jay? Halay nahi ke chalay nahi. Besi rahu padtu sum saam. Jo, ae bole toa mane samjh padtee j nahi toa pachi su bolu. Aakkho diwas my baby my bay kartee. My baby good boy evu kare. Hu ketee tu ahiya babadiya kare pan mane toa unghwa de jara!

It is evident from the Minakshi’s narrative that the constant presence of the commissioning mother restricted Minakshi’s personal freedom despite the care and affection expressed by the commissioning mother. Minakshi’s inability to communicate her feelings with the commissioning mother severely curtailed humane potential of their relationship. It appeared that the commissioning mother did not mean to exert undue control or use coercion but in general prevailing power differences between the surrogate mothers and the commissioning parents along with language barriers could have limited Minakshi’s ability to resolve the issue. When asked to compare this experience with her experience with the commissioning mother in her second surrogacy, Minakshi preferred the constant caring presence of the commissioning mother over complete detachment or absence of contact. She shared,

This time, (I) have not seen commissioning parents yet. Staying with her (the commissioning mother during first surrogacy) was a better experience. She was good; she would save (good things) and get it for me. In a way, if we are with the commissioning parents, they take good care of us. They get anything that we want to eat. And in this (second surrogacy) I must spend my own money and eat. In this I, must purchase it on my own and eat from my own money. Half my salary is spent on food.

“Aa wakhte aju joya j nahi partywala. Eni jode rehwanu saaru hatu. Mari maate bachai ne laawatee hati hari. Ae bahu sari hati. Em toa partiwala jode hoy ne toa sachawe aapn ne. Ane aapde aa khau hoy toa baddhu lai ne aape. Aa aam toa aapde jaate j paisa kharchi ne j khawanu ne? Ane ahiya toa ekalu eklu jate lai lai ne khawanu. Paisa kadhi ne, pagar aape ae ardha paisa aapda khawa peewa ma j jata rahe.”

Minakshi valued caring gestures of the commissioning mother in her first surrogacy. In the absence of any contact with the commissioning mother in her second surrogacy, Minakshi had to ensure her own care.

Closure issues were reported for 16 percent surrogacy cycles wherein women expressed intense feelings of dissatisfaction about their post-delivery experiences. Indifferent attitude post-delivery by the commissioning parents led to feelings of intense dissatisfaction and regret amongst six surrogate mothers. Two of the surrogate mothers reported that their commissioning parents did not show the child born to them, another two shared that commissioning parents did not visit them even once post-delivery and left with the child. Koyal (34 years) a second-time surrogate mother shared her experience during first surrogacy with the Indian commissioning parents based in Baroda from her first surrogacy, “I felt, why my commissioning parents did

this? They maintained good relations so far. But in the end when I delivered the baby, why they did not visit me, did not show me the baby? Made the payment and left. Did not meet me.”

Mane aavu laagyu je mari parti kem aawu karyu? Chek sudhi toa sare sambandh rakhe. Pan chelle maru baalk thayu toa aawu kem karyu ke mane malwa na aya, baby na batai. Payment kari ne jata rahya. Malwa na aaya.

Three women revealed that their commissioning parents (2 Indian and 1 NRI) were disappointed over the birth of a female child and therefore severed contact with them. Swapana (32 years) shared her experience with the NRI commissioning parents from her first surrogacy, “They got two girls therefore they did not respond much. They had met me at the time of (embryo) transfer and left. They would call up; ask me, ‘Is there a boy?’ I told them I did not know. It is a secret and we are not told about it. (One) can know only when it is born.”

Emne pachi be baby aai etale emne bahu response natu aapyu ne evu baddhu. Transfer wakhte mali ne jata rahya hata ane pachi phone karata..., mane ke babo hash eke? Me kidhu mane nahi khabar. Ae toa secret hoy che, amne nahi kaheta. Ae toa last je aawe ae j khayal aawe.

Three surrogate mothers reported disappointment about unfulfilled expectations for extra monetary support. Women justified these expectations stating that the gift of the child they gave to the commissioning parents was priceless due to the immense sacrifices they made during surrogacy.

Sugarman (2008) accorded special significance to the distinction between 'functional' and 'personal' relations. A functional relation is instrumental as it is motivated by some common goal which ones achieved ceases the relationship and is impersonal in nature. A personal relation, on the other hand, is conceived to exist in

its own right without giving primacy to social functions and is based on mutual personal significance and worth. The experiences of the surrogate mothers with commissioning parents indicated intermeshing of the personal and functional aspects of human relationship.

Throughout the surrogacy process, primarily monetary and contractual character of the surrogate and commissioning parent relationship was emphasised by the medical practitioners. This was evident in the great emphasis laid on the 'surrogacy contract' that protected interests of the commissioning parents by giving them the decision-making powers and delineating desirable behaviour of surrogate mothers. In the crucial decisions surrogate mothers had no say. Medical practitioners consulted only commissioning parents for such decisions. Interactions between medical practitioners and the surrogate mothers reduced surrogate mothers to mere 'means to an end' and their contributions were unacknowledged.

Despite such a monetary and contractual nature of the relationship at the outset, originally intended 'functional' form of the surrogate mother – commissioning parents' relationship entered the realm of a personal relation, at least from the perspective of the surrogate mothers. It was evident in the keen desire expressed by more than half (54%) of the surrogate mothers to establish a personal relation with their commissioning parents. These expectations were built based on the experiences of fellow surrogate mothers with their commissioning parents and the term '*sara partiwala*' (good commissioning parents) which commonly appeared in the casual conversations of women.

The term '*sara partiwala*' described good commissioning parents as those who were responsive and humane in their approach towards surrogate mothers and acknowledged the sacrifices she made to give birth to their child. Glorious stories of

generous and kind commissioning parents – where they made hefty payments of up to 14 lakh rupees (the highest amount shared by the women) to a surrogate mother, gifted them gold ornaments, bought them well furnished homes exceeding the terms of surrogacy agreement, or maintained long term contact with the surrogate mother continuing with monetary support and gifts in kind – largely shaped the ethos of such expectations. A strong desire for a personal connection with the commissioning parents also emerged from the ‘invaluable’ extensive care work surrogate mothers undertook to ensure the survival of the foetus and expectation of reciprocity from the commissioning parents thereby.

Women (49%) expressed their expectations for affection, attention and need to be cared for during surrogate pregnancy especially during institutionalisation when they were separated from their close family members. Women imagined a reciprocal relationship with the commissioning parents wherein commissioning parents would maintain regular telephonic contact with them or in the case of language barriers at least with the medical practitioners to enquire about their general well-being. Surrogate mothers expected that the commission parents should enquire about the wellbeing of their children and bring them gifts (17%) on occasional visits or birthdays and acknowledge their presence. The exercise of ‘gift giving’ primarily acknowledges reciprocity and recognises the receiver of the gift as an important and worthy person if not an equal. On rare occasions, surrogacy agents and at times hostel matron were observed supporting surrogate mothers by negotiating gifts for them.

Women (27%) expressed a desire for continued contact with the commissioning parents post-delivery and expected recognition of their maternal contribution through the exchange of photographs of growing children, knowing about their development and occasional telephonic if not direct contact. Sargam (28

years) a second time surrogate mother shared her feelings of dejection with her NRI commissioning parents from her first surrogacy,

Now absolute no contact. Like I am forgotten. After they left from here they never called or contacted. They did not even send an email to madam enquiring – how is our surrogate? Is she fine? How is she doing? They left from here forever. Now I think that their need is fulfilled. Once they take their child these people forget us. She had said, ‘I will send you photographs, I will call you.’ But there are no whereabouts after they left. They never call; neither have they sent photos of daughters.

Bilkul contact nahi. Mane bhooli gaya have evu. Ahiya thi gaya pachiemne ek bhi phone nahi karyu ke kasu nahi. Ke madam ne ek email pan nahi miklyu ke Amari surrogate kevi che? Maja ma che? Su che su nahi? Ahiya thi gaya te gaya. Have evu laage ke have emni garaj pati gai. Etle emnu baalk lai jay ne toa aapn ne bhooli jay aa loko. Emne evi kidhu hatu ke hu photo moklaish, hu tane phone karish. Pan Ae gaya pachi kasu emno patto j nahi. Phone bhi na kare ane chokario na photo pan nahi moklawe.

In a way, overcoming a purely ‘functional’ nature of surrogacy relationship to form a ‘personal’ relationship with the commissioning parents could be viewed as an attempt of the surrogate mothers to subvert objectification to some extent (Figure 25). The Figure depicts that through the investments surrogate mothers made in the form of extensive care work to ensure survival of the surrogate foetus, they expected reciprocity from the commissioning parents in the form of a personal relationship with them. Women envisaged that such a relationship will bestow them with care and love of commissioning parents, give them recognition as an equal and worthy human being through reciprocal care and gift giving and ensure long term bonding.

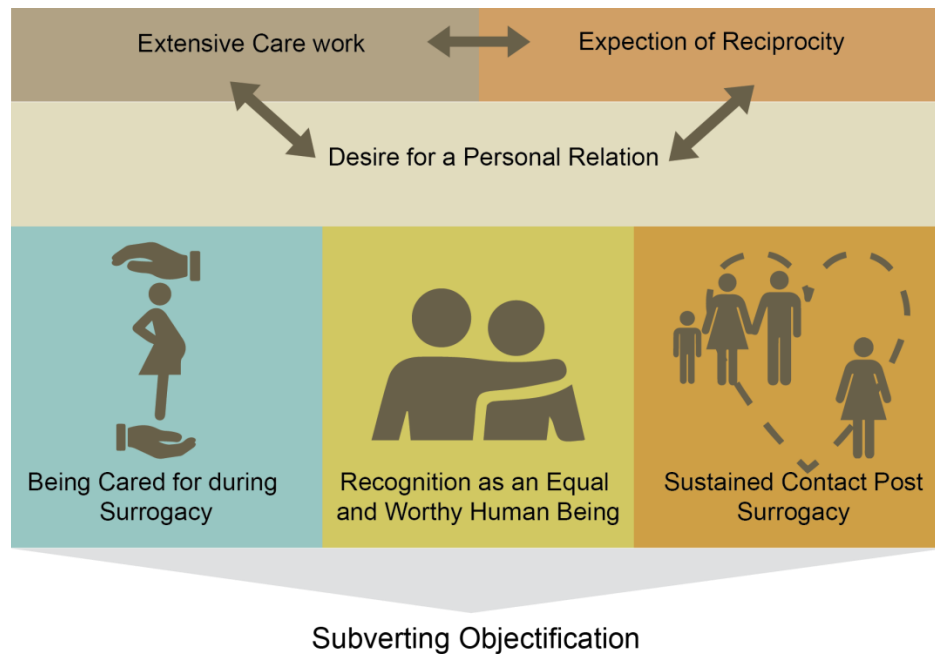


Figure 25. Surrogacy perceived as a personal relation.

The Figure depicts that through the investments surrogate mothers made in the form of extensive care work to ensure survival of the surrogate foetus, they expected reciprocity from the commissioning parents in the form of a personal relationship with them. Women envisaged that such a relationship will bestow them with care and love of commissioning parents, give them recognition as an equal and worthy human being through reciprocal care and gift giving and ensure long term bonding.

Surrogate mothers in few instances also expressed empathy towards commissioning parents not wanting to maintain a sustained relationship with the surrogate mother for the fear of adverse impact it may have on their relationship with their child. The relationship visualised by the surrogate mothers thus had the power to overcome the exploitative nature of surrogacy to some extent, however, could become a reality in very few cases. Over 54 percent surrogate mothers expressed a strong desire for a personal relationship with the commissioning parents only 15 percent women reported experiencing such personal connect with the commissioning parents. Functional orientation by commissioning parents was reported by 39 percent women

wherein, the commissioning parents maintained minimal or no contact during and post surrogacy and made payments as specified in the contract agreement without the exchange of any gifts as expected.

Contrary to this larger picture, 15 percent women preferred a purely functional relationship with the commissioning parents. Mangal (35 years) a first-time surrogate mother who underwent embryo transfer with frozen embryos and had never met her commissioning parents reacted, “Once these people pay us money and we give them the child, we are free. It’s like these strangers become our guests. A child in one hand and money in another hand. That’s what it is (an even deal).”

Aapn ne ae loko paisa aapi de ane aapn baalk aapi de etale chuta. Aapde toa jan na pehchaan tu mera mehman evu j ne wari? Ek haat ma chokara an ek haat ma paiso evu.

Mangal expressed a purely practical and functional approach to surrogacy where nothing other than the money she earned through surrogacy mattered to her.

Reshma’s Canadian commissioning parents from her first surrogacy expressed a desire for a sustained contact with her post surrogacy and asked for her personal contact number but Reshama refused to share it out of the fear that prolonged contact with the commissioning parents sooner or later will unveil her secret surrogacy endeavour with its repercussions. Never-the-less the commissioning parents sent extra money for her at the ART clinic which she collected from there.

Overall, while surrogate mothers painted a personal character of their relationship with the commissioning parents, they were aware of the higher power commissioning parents had in determining the nature of their relationship they shared with the surrogate mothers. Women could only hope for a fulfilling relationship but could not demand it.

Handing away the surrogate child. Women (39%) experienced an intense sense of attachment with the foetus. Among the experienced surrogate mothers who had completed at least one surrogacy arrangement and had relinquished a child, 60 percent shared experiencing a sense of loss and sadness at the time of handing away the baby. Similarly, 17 percent of the first-time surrogate mothers nearing their delivery anticipated that experience of handing away the child would be difficult for them because of the sense of attachment they had developed with it during gestation.

Overall, the primary barriers women experienced during the course of surrogacy spanned across familial, social and clinic contexts. Narratives of women also revealed facilitators aiding their surrogacy journey which are described in the next section.

Facilitators that eased surrogacy journey for women.

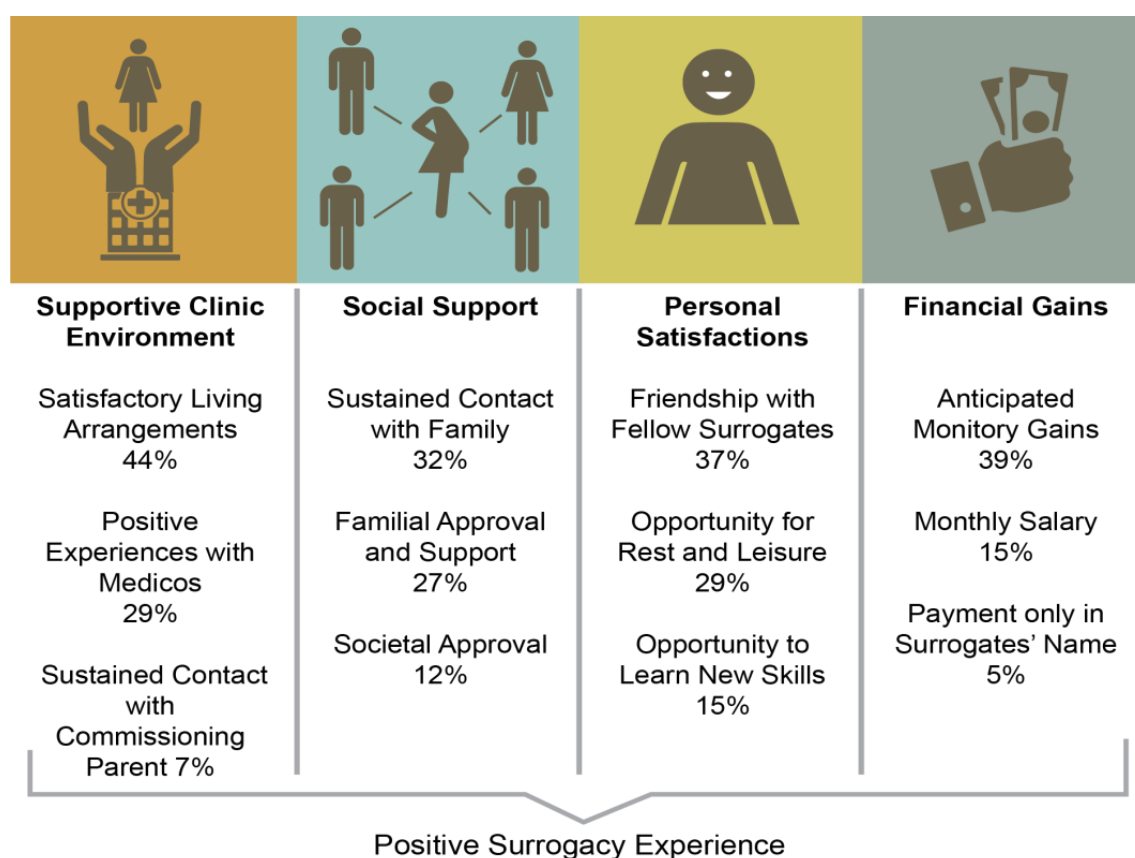


Figure 26. Facilitators during surrogacy.

Along with the series of barriers that women experienced, certain facilitators eased the women's journey through surrogacy. These facilitators could broadly be organised as supportive clinic environment, availability of social support, personal satisfactions during surrogacy, and financial gains earned (Figure 26).

Supportive clinic environment. In general women viewed the ART specialist in a positive light for creating an opportunity for the surrogate mothers to break the cycle of poverty and giving them monetary resource to ensure a stable and secure future for their children. Women (29%) explicitly shared that they experienced a positive and satisfying relationship with the medical practitioners. Stories of the medical practitioner's efficiently handling medical emergencies and life threatening situations for the surrogate mothers in past were frequently retold by the experienced surrogate mothers. Situations like these and the income earned through surrogacy made surrogate mothers equate the medical practitioners with God. Surabhi (34 years) a first-time surrogate mother expressed, "For us Madam is great, like God, because of her we progressed. She opened this clinic because of which we became happy."

Aapda madam saara che, bhagwan jewa che, etle emna lidhe aapde aagd wadhiya. Emne aawu kholi dawakhane toa ame aatla sukhi thaya.

In a way, unquestioning faith in the healing powers of the medical practitioners relieved some stress off the minds of surrogate mothers.

Generally, women (44%) expressed satisfaction about the quality of the residential facility provided and timely availability of meals (except taste of food). Some also found it convenient to keep their surrogacy endeavour secret. A generic response about the living arrangements included,

All facilities are good here, in winter hot water is available, toilets have running tap water for 24 hours and it is cleaned twice a day. Sweeping and

mopping is done. Lights and fans are available all 24 hours. Bed and bedding is provided. All facilities are good. We get food on time. In the morning, they give milk, breakfast, fruits. Everything is good. Along with dinner they provide milk.

Ahiya suvidha baddhi sari che, thandi ma garam paniche, sandas ma chowees kallak paniche. Be time saaf kari ne jay. Kachara potu kare che. Light pankha chowees kallak. Sui rehwanu, gadlu palang ane odhwa mate chadar aape che. Baddhi suwidha saari che. Time sar tiffin aawe che. Sawar ma doodh, nasto aape. Fruit aape agyarwage. Baddhu saaru j che. Sanje bhee doodh aape che tiffin saathe.

Table 6.

Positive Surrogacy Experience by Nationality of the Commissioning Parents

Surrogacy Cycles	Nationality			
	Indian	NRI	Foreigner	Total
First Surrogacy	8	5	8	21
Second Surrogacy	2	4	3	9
Total	10	9	11	30

Note. N=57 surrogacy cycles undertaken by 41 surrogate mothers interviewed

For 53 percent of the 57 cycles surrogate mothers reported a satisfactory positive relationship with the commissioning parents. Table 6 presents nationality of the commissioning parents with whom surrogate mothers reported a positive experience. The enabling conditions for satisfaction of the surrogate mothers included commissioning parents treating them humanely, maintaining sustained contact during and post surrogacy and caring for the surrogate mothers. Narratives of the women were analysed to cull out these enabling conditions (Table 7).

Table 7.*Enabling Conditions for Satisfactory Relationship with the Commissioning Parents*

Enablers of Satisfaction	Indian	NRI	Foreigner
Humane Treatment	10	9	16
Expressed gratitude	2	1	3
Treated as equal and worthy person	2	1	1
Shared Gifts	3	2	4
Referred each other's children as siblings	0	1	1
Paid money despite ET failure	1	0	2
Allowed stay at home during gestation	0	1	0
Allowed contact with the baby	1	1	2
Expressed willingness to sponsor foreign education for surrogate's child/ foreign visit for her family	0	1	2
Expressed willingness to share snaps of the child/ visit with child in the future	1	1	1
Sustained Contact and Care during Surrogacy	6	5	4
Maintained contact and provided support during institutionalisation	5	4	2
Provided post-natal care and support	1	1	2
Sustained Contact Post Surrogacy	1	1	6
Maintained telephonic contact	1	1	2
Continued monetary support	0	0	4

Note. n=30 surrogacy cycles in which surrogate mothers reported satisfactory relationship with the commissioning parents.

Table 7 indicates that the key elements contributing to the satisfaction of surrogate mothers were consistent irrespective of the nationality of commissioning parents. Though, surrogate mothers shared more instances of foreign nationals treating them humanely and continuing contact post-surrogacy.

Overall, humane treatment involved commissioning parents treating surrogate mothers and their family members as equal during interactions, acknowledging

efforts of the surrogate mothers, expressing gratitude, referring to the surrogate mother's child as a sibling of the child born through surrogacy, and expressed willingness for continued association in a couple of cases. In an instance NRI commissioning parents also approved surrogate mothers stay at home for the first four months of surrogacy. Commissioning parents interacted with surrogate mothers and their family members with respect, fondly enquired about her children, paid some cash even when pregnancy report failed, and offered monetary help in the crisis times like hospitalisation of surrogate mother's child for illness detected. Commissioning parents communicated their satisfaction to the surrogate mother, and appreciated her contribution. Some expressed their gratitude through generous gifts in cash and kind beyond the specified terms of the surrogacy contract that they had signed with the surrogate mother.

Indian or Indian origin commissioning parents were more likely to maintain direct regular contact with the surrogate mothers and enquire about their health and nutrition, satisfaction with the living arrangements and facilities provided at the clinic, need for any support financial or otherwise, and well-being of her own children. They visited at the time of sonography when possible and ensured adequate care for the surrogate mother. Geographical distance and linguistic constraints severely curtailed contact and communication between the surrogate mother and the commissioning parents. A few foreign nationals enquired about their surrogate mothers' well-being over email and telephonic contact with the medical practitioners. Sheela (25 years) first-time surrogate mother shared that her Indian commissioning parents based in Pune maintained regular contact during surrogacy, "I got nice commissioning parents. They would visit me every month and gave me so many things, dress for me, things

for my daughter. Throughout nine months she got me almonds, cashew nuts, butter milk etc. Commissioning parents took very good care of me.”

Mane party hi sari mali. Mane dar mahina malwa hi awatee hati ane mane ketalee baddhi vastu aapi, mane dress pachi mara baby mate baddhu aapta hata, pachi badam, kaaju chaach baddhu laawata hata mane nav mahina. Partiwala ae poori rite baddhi mari vyavstha sari rite kari hate.

Post-delivery, commissioning parents enquired about surrogate mother's recovery, at times offered help with post-partum care, and fed them nutritious foods. They allowed surrogate mothers to contact and play with the surrogate infant and a few also allowed them to directly breastfeed the baby. Bhagwati (35 years) a twice surrogate mother shared that her NRI commissioning parents during her first surrogacy supported her throughout institutionalisation and cared for her post-delivery.

My commissioning parents were too good. They were very nice. After delivery, they lived with me for one month. They had kept me with them for a month. I don't have a girl child of my own, therefore she allowed me to breast-feed her baby girl. I gave some gift for the girl and they took it with them. They kept me for one month, made me eat nutritious foods so that my body will recover well and I will not suffer. They still call up and let me hear children's voice. My commissioning parents tell me not to become a surrogate again because I am so thin. They don't know yet that I am here for another surrogacy.

Bahu saara hata mara partiwala. Bahu j saras hata ae. Mane delivery pachi ek mahina mari saathe rahya. Mane saathe rakheli emane. Mahina sudhi saathe Raakhee, mane mari potanee baby natee ne, toa emni baby mane

doodh peewdawa mate aapta hata. Baby mate kai gift aapi toa ae loko lai gaya. Mahino rakhi khoraki karai mane. Saru khwadaywu, etle taru sharir whaysatheet thay ke. Tane kai takleef na pade. Atyare bhi phone kare che. Ae loko, chokrao ni awaj sambhdawe. Mara partiwala ke ki have tu surrogate wadhare na banes. Tara ma su che tu aatlee baddhi patali che. Toa hu farethi bani ae aju ae loko ne khabar nathi.”

Foreign commissioning parents were more likely to maintain contact with the surrogate mothers post-delivery, mostly through the clinic. In rare cases where surrogate mothers' spouse or children could understand English, contact was maintained telephonically. Reshma (35 years) a twice surrogate mother shared how her Canadian commissioning parents from her first surrogacy maintained contact with the medical practitioners and continued monetary support to her.

Some time back, around 5-6 months back, they sent me INR 35,000 from there. And they had given me INR 50,000 cash in hand. They helped. They still remember me, when they call madam she tells, ‘your commissioning parents had called, and they remembered you.’ I feel good. I feel glad, that they remember me.

Ae toa hamana vacche paanch cha mahina pahle mane patrees hajar tyaathee moklaya. Ane pachas hajar em haath ma rokda aapela. Em toa madat kari emne. Atyare pan yaad kare, madam na pase phone aawe ne toa kahe mane ke tara partiwala no phone aawelo. Yaad karta hata. Toa saru lage aapn ne. Khushi thay ke chalo yaad karta che.

A few surrogate mothers also reported commissioning parents making promises of returning and introducing the surrogate child to the surrogate mother

and/or sponsoring surrogate mothers' family visit abroad and/or foreign education for her children.

Social support. Support in the form of familial approval and support for participation in surrogacy, sustained contact with the family during surrogacy and social approval for surrogacy facilitated surrogacy journey for 51 percent women. Thirty-two percent women reported that the approval of family members for surrogacy and support in childcare eased their worries during institutionalisation. Dhara (25 years) a second-time surrogate mother shared, “my mother-in-law said, you go. I will handle everything. You are doing it for your son, then I have no problem. My mother-in-law does all the chores. She was happy.”

Mara sasu toa ae j kehta hata ke tu ja, hu baddhu karish. Tara baba mate kare che ne toa mane kai wandho nahi. Mara sasu toa baddhu kaam kare che. Ae toa khush thata hata.

Sustained contact with family during surrogacy was reported to be helpful by 27 percent surrogate mothers. Visits by family members gave women a sense of belongingness and helped them manage feelings of alienation and homesickness. Bhagwati (35 years) a second time surrogate mother shared, “family members along with children can visit once a week on Sundays. It feels good, it feels like we have someone our own.”

Ravivare malwa de che athwadiya ma ek waar baalko saathe. Saru lage, evu lag eke potanu koi che.

Twelve percent surrogate mothers shared surrogacy being a well-known practice in the villages they came from and the resulting absence of stigma facilitated their positive surrogacy experience.

Personal satisfactions. Participation in surrogacy offered women a rare opportunity to relax, rest, and spend time at leisure without any responsibility of running a household or caring for children. Some women (27%) reported making the most of this opportunity and enjoying their time with the fellow surrogate mothers. Surabhi (34 years) a first time surrogate mother shared, “I like it, and I am living life of a hostelite that’s why I like it (laughs). I only eat, sleep and watch TV (laughs).”

Game che ne, hostel ni life jiwani male che etale game che (laughs). Bas khavu peevu, sui rahu, ane TV jou, sui rahu (laughs).

At the surrogacy hostel, interested women (12%) also enjoyed an opportunity to learn new skills like *mehendi* (making henna patterns), beauty courses, tailoring and embroidery. Surrogate mothers (14) reported forming friendships with fellow surrogate mothers and enjoying their time. Sapani (32 years) a twice surrogate mother shared, “I love it. Won’t one love it? I eat, rest and watch TV (laughs). I joke and have fun with others. Once we make friends then its all fun. If one is lonely one doesn’t like it.”

Maja padi gai mane toa. Maja j pade ne? Bas khai pi ne aaram karwano. TV jowano (Laughs). Majak masti karwani. Friends baddhi bani jaay toa maja aawe pachi. Ekala ekala hoy ne toa na fave.

Regular monthly salary and anticipated monetary gains helped women make sense of their participation in the surrogacy.

Key Take Aways
Surrogacy Journey a Roller Coaster Ride

- The primary barriers women experienced in the context of family and society included alternative childcare arrangements for own children during institutionalisation, conflicts with spouse and family over the decision to participate in surrogacy and the social stigma. Barriers women experienced at the clinic were alienation from the family, medical regimen and health challenges, extensive care work, limiting experiences with commissioning parents and fear of loss of pregnancy.
- Inadequate or excessive contact with commissioning parents during gestation, linguistic barriers, ‘womb envy’ (Berk 2015), and unsatisfactory closure of the surrogacy were primary challenges reported with the commissioning parents.
- Women’s positive experiences with the commissioning parents outnumbered negative experiences. Supportive clinic environment, social support, personal satisfactions, and financial gains contributed to a positive surrogacy experience for women.
- It appeared that micro-context of women especially; stability of their marital relationship was a crucial for a positive surrogacy outcome.
- Need for professional counselling and guidance was evident for addressing varied issues like sharing of failed pregnancy report, inadequate psychological preparation of women for surrogacy, miscarriages, repeated failures, ideal time to discontinue embryo transfer cycles, alienation during institutionalisation, coercion from family and the financial management post-surrogacy.

The Mother or the Other? Creation of the Surrogate Role.

The medical practitioners, surrogacy agents, and the experienced fellow surrogate mothers greatly shaped formation of the surrogate role and maternal identity through a carefully propagated discourse. The discourse aimed to ensure success of surrogacy arrangement – attainment of a live birth and relinquishment of the infant born. The concept of '*Dava Goli Nu Balak*' (a child born through medication) placed the stigmatised surrogacy work within the moral realm, encouraged participation of women in surrogacy and ensured extensive care work by the women which was necessary for the survival of the foetus. While women embraced this new form of work, deep-rooted cultural mentalities associated with the maternal identity were rendered resistant to change.

“Dava goli nu balak”: Idealising the surrogate role. A central theme that kept reoccurring in the narratives of women was that of '*Dava Goli Nu Balak*', in the literal sense, 'a child conceived through medication.' Women used the concept to legitimise their participation in surrogacy, to make sense of the rigorous medical regimen and the associated care work they engaged in. Use of the concept was also prevalent amongst surrogacy agents as well as the medical practitioners. The concept served distinct purposes for the multiple stakeholders involved in the surrogacy arrangement.

Surrogate mothers construed '*Dava Goli Nu Balak*' as '*krutrim*' meaning an 'artificial' entity mainly because conception involved medical procedures as against natural mating. The 'artificial' was invariably considered 'fragile' which in order to survive required extensive medication and careful monitoring of the diet and mobility of surrogate mothers. Despite its 'fragile' character, '*Dava Goli Nu Balak*' was considered invaluable for the huge monetary investments made in it by the

commissioning parents, the medical practitioner's reputation at stake, and the innumerable unfulfilled dreams of the surrogate mother and the commissioning parents that vested in the survival of the 'artificial'. Medical practitioners orchestrated success of the surrogacy arrangement through careful management of multiple stakeholders.

The surrogacy agents, as well as the medical personnel, carefully used the '*Dava Goli Nu Balak*' discourse to legitimise surrogacy. They emphasised involvement of the medical procedures in the conception and the asexual nature of surrogacy to encourage participation of women. Surabhi (34 years), a first-time surrogate mother and a nurse by profession shared, "our neighbour had been a surrogate here. I came to know about it from her. She also explained that there is nothing (morally) wrong in surrogacy. Everything happens through medication."

Amara bajumathee ek ben aawela pahela ahiya, surrogate banela. Etale emna dwara jaanyu ane emane samjhayu pan ke surrogacy ma beeju kai khotu nathi, baddhu dawao dwara thay che.

Grace (32 years) a first-time surrogate mother and a teacher by profession remembered the initial counselling session where medical practitioners explained to her asexual nature of surrogacy. She shared, "madam had shared that it's true, that one can get pregnant through medication, when seeds are placed and fertilised one gets pregnant and the foetus is formed in our womb but through medication without sex. All this happens through medication."

Madam ne bhi bataya tha ke yah baat sach hai. Ke dawai se aisa pregnancy rahatee hai, beej daalte hai toa falit hote hai toa pregnancy taktee hai, garbh dharan hota hai apni kokh me lekin dawai se, bina sex kiye. Dawai se hota hai yah sab.

Medical practitioners distinguished the ‘artificial’ from the ‘natural’ to subdue maternal identity of the surrogate mother and thereby her resistance to relinquishment of the new-born – a risk for the successful culmination of a surrogacy arrangement. They highlighted an absence of the genetic material of surrogate mothers and their spouse in conception and reduced the role of surrogate mothers as mere providers of womb space. Lack of a genetic link with the foetus scientifically negated maternal identity of the surrogate mothers. Sheela (25 years) a former agricultural labourer and a first time surrogate mother attempting embryo transfer recalled her initial interaction with the medical practitioners. She was briefed that she had no contribution in conceiving the surrogate foetus other than her blood (which nourished the child) and she was a mere provider of a womb. Sheela said, “She told me, ‘seeds are of commissioning parents and from your body it’s only your blood. You have no rights over the child. There is nothing yours in it.’ It involved only renting my womb. We were explained all this.”

Emane kidhu ke partiwala na beej hoy ane khali tamaru toa andar sharir ma khoon eklu j hoy tamaru. Ane balak ma tamaro kaso haqnahi. Ema toa kassu tamaru nahi’ khali kokh j aapde bhade aapwani hate. Evu amare baddhu samjhaywu hatu.

Isha (30 years) a former homemaker and a first-time surrogate mother shared how the medical practitioner had warned her against developing any sense of attachment towards the foetus, “First of all, madam explains, ‘do not consider this as your own child, don’t think that it’s mine. Think of it only as you have rented (your) womb.’”

Madam pahela j samjhawe che ki ae tamaru baalk bilkul tame ae gansoj nahi ke aa maru che. Kokh bhade aapi etlu j wicharwanu.

In one of the preliminary counselling sessions observed, the medical practitioner began the session by stating, “What is surrogacy? It means that the child is not yours.”

Surrogacy etale shu? Balak tamaru na hoy.

Such narratives distancing the surrogate mother from the foetus were common in the interactions that surrogate mothers had with the medical practitioners and the surrogacy agents. Certain practices at the clinic too were indicative of distancing the surrogate mother from the child. Women underwent regular ultra-sound examinations, however were denied the opportunity to view images of the growing foetus/es. The practitioner maintained eye-contact and dialogue only with the commissioning parents, even when medical procedures were performed on the surrogate mother. Pooja (39 years) a first-time surrogate mother described her ultra-sound examination conducted in presence of the commissioning parents as follows,

They (commissioning parents) came inside (the room) at the time of sonography, (the specialist) was showing the inside (of my womb) they were watching it and were smiling. I couldn't see it though! It (the screen) is kept like that; it (the screen) is not in front of us therefore we can't see anything. If it (the screen) is not kept in front of us then obviously we can't see it! We only experience that the sonography is being done.

Ae sonography na wakhate andar aawela toa jota hata, toa andar nu batawata hata toa ae loko hasata hata. Mane toa na dekhay ne! Aam mukelu hoy, aapada saame na hoy toa aapan ne na dekhay. Toa saame na hoy toa aapan ne toa na j dekhay ne! Aapan ne khali khabar pad eke sonography kare.

Other distancing practices surrogate mothers reported were immediate segregation of surrogate mothers from the new-born that was immediately shifted to the neonatal

for ‘to care’ included ‘*kalaji lehwani*’ and ‘*dhyaan rakhwanu.*’ Women shared that the commissioning parents laid great trust (*wishwas*) in them while appointing them for this work, and therefore it was critical that they adhere to the prescribed rules and regulations (*niyam* and/or *bandhan*) during surrogacy.

Another set of words which appeared in Figure 27 was linked with the ‘fragile’ nature of the surrogate foetus conceived. Words like bleeding, miss (miscarriage), ‘bagadee’ (get spoiled), ‘bagaad’ (to spoil), ‘nuksaan’ (loss), and problem referred to miscarriage which was associated with feelings of tension, ‘chinta’ (worry) and ‘dukh’ (sorrow). Women revealed experiencing anxiety about miscarriages and associated financial loss which motivated them to undertake extensive care work. Vishakha (29 years) a former agricultural labourer and a second-time surrogate mother justified institutionalisation to ensure extensive care work for the survival of the ‘artificial’ and ‘fragile’ foetus. In her words, “Here (one needs to) take rest and take care of health. This can’t be considered natural, this is artificial. Therefore, it can suffer miscarriage any time if one works. Therefore, we are put up here only to rest.”

Ahiya gadi aaram karwani ane tabyat sachwani. Ane aa toa kudratee na kahway ne krutrim kahway. Etale game tyare mis thai jay kaam karie toa. Etale ahiyagadi aaram j karwa raakhe.

Hiteshi (35 years) a former domestic help and a second-time surrogate mother described uncertainty experienced by women during surrogacy, “This (child) of medication is such that needs utmost care and requires taking rest. Suddenly, bleeding may start while talking or laughing. Therefore, this pregnancy of medication needs utmost care. One must rest and take medication on time.”

Aa dawa nu evu che ke bahu j sachawu pad e ke aaram karwo pade. Achank j em hamna waat karta hoy, hasta hoy ane pache, achanak j bleeding thai jay. Etale aa dawanu pregnancy ae che, bahu sachwu pade che ema. Aaram j karwo pade, time sar dawa lehwee pade evu che.

Rukshar (32 years), a second-time surrogate mother and a former nursemaid (*aayah*) at a nursing clinic shared the anxiety women experienced which motivated them to adhere to the restrictions imposed, “This is a child conceived through medication therefore we have to take utmost care. In this, when we get up or sit up, (we) feel like it can cause problems (anything can go wrong). By the time (we) complete nine months and give away the baby, we do experience some anxiety.”

Aa toa dawa goli nu che toa aapde puru dhyaan devu pade. Ane aama aapde upade ke bessu toa aam thashe ki kai problem thai jashe. Pura nav mahina jyaasudhi bacchu naa aapi tya sudhi thodu tension toa rahe j che.

When asked what does caring for the surrogate child involve, women mentioned various rules and regulations, mainly of two types, restrictions over mobility to ensure complete bed-rest and dietary restrictions to avoid miscarriage thought to be induced by certain foods and infections caused by street food. Balanced diet was recommended to promote optimal growth and development of the foetus. Restrictions over mobility involved avoiding exertion and vigorous movements like climbing stairs or even frequently getting out of bed and moving around and practicing sexual abstinence. Women were advised against taking a head bath, carrying any heavy load, were prevented from making home visits during surrogacy and discouraged to bring their children at the hostels. Grace (32 years) a former teacher and a first-time surrogate mother summed it all in her narrative,

In own pregnancy, one can do any work, lifting load and all household chores. One can also have sex with husband during pregnancy. But here, you can't do any of this. There is no work here. Eat medicines and tablets, have food and sleep, rest. Don't venture out much, don't work much, and don't sit upright for long. Why? One may start bleeding, there are chances. It's (foetus) made of medicines (Dava Goli). That's why we must live like this. We have to take a lot of care. We can't eat a lot of things like chicken, eggs as they increase body heat. We can't keep our child here (with us). Doctor had said yes to bring my child here but in a bed this small, I can't sleep along with my son, what if he kicks me while asleep? If he would not sleep in the afternoon, plays and creates noise then other women will get disturbed, thinking all this I decided against bringing him here with me.

Khud ki pregnancy me apne kuch bhee kaam kar sakte hain. Wajan uchkana, ghar ka sara kaam kar sakte hain. Ek samay apne husband ke saath sex bhi kar sakte hai tum log pregnancy main. Lekin yaha aisa kuch bhi nahi kar sakte. Yaha kuch kaam nahi. Dawa khao, dawa goli khao, tiffin khake so jav, aaram. Bahar bhi jyada mat jav, jyada kaam mat karo, jyada baithe mat raho. Kyo? Bleeding ho jaegi, sambhawana rahatee hai. Dawagoliyon ka rahata hai isliye eisa hi rahana padta hai. Bahot sambhalna hota hai. Aur jyada kuch kha bhee nahi sakte. Nonveg nahi kha sakte, chicken nahi kha sakte, anda nahi kha sakte. Garam padta hai na isiliye. Yaha nahi rakh sakte hai bachhe ko. Doctor ne ha bola tha lekin itane palang main mai nahi so sakte na use leke, mujhe laath waath maar de nind main. Meri wajah se dusare kisi ko disturb ho, wo dopahar ko nahi soega, aawaj karega khelega toa. Toa yah sab sochke maine na bola ke nahi rakhana hai isko.

Surrogacy agents served as a link between medical practitioners and the new surrogate mothers. They guided as well as managed behaviour of the newly recruited women to ensure success of the surrogacy arrangement. Surrogacy agents were paid for their services only after the woman they introduced handed away the baby to the commissioning parents. The agents to some extent were also held responsible for the behaviour of the surrogate mother they introduced. Pipasa (25 years) a second-time surrogate mother had introduced Yashshree (26 years) a former textile mill worker for surrogacy. Overwhelmed and homesick, Yashshree left surrogacy hostel premises without seeking permission of the medical practitioner and stayed with her family for a couple of months during pregnancy. Pipasa expressed her dissatisfaction with Yashshree's behaviour and presented the episode from the perspective of the medical practitioner. Her narrative exemplifies how medical practitioners manage newly recruited surrogate mothers through surrogacy agents.

When she left for the first time, I received a phone call (from the clinic). Even I got angry. Then I told them, that we must cajole her and manage until she delivers (the baby). She went home now, if something happens who will be responsible? What will madam tell to commissioning parents? She too is answerable to them as they spend so much money on us. Then they question madam that 'after spending so much money what did you give us? What kind of treatment do you offer? When she was staying with you how did the treatment fail?' Isn't it difficult for her to answer all these questions?

Pahliwar ghare kidha wagar jata rahya hata. Toa pachi mara upar phone aaya hata. Ane mare bhi gussa aai gaya hata. Pachi main kidhu jo ene patai ne rakhwee padshe jab tak na thay evu che ne. Atyare ae ghare gaya. Agar kasu thai jaay toa kon jimmedar che? Ae madam partiwala ne su jawab

aapshe? Ene bhi saame jawab aapwu pade ne kem ke ae ketala paisa kharcha kare aapdi maate? Pachi parti madam jode kheejway ke 'aatla baddha paisa kharchi ne tame amne aaje shu aapyu? Tame kevi treatment karo cho? Tame kahe ke beno tamari jode ahiya rahe. Toa tamari jode raheene pan kevi rite case bagadi gai?' Pachi madam ne jawab aapwanu agharu padi jaay ne?

The agents and experienced surrogate mothers at the clinic/ hostels also played a vital role in the surrogacy management by anchoring on the concept of '*Dava Goli Nu Balak*' and 'fragility' of the fetus conceived to informally propagate rules of conduct amongst the new surrogate mothers. The informal discourse set out subtle guidelines about what constituted an appropriate and inappropriate behaviour for the surrogate mothers.

In sync with this carefully crafted discourse, surrogate mothers used the concept of '*Dava Goli Nu Balak*' to justify the morality of the surrogacy work to their spouse, extended family members and in rare cases to members of the immediate society they belonged to. The absence of sexual activity in the surrogacy arrangement helped surrogate mothers see themselves in a positive light while they engaged in a fairly novel and unusual process of surrogacy. The 'artificial' nature of the fetus conceived allowed them to distance the fetus as 'not fully theirs' and eased the stress of selling an own child for money. At the same time, 'fragility' of the artificially conceived fetus required surrogate mothers to care for the fetus as their own. The concept of '*Dava Goli Nu Balak*' juxtaposed non-maternal and maternal identity of the surrogate mothers pushing them to idealise the surrogate role. Figure 28 projects multiple dimensions of the ideal surrogate role that appeared in the narratives of the surrogate mothers. The surrogate mothers strived to abide by the formal and informal rules of the setting and demonstrated a moral obligation for successful completion of

the surrogacy. Surrogate mothers construed surrogacy as an important job for which they were hired and laid great emphasis on fulfilling all their duties, especially towards the fetus.

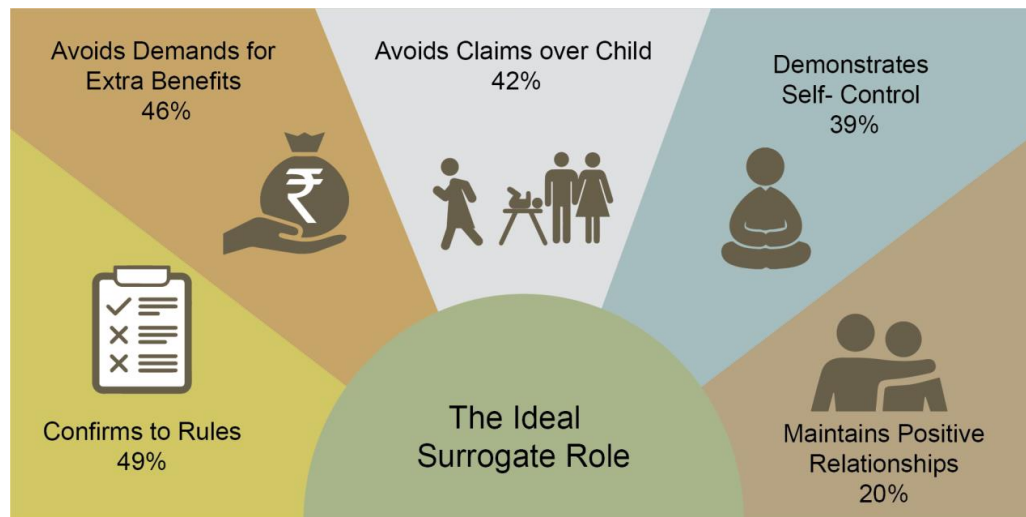


Figure 28. The ideal surrogate role.

N = 41 surrogate mothers

Kalika (35 years) a former agricultural labourer and a first-time surrogate mother shared, “I will fulfil my responsibility for nine months. I am taking much more care than they would have. I am not eating inappropriate foods; I take good care of myself. I should do well for these people.”

Main toa mari faraj no mahina sudhi ni poori thai jashe. Emana karta hi hu wadhare saachwu. Etale kasu hi awaru chindu khaati nahi. Hun bahu kaaljipurvak rahu chun. Mare ae loko nu bhalu karwanu.

The ideal surrogate was expected to be satisfied with the financial terms set out in the surrogacy contract and to avoid seeking any additional benefits in cash or kind from the commissioning parents. Most of the surrogate mothers were, therefore, cautious about articulating their needs and preferences to the commissioning party with a few exceptions and expressed concerns over negative repercussions of communicating their needs. Surrogate mothers downplayed the need for any external

assistance from the commissioning party. Grace (32 years) a former teacher and a first-time surrogate mother explained,

She (commissioning mother) tells me, you can order whatever you want; tell us what you feel like eating. But I don't ask for anything. What can I say? Say, I feel like eating pickles, sour pickles. How much does a packet of sour pickle cost? 25 rupees or 50 rupees. If I ask for it over a phone call what will she think of me? Won't she judge me, 'What kind of person does not spend as much for self?'

Wo bolte hain jo bhi mangawana hai, jo bhi khana hai tum bol doa. Lekin mai nahi boltee. Kya bolne ka? Mujhe chalo achar khane ka man mujhe ho gaya, khatta achar. Khatta achar ka packet kitne rupaye main aata hai? Pachhis rupaye ya pachas rupaye me aa jata hai. Toa main aisa phone pe bolungi toa wo kya sochege? Meri kimmat karegi na? Ye kaisi hai? Itana bhi kharch nahi kar saktee apne liye?

Though surrogate mothers experienced a maternal bond with the baby, they avoided any explicit claim over the baby. Sheetal (26 years) a former homemaker and a third-time surrogate mother explained it as, "right from the time of transfer, we are aware that nothing is ours. Some attachment develops but it is alright. There is no point taking utmost care for nine months and then cry over handing away the baby, it doesn't look good."

Pahela thee j aapn ne jyare transfer karawe tyathee j aapan ne khabar toa hoy ke aapdu kasu che j nahi. Pan thodi ghani lagnee bandhai jaay pan kasu nahi. Jeev bari ne pan na chale ne nav mahina aatlu sachweene mukhe ne pachi radi ne aape toa pan saaru na dekhay ne?

Berk (2015) concluded that ‘legalisation of emotion’ in the U.S. based surrogacy programmes whether enforced or not was ‘influential and institutionalising.’ In this study, the medical practitioners and surrogacy agents were found to carry out such ‘legalisation of emotion’ through informal discourses that guided and shaped ideal behaviour of the surrogate mothers. Surrogate mothers narrated great self-control they demonstrated while they controlled their urge to visit home during institutionalisation and following a strict diet for the good health of the baby. Idealising surrogate role also involved maintaining positive relationships with the fellow surrogate mothers, medical practitioners, as well as commissioning parents.

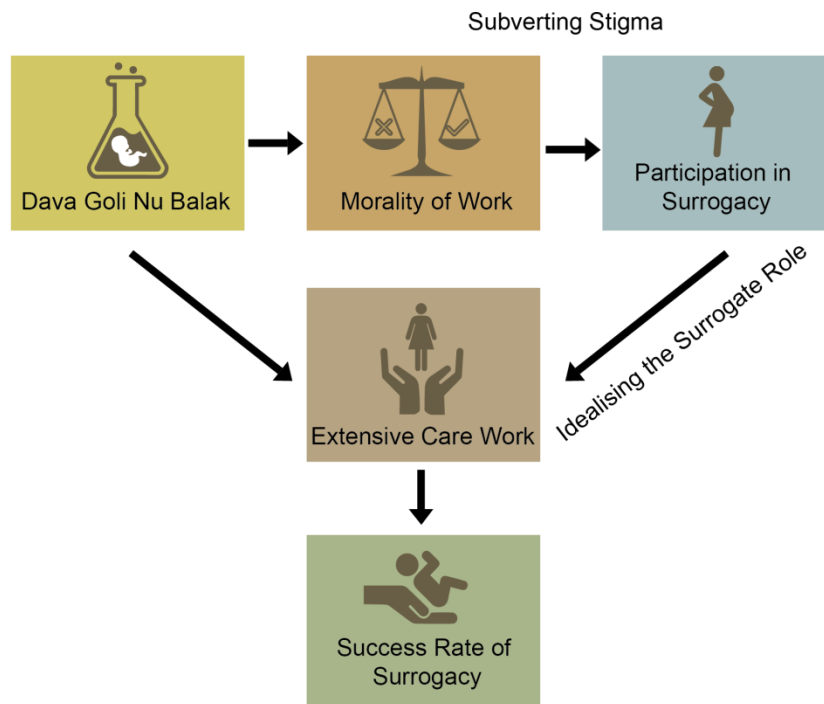


Figure 29. Management of the surrogacy enterprise.

In summary, the concept ‘*Dava Goli Nu Balak*’ played a central role in the organisation, management and the success of the surrogacy enterprise as displayed in the figure 29. The ‘*Dava Goli Nu Balak*’ discourse legitimised participation of women in surrogacy by constructing surrogacy as a moral form of work. It negated portrayal of surrogacy as sex work by stressing the asexual nature of surrogacy and

disassociated genetic relationship between the surrogate mother and the foetus thereby challenging the discourse that equated surrogacy with selling own child. When women participated in surrogacy, the ‘fragile’ character of the artificial ‘*Dava Goli Nu Balak*’ required women to idealise the surrogate role by engaging in extensive care work and enhanced the success rate of surrogacy.

Genetic disconnect versus pregnant connect: Maternal identity of the surrogate mothers. The practice of surrogacy placed the mothering ideologies at the crossroads of the scientific and the cultural realms. Medical practitioners emphasised the lack of genetic link between the surrogate mother and the foetus and thereby scientifically defied her maternal identity. At the same time, the surrogate pregnancy was housed in the body of the surrogate mother and her pregnant personhood ascertained her maternal identity. Despite the carefully propagated ‘ideal surrogate role’, women continued to uphold traditional Indian mentalities associated with the maternal identity which found varied behavioural manifestations. Majority of the surrogate mothers (85%) ascertained their maternal identity as ‘one of the mothers’ of the surrogate child if not the primary mother.

Table 8.

Justifications Surrogate Mothers Provided to Assert Maternal Identity

Justifications	Surrogate Mothers (%)
Extensive care taken for survival of the foetus	71%
Act of giving birth	71%
Feelings of attachment	49%
Pain endured during surrogate pregnancy	27%
Nourishment provided through shared blood	22%

Table 8 displays justifications surrogate mothers provided when they asserted a maternal identity in surrogacy. Women justified their maternal identity based on the

extensive care work they did for over nine months, through the intense attachment (*lagani*) that they experienced with the foetus, through the pain they endured during surrogacy, through the shared blood that nourished the foetus, and through the process of birthing. Surrogate mothers relied on several cultural constructs to justify their maternal identity. The commonly used cultural constructs included *Daan* (alms/gifts), *Punya* (noble act), mythological characters of ‘Devaki’, ‘Yashoda’ and ‘Lord Krishna’, and local theories of reproduction as ‘the seed and the earth’.

Daan (alms/gift). Surrogate mothers (17%) referred to relinquishment as a ‘*daan*’ – in the literal sense ‘alms’. A similar finding was reported by Ragone (1996) in an ethnographic study of six surrogacy programmes in the U.S. wherein surrogate mothers construed relinquishment of the surrogate child as a ‘gift’ to the commissioning parents. Ragone explained that the discourse of gift giving helped surrogate mothers to add a personal value to their relationship with the intended parents which would otherwise remain a purely commercial transaction.

Essentially, a ‘*daan*’ involves giving away something that one rightfully owns and is considered as a ‘*punya*’ – a noble act. The discourse of ‘*daan*’ allowed surrogate mothers to view themselves in a superior position of a ‘giver’ and thereby helped them to overcome to some extent the subjugation that they experienced in surrogacy. The act of relinquishing the infant when construed as a ‘*punya*’ helped them justify its morality. Heena (36 years), a former domestic help expressed,

For the one, who becomes a surrogate mother, it is a good deed and even if she is giving her womb for money, for her it is a good deed (with force). If we have to adopt a child then so many questions come to the fore? And we can’t predict what kind of qualities the child has inherited. What kind of blood

child has? But in this their heart knows that the ‘child is our own’ (with force in voice).

Etle je pote surrogate bane che ani maate evu che ke punya nu kaam che ane bhale hee e ani kok ma ae paisa maate kare che pan ek jaat nu toa daan che j ne! (With great force in voice). Ke aapde dattak lehwaanu hoy che baalak toa ketala baddha prashna udbhave che? Ane te aapn ne ae khabar nathi hoti ke baalak kewa sanskar nikadse? Kevu enu loi hashe? Aa toa ae loko ne man ne evu ke aa amaru j che (with force).

Heena’s narrative demonstrates that despite monetary exchange, surrogate mothers considered relinquishment as ‘*daan*’ because they help the commissioning parents to continue their progeny, to continue their ‘bloodline’. Her comparison of the surrogacy with adoption brought to surface a deep-rooted and disturbing notion about ‘purity’ of blood line and biased perspectives that hinder adoption and drive the surrogacy industry.

Devaki, Yashoda, and Lord Krishna. A few (10%) surrogate mothers revived mythological characters of Devaki, Yashoda, and Lord Krishna to draw parallels with surrogacy. They associated themselves with Devaki – the birthing mother of Lord Krishna – claiming higher stakes over the infant born, while referred to the commissioning mother as ‘Yashoda’ – the adoptive mother of Lord Krishna. Additional 46 percent women referred to the commissioning mother as an adoptive mother of the child, without referring to the mythological characters. Women shared that the commissioning mother had control over whether to disclose surrogacy endeavor to the child and therefore determined the maternal identity of the surrogate mother. Women conceded that possibility of the child born through surrogacy recognising them as a mother was rare and reported coping with this loss of a

maternal status by thinking of their own children. They emphasised that they participated in surrogacy to ensure a better care of their own children, that they were struggling to make ends meet and would fail to care for an additional child. Women also justified the loss by stating that they were aware at the outset that they were hired to gestate and then relinquish the baby. Vishakha (29 years) second-time surrogate mother explained, “One feels sad but must contain one’s mind. We know that we already have our own child; this is their child which we must relinquish. Now-a-days, no one raises someone else’s child. People are unwilling to raise own children, who will keep someone else’s child?”

Dukh thay pan aapde aapdu dil rakhwanu. Aapan ne khabar che aapdu chokaru toa che aapanni jode already, aa toa emnu chokaru che ae toa aapade aapi j dewanu. Ane atyare koi paarku chokaru raakhe nahi koi motu na kare. Potana chokara koi rakhawa taiyar nahi ane parku chokaru koi rakhe atyare?”

Vishakha justified relinquishment by referring to the surrogate child as ‘someone else’s child.’ Women stated that though they gestated the foetus it was not conceived using their husband’s sperm. Therefore, the child did not have husband’s blood running in its body and would not be accepted by their spouse. Women revealed that after reintegration with their family they got busy caring for their own children and got on with their regular life. Minakshi (36 years) a twice surrogate mother shared, “we need money, they need a child. Once we return home (we feel) nothing, once we see our own children, we (forget) any problems. After seeing our children we don’t regret (handing away the surrogate infant). One forgets (the surrogate infant).”

Aapne paisa joyata emane chokaro joyto. Ghare jai ae toa kasu nahi, aapda chokara ne joi ae toa kasu hi wandho nahi. Aapda chokrao ne joe toa pachi jeev na bare. Pachi bhooli jaway.

A few women did not let the memory of the surrogate child fade from their minds either by remaining in touch with their commissioning parents when feasible or by imagining that the surrogate child was part of their own family.

The seed and the earth. Surrogate mothers largely obliterated significance of the genetic link as a determinant of the maternal identity by invoking a traditional understanding of the maternal role as limited to the provider of nourishment (the earth) to the male gamete (the seed). They selectively used this traditional knowledge of patriarchal kinship (Dube, 2001) in combination with the medical discourse equating surrogacy with artificial conception sans sex to reinforce the ‘non-mother identity’ of the commissioning mother. Women claimed that commissioning mother neither involved in sex to ‘naturally’ conceive nor did she ‘gestate’ the foetus through use of medical technology. Grace (32 years) a former teacher and first-time surrogate mother emphasised her own maternal identity stating, “Doesn't Madam put only seeds? But blood, food and fluids isn't everything mine? Then won't my qualities appear (in the child)? Fifty percent? Impact will be there.”

Madam toa beej hi daalte hai naa? Lekin blood, khana, peena, blood sab mera na? Toa mera sanskar nahia aega? Pachas taka? Asar toa aaega.

Kalika's narrative has subtle undercurrents of this theory where she completely overlooked the genetic contributions made by the commissioning mother and firmly believed that she was the ‘real’ mother of the child born through surrogacy because it developed in her womb. Kalika (35 years) a former agricultural labourer and a first time surrogate mother shared, “I feel that the father is different but (the children) lived

in my womb. They will not face any hardships. But they will not come know of their real mother ever. She will raise them, they will see only her, and think that she is their mother.”

*Mane em thaay ke chalo baap juda che pan mara kotha ma toa chokara
rahela ne. Eetale emne dukh kasu nahi padshe pan emni asal maa emane
nahi samajh padshe. Pelli je motta kare e j same ne ke aa amari ma ache.*

This evidence was contrary to the ethnographic findings of Temen (2009) wherein Israeli surrogate mothers engaged in a ‘dyadic body-project’ to distance self from the surrogate pregnancy and establish an unambiguous maternal identity of the commissioning mothers. The evidence also contradicted with Levines’ (2003) findings where experienced surrogate mothers in UK emphasised gestational role of the new surrogate mothers and reinforced the parental identity of the commissioning couple through the online discussion forums. Surrogate mothers in this study, experienced or newcomers, were found to emphasise own maternal identity and referred to the commissioning mother as an adoptive mother. Such a perspective could have stemmed from widely prevalent maternal valorisation in Indian society and could have served a distinct purpose for the surrogate mothers. Asserting maternal identity probably allowed surrogate mothers to view self in a ‘superior’ position of a ‘giver’ while they relinquished the child as a form noble act, ‘punya.’ The ‘sacrifice’ of their maternal instincts might have helped them view their participation in surrogacy as an altruistic endeavour despite monetary exchange involved. In a way, such a perspective could have helped women to resist their objectification at an ideological level and make sense of their surrogacy endeavour.

In departure from this generic understanding, 15 percent surrogate mothers did not claim maternal identity and exhibited a clear understanding of the role that

maternal gametes played in the process of conception. These 15 percent surrogate mothers reported consciously distancing themselves from the foetus early on during surrogacy and refused any experience of intense attachment which helped them cope with the relinquishment of the baby. One even challenged the general discourse that portrayed surrogacy arrangement as a 'daan' or 'punya' by emphasising monetary exchange for the surrogacy services rendered. She shared, "(We) can't be considered Mummy (of the surrogate child) because we did this for money. We kept it in the womb for nine months and then gave birth but the eggs and semen are theirs. Therefore only she can be called a mother."

Mummy etle nahi kahwaay kem ke aapde toa paisa maate karyu che. Kok ma rakhyu ane no mahina ma janam toa aapyo khara pan je beej ne virya toa emnu j kehwaay che ne? Etale emnej ma kahi shakaay.

In essence, with few exceptions, surrogate mothers reinforced their own maternal identity by weaving together indigenous perspectives and selective understanding of the role that the medical technology played in surrogacy. Both indigenous and scientific perspectives were selectively used by the women to obliterate maternal identity of the commissioning mother; albeit with the recognition that the surrogacy contract would eventually lead to the relinquishment of the baby. Despite claiming the maternal identity, surrogate mothers justified relinquishment of the baby by stating the absence of the paternal link between their own spouse and the surrogate child. Neither flawless acceptance of the scientific attitudes towards reproduction nor the rejection of traditional knowledge was reported; rather both the perspectives were selectively used by the surrogate mothers to reinforce own maternal identity.

Key Takeaways

The Mother or the Other: Creation of the Surrogate Role

- The theme '*Dava Goli Nu Balak*' (a child conceived through medication) played a central role in the successful organisation and management of the surrogacy arrangement.
- '*Dava Goli nu Balak*' was construed as 'artificial' (conceived through technology - asexual) and 'fragile' (prone to miscarriage) which required extensive medication and careful monitoring of the behaviour, diet and mobility of surrogate mothers.
- Surrogacy agents and medical practitioners emphasised 'artificial' nature of the '*Dava Goli Nu Balak*' to legitimise surrogacy as a 'moral' form of work and to encourage participation of women in surrogacy.
- Medical practitioners also used the 'artificial' nature of the '*Dava Goli Nu Balak*' to highlight absence of a genetic link between surrogate mother and the foetus thereby negating her maternal identity scientifically.
- Agents and medical practitioners emphasised 'fragile' nature of the '*Dava Goli Nu Balak*' to propagate a fear of miscarriage and associated financial loss amongst surrogate mothers. This encouraged women to strictly adhere to the medical regimen and extensive care-work to ensure survival of the foetus.

Key Takeaways

The Mother or the Other: Creation of the Surrogate Role

- The theme '*Dava Goli Nu Baalak*' juxtaposed non-maternal and maternal identity of the surrogate mothers pushing them to idealise the surrogate role. An ideal surrogate mother confirmed to the rules, avoided demands for extra benefits, avoided overt claims over child, demonstrated self-control, and maintained positive relationships throughout surrogacy.
- Majority of the surrogate mothers (85%) asserted their maternal identity as 'one of the mothers' of the surrogate child if not the primary mother.
- Surrogate mothers justified their maternal identity based on the extensive care work they undertook, act of giving birth, attachment experienced with the foetus, pain endured in the surrogate pregnancy, and the nourishment provide to the foetus through shared blood.
- Relinquishment of the foetus was justified as a '*daan*' (alms) and as a '*punya*' (noble deed) and probably helped surrogate mothers to view their participation in surrogacy in a positive light.
- Almost half of the surrogate mothers referred to the commissioning mother as an adoptive mother of the child born through surrogacy.
- Surrogate mothers selectively used both indigenous and scientific perspectives of procreation to obliterate maternal identity of the commissioning mother; albeit with the recognition that the surrogacy contract would eventually lead to the relinquishment of the child.

Psychological Agency of Women in the Context of Surrogacy in India

Surrogacy is critiqued for its exploitative potential in the macro context of colonisation, neo-liberal profit driven private ART industry, and the hierarchical patriarchal social set-up. Most of the discourse, though geared towards protecting surrogate mothers tends to be patronising and often reduces Indian surrogate mothers to passive acceptors of subjugation failing to acknowledge them as ‘agents.’ Recent academic literature has expressed interest in identifying the ways in which women exercise psychological agency in seeming oppressive conditions. Here, the narratives of surrogate mothers are analysed to explore their exercise of psychological agency, its nature, and conditions enabling or hindering it.

Women’s control over decision to participate in surrogacy. Ahearn (2001) and Duranti (2004) suggested that a keen attention to language and linguistic forms can elucidate micro and macro processes of the agency. While linguistic anthropologists have demonstrated that languages of the world differ in the ways they express agency and delve deep into the analysis of how language and agency make each other up (Duranti 2004); here analysis of women’s narratives is limited to identify their own perceived role in the decision-making to participate in surrogacy. Based on Roland’s (1988, 2001) concept of the ‘expanding self’ - when a predominant ‘we-self’ experienced by the Indians comes in contact with global civilizational forces and social change, it grows in individuation –narratives of women were explored for the degree of individuation reflected. ‘Sentence’ was treated as a unit of analysis and use of singular pronouns like ‘I’, ‘me’, and ‘mine’, as well as plural pronouns like ‘we’, ‘us’, and ‘our’ by the women was examined along with the use of active and passive voice to determine whether women assumed responsibility for the decision to participate in surrogacy or they attributed the decision to others.

The assumption was that the women who played a key role in the decision-making were more likely to use singular pronouns and active voice in their narrations of the process.

Keen attention to the sequence of events during decision-making and involvement of family members and agents at different points revealed the complexity of the process and variations in the experiences of women. Such an analysis of the narratives revealed that majority of the women (68%) played a lead role in making the decision to participate in surrogacy and convinced their often reluctant spouse to permit surrogacy. Less than a quarter of women experienced participation in surrogacy as a mutual decision among them and their spouse (17%) wherein both of them were equally favourable towards participation in surrogacy. A small number of women (15%) suggested initiating surrogacy on request or insistence of their spouse (Figure 30). Overall, most women (85%) appeared to have control over the decision to participate in surrogacy. However, even the slightest forms of coercion experienced by 15 percent women cannot be overlooked.



Figure 30. Role of women in the decision-making to participate in surrogacy.

Of the 68 percent or 28 women who played a lead role in initiating surrogacy, 26 cited resistance of their spouse for one or more reasons (Figure 31).

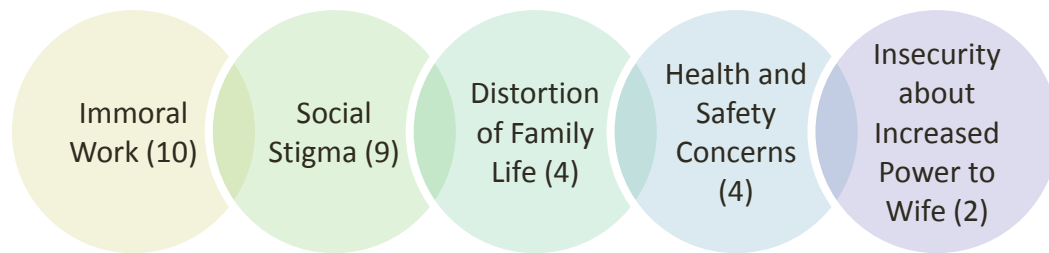


Figure 31. Reasons for spousal resistance for participation in surrogacy.

Note. n=26 surrogate mothers, multiple responses.

Association of surrogacy with sex work and resulting stigma were most reported reasons for spousal resistance to surrogacy. Men anticipated role reversal in the absence of their wives during institutionalisation for surrogacy and resisted participation in surrogacy for the possible distortion of regular family life. Health and safety concerns were articulated less frequently as a reason for spousal resistance, which indicated the possibility of trivialisation of health risks involved in surrogacy. Two women reported that their spouses viewed earnings of women and associated power gains as a threat to their authority within family. Nevertheless, women persuaded their husband and family members for participation in surrogacy.

Narratives of women who played a primary role in the decision to participate in surrogacy revealed their resolve and determination despite resistance of their spouses. Rukshar (36 years) lived in a rental home with her spouse and two children – an adolescent daughter and a young adult son. She worked as an *ayah* (nursemaid) at a small maternity clinic in her town while her husband made irregular earnings as a rickshaw driver. She aspired to own a home, was determined to change the destiny of her son by providing him an Engineering college education and accumulate savings for her daughter's wedding – her primary motivations for participation in surrogacy. At the time of the interview, in the last trimester of her second surrogacy, Rukshar

shared her journey from an initial disbelief about the authenticity of surrogacy when she first heard it to her firm resolve to participate in surrogacy. In her words,

At that time I thought, how can a child be conceived like that? Then I asked my husband, ‘is that true?’ He said, ‘it is possible, I have read such an article in the newspaper. Later one day, I saw in the news that one mother became a surrogate for her daughter who could not conceive. Eventually, the thought struck me, that it is possible. Then **I decided** I will become (a surrogate). At least once, **I will become** (a surrogate) **certainly**.

*Us time toa mere ko vichar aisa aa gaya tha ke aise toa koi baccha hota hai? Fir maine pati ko baat kee ye sahi baat hai? Toa ke aisa ho sakata hai, maine bhi chape main aisa lekh wachela hai. Baad me ek baar samachar me vo sabhi ma ne beti ke uspe nahi rehata tha toa ma surrogate bani thi aisa dekha tha. Baad me mere ko ekdam magaj me aa gaya ke aisa ho sakata hai. Baad me **maine aisa nirnay le liya** ke abhi toa **mai banungi**. Ek baar toa **mai banugi hi**.*

Other than her resolve to participate in surrogacy, Rukshar’s narrative also indicates that she did not accept information received at the face value. She discussed her apprehension about the accuracy of information with her spouse and despite his assurance; Rukshar fully accepted the authenticity of surrogacy only when she saw it in the news. Her experience is indicative of her psychological agency wherein she played an active role in thinking about surrogacy and deciding to participate in it.

Pipasa (25 years), a homemaker and a second-time surrogate mother shared participating in surrogacy against the resistance of her husband. She revealed, “he said, ‘Don’t go. If you earn so much, then you will say these are my things, this is my money, and then I won’t have any value.’ My husband thought, ‘If she tells anyone,

no one will respect me. I won't have any value.' That's why he refused. **Then I said I am going.** Then **I joined** (surrogacy programme).

*Ae ke ki tu na ja. Ke aaje tu etlu kamaine laish toa kale uthine tu mane kaish je toa mara vastu che mara paisa che, toa mari kai value na rahe. Mara mister ae wicharta hata ke, 'ae jaine bolshe toa mara ijjat koi k na rahe. Mare value bhi na rahe.' Toa ae mare eni mate na padi. Toa **me kidhu ke me toa jawani chu.** Pachi **me aai gai.***

Hiteshi (35 years), a former domestic help and a second-time surrogate mother shared that she was inspired when she witnessed newly acquired affluence of her close relative through participation in surrogacy. She too then decided to participate in it. "My sister-in-law became (a surrogate). Seeing her standard of living, even **I felt that I should** become (a surrogate) once. Then **I decided I must** embrace this path (of surrogacy) to happiness."

*Amara bhabhi baniya. Emni paristheeti joi ne **mane pan evi thayu ke hun pan ekwaar banine javu.** **Me pachi evu nirnay karyu** ke bas have sukhi thayu che toa aapde aa rasto apnawo jaruri che.*

These and other similar narratives of women indicated the predominant use of singular pronouns in *Gujarati* like 'hun' (I), 'me' (I) and 'mane' (me) and in *Hindi* including 'main' (I), 'mujhe' (me). The use of verbs in active voice coupled with singular pronouns indicated primary role 68 percent women played in the decision-making process to participate in surrogacy.

The narratives of a few women (17%) involved the use of plural pronouns in combination with singular pronouns indicating a mutual decision among them and their spouse to participate in surrogacy. The plural pronouns in *Gujarati* included, 'ame' (we), 'aapde' (we), 'amane' (to us). A first-time surrogate mother Prerna (22

years) was a professional nurse. Prerna donated her eggs twice to meet her immediate financial needs when she and her husband moved out of the joint family household. During her egg donation stints, she and her husband grew familiar with the ART clinic and gained confidence in the authenticity of the surrogacy process. Prerna narrated her experience as,

A couple of times we donated eggs so we had experienced it all. We knew everything, that the pregnancy through medication was possible. Therefore, we didn't discuss it much. Then my husband said 'if you want to go, it's your will. I am not refusing you.' Therefore, there wasn't much of a discussion or deliberation. Then I was willing and he (husband) was desirous too. Therefore, I came into surrogacy.

Ek be waar toa ame beej aapi aaya toa baddha anubhav thayaa hata amne. Ame baddhi hakikat jaanta hata ke aawee rite dawa thee pregnancy rahe che. Etle ek wishwas aai gaylo amne kena aawee rite aawu thay che. Etle pachi ame bahu charcha nahi kari. Pachi mara mister ne kidhu ke, 'tare javu hoy toa tari iccha. Tare javu hoy toa hu tane na nathi padto.' Etle bahu charcha wichar nato. Pachi mari bhi haa hati ane emani bhi mariji hati. Etle pachi hun surrogacy ma aai.

Sargam (28 years) was a second-time surrogate mother and a homemaker with a young son. Her husband earned INR. 3000 per month as a driver. When Sargam first heard of surrogacy she was interested in it but her son was barely two years old. Her husband could not believe in the authenticity of surrogacy and resisted her participation out of the fear of stigma and in absence of the alternative childcare support. Eventually, after meeting a medical practitioner at the clinic he agreed for participation in surrogacy. Sargam's narrative was neither assertive nor passive; she

took initiative for participation in surrogacy but did not take bold ownership of the decision indicated by the use of personal pronouns in the previous narratives of Rukshar, Pipasa, Hiteshi or Prerna.

At first, he (spouse) argued with me that such things can't be done. When my son became three years old, I asked him again. He told me, 'Let's find out the details first.' We then came to the hospital. Both of us then decided that we should do this work.

Pahala toa ae mane ladta hata ke aavu badhu na karay. Pachi ae thodo motto thayo tran waras no toa hu mara husband ne fari waat kari. Mane emne kidhu ke aapde baddhu janeeae pachi haru. Pachi ame hospital aaya hata. Pachi be jana ae nirnay lidha ke aapde aa kaam kariae.

A predominant use of passive voice in the narratives of six women indicated that their surrogacy endeavour was initiated by others. Such narratives revealed a range of women's experiences from a mild coercion to participate in surrogacy to grave threats for a share in the money they earned through surrogacy in a rare case. Further, narratives revealed that women experienced coercion from both, persons within and outside their family. Though relatively small in numbers, these narratives can have significant implications for the policy.

The narrative of Suman (32 years) a first-time surrogate mother revealed how she was bullied by her extended family members to participate in surrogacy. Suman's husband had lost his leg in an accident, was unemployed and was bullied by his siblings. On persistent nagging by her in-laws, Suman had enrolled her two sons in a residential hostel and had participated in surrogacy. She shared, "These people (relatives) brought me here. They assured me, nothing will go wrong, (I) need not

worry, I must demonstrate courage for (well-being of) my children. **I was sent here** (by them). They **persuaded me** for last two years. **Ultimately, I came** here now.”

*Ae loko **mane ahiya laya.** Ke bheevanu nahi ke himmat rakhi ne jawanu ke chokraona lidhe, em ke kasu thatu nahi. Evi rit na pachi **mane ahiya mokli.***

Be varas thi keh keh karata hata** toa hu **hamana aai bolo.

The predominant use of passive voice in the narrative of Suman indicated that she was pushed into surrogacy by others.

At times, although women took ownership of the decision to participate in surrogacy, their narrative revealed subtle forms of coercion. Ramila’s narrative was one such example. Ramila (26 years) was a homemaker and lived with her husband, two children and parents-in-law in a small town. Her husband, the sole breadwinner of the family drove a rickshaw and earned a meagre monthly income of INR 6500 to support the six-member family. He suffered from a prolonged illness, had mortgaged their home and was in debt. Ramila shared, “My husband’s brother told (him), that’s how (we) came to know. Then **he** (husband) **asked me**, ‘Should we go, we have debt?’ Therefore, I came. We had problems, therefore I agreed. I didn’t think, came because of the debt.”

Mara gharwala na bhaibandh che, toa emne waat kari etle khabar padi.

*Pachi **emne mane puchyu ke ‘aapde jaiye** toa aapadu devu che te?’ **Etle me aawi.** Amne problem hato etale ha padi didhi. Kasu wicharelu nahi, aatala dewa mate toa aya che.*

Although, Ramila stated that her husband ‘asked’ her for participation in surrogacy, whether Ramila was in any position to decline such a request is questionable. In the hierarchical and patriarchal family set-up, a ‘request’ or a ‘suggestion’ of elder men and women may be experienced as moral obligations by

women. In addition, the life context of Ramila also exposed her glaring poverty in which surrogacy may have seemed to her as a last and only resort to escape it.

Initially, during the interview, Pooja (39 years), a mother of two and a first-time surrogate shared that she willingly took up surrogacy. However, later she revealed that her husband had never allowed her to take up any job – until he learnt of the enormous monetary gains involved in surrogacy. Despite being coaxed to enter surrogacy against her will, Pooja defended her husband as a ‘trusting’ spouse who did not object participation in surrogacy on the moral grounds. In her words,

***My husband told** me, **‘you should go’**. He immediately agreed. He is very trusting. In fact, **I was reluctant** to come (laughs). (I was) Thinking family members would gossip about me, and I had never taken any injections which I would have to (laughs), that is why I was reluctant. Then he said, **‘it’s not bad** (work), **if anyone says anything, I am answerable.**’ Then he said, **‘you must go.’** **Therefore, I came.** He never allowed me to take up (paid work)... stating he did not need my earnings (laughs). But now this because of hardships (of poverty)*

*Toa mara **var ne j mane kidhu ke ja ke.** Ae toa tarat mani gaya. Ke mara toa bahu vishwasu. **Uparthee hu natee aawtee** (laughs). Etle tamaru baddhu kehashe, gharma koi waato karshe evu thay ne. Ane injection aavu baddhu lidhelu na hoy ane lehwanu thay (laughs). Etale laagtu hatu nathee javu. Pachi **aa kahe, ‘kasu kharab nahi, koi kese toa hu baitho chu.’** Pachi **ae kahe ke ‘tu ja j ke.’** Etle pachi me aavi. Pahala mane nahi jawa deta kaam par...ke mane tara kamai nu nathi joytu. (laughs) pan have aa toa dukh ma.*

Not only family members, but also friends, acquaintances and surrogacy agents led women into surrogacy. Shalini (34 years) was a nurse at a hospital in the town. She narrated how she was introduced into surrogacy by an agent,

*I wanted to become a surrogate, but I was scared therefore **I refused**. The night shift lady told me everything. I said I want to come (for surrogacy). Then **she brought me (here)**. Then **I refused but she explained to me a lot** that, ‘You will be able to get your own home.’ My in-laws would every day tell me to leave their home; therefore **I decided to do this**.”*

*“Mane lagyu ke hu surrogate thavu pan pachi mane beekh laagtee hatee etle, **me kidhu nahi thavu**. Pachi night wala masi ae mane baddhu kidhu. Me kidhu mane bhee aawu che. **Ae pachi mane em laya**. **Pachi me na padi pan ene mane bahu samjhai** ke taru ghar thai jashe potanu. Mara sasu sasra mane roj kehata ke tu gharmathee nikdee ja amaru ghar che. Etala mate, **me aa decide karyu**.”*

Shalini’s quote demonstrated how the agent used persuasive power, focused on the limiting life circumstances of Shalini and posed surrogacy as the only way out of personal difficulties she faced.

Overall, despite the macro-context of poverty, a majority of women (85%) appeared to have control over the decision to participate in surrogacy. The varying forms of coercion experienced by 15 percent women indicated that both family members and surrogacy agents could subtly push women in surrogacy against their will highlighting the need for a robust monitoring mechanism to prevent it.

The complexities of the decision-making. Women’s narratives also indicated that the decision to participate in surrogacy was rarely straightforward. Not only women, but their husbands and family members participated in decision-making and

different people took the lead at various times during decision-making. Kalika's (35 years) reflections on her surrogacy journey indicated fluidity of the decision-making process. Her hopes for a better life and her concerns over her health and safety during surrogacy were juxtaposed and left her indecisive about participation in surrogacy. Eventually, Kalika embedded in her familial context prioritised the needs of her children and family and participated in surrogacy. The key events from her detailed narrative are presented temporally along with the key persons who played a lead role during decision making in Figure 32.

Shifting lead positions of various persons during the decision to participate in surrogacy presented in Figure 32 are noteworthy. At the outset, Kalika's 'sister turned surrogacy agent' directly contacted Kalika's husband encouraging him to send Kalika for surrogacy. She possibly viewed him as the primary decision maker in the family and was aware that the ART clinic did not accept women in surrogacy without spousal approval. Only at his outright refusal she contacted Kalika and highlighted surrogacy as the only solution to the difficult life circumstances Kalika faced.

Kalika, convinced of the economic potential of surrogacy was assertive with her husband about her desire to participate in surrogacy and challenged his fear of stigma. Even when he turned down her surrogacy proposal, Kalika did not give up and approached her sister for help. Initially, to avoid resistance of her husband, Kalika proposed that her sister could sign the consent form for surrogacy instead of her husband. However, when her sister insisted that spousal consent was mandatory for participation in surrogacy at the clinic, Kalika sought sister's help for convincing husband. This is indicative of the alliances women may form in the familial setting to utilise collective power in pursuit of their own goals either to seek approval of the male family members or to override decisions taken by men.

Persons in Lead

Events

Surrogacy Agent (sister)	<ul style="list-style-type: none"> •Kalika's sister – a former surrogate – approached Kalika's husband asking him to send her for surrogacy. Kalika's husband refused. She then invited Kalika over her home and motivated her for surrogacy saying, <i>"You don't own a house, and inflation makes it worse, you barely meet food and educational expenses of children. You should do surrogacy."</i> Kalika responded, <i>"I will ask my husband."</i>
Kalika	<ul style="list-style-type: none"> •Kalika asked her husband, <i>"Should we do surrogacy like her?"</i> Her husband responded, <i>"I will think over it and let you know. Villagers will condemn us."</i> Kalika announced, <i>"People will say things, but they will not provide us money. I will do surrogacy."</i> Her husband refused stating, <i>"You may go, but I will not sign (the mandatory spousal consent for participation in surrogacy)."</i>
Kalika and Surrogacy Agent (sister)	<ul style="list-style-type: none"> •Kalika sought her sister's help to convince her husband and both managed to convince him for at least a preliminary visit to the clinic. Kalika's husband told her sister, <i>"First, I will see it and then tell you whether I can send my wife."</i> He accompanied Kalika's sister to the clinic and met medical practitioners and other surrogate mothers. Kalika was not involved in this preliminary visit.
Kalika's Husband and Mother-in-law	<ul style="list-style-type: none"> •Kalika's husband was convinced of the asexual nature of surrogacy. He then conveyed to Kalika that many women participated in surrogacy but it involved risk to life, though very rare. Despite the risk, Kalika expressed her interest in surrogacy to alleviate their poverty. She felt permission of her mother-in-law was necessary. Her husband upon her request ensured permission from his mother for Kalika's participation in surrogacy.
Kalika	<ul style="list-style-type: none"> •After seeking mother-in-law's approval for surrogacy, Kalika experienced anxiety about labour pains but her sister assured her of a caesarean section delivery. Kalika felt indecisive and refused to participate in surrogacy as she could not bear the thought of separation from her children and staying at the clinic for nine months.
Kalika's Husband	<ul style="list-style-type: none"> •Kalika's husband coaxed her stating, <i>"You have agreed for surrogacy ones, now don't back off. Why don't you go and experience it ones."</i> Kalika agreed, attained surrogate pregnancy in 2nd attempt and later regretted it. In her words, <i>"I regretted it. I shouldn't have come here. How can I live without my children and husband, I am eager to see them. All I keep thinking is when will I return home."</i>

Figure 32. Complexities in the decision to participate in surrogacy.

Despite Kalika's ability to assert her desire for participation in surrogacy and her success in convincing her spouse for a preliminary visit to the ART clinic, Kalika was excluded from this visit. Her husband made it clear that he withheld the authority to make the decision. At this point in the decision-making process, Kalika graciously accepted her husband's lead, patiently waiting for his approval. This indicates that Kalika did acknowledge the power of her husband over crucial family decisions and chose to 'negotiate' her goals when 'assertion' did not work.

Kalika's husband, during his inquiry with the Doctors, ascertained asexual nature of surrogacy. On returning home he shared with Kalika that there was nothing immoral in surrogacy and death during surrogacy was a rarest possibility - a matter of Kalika's fate. Though initially taken aback, Kalika made up her mind to participate in surrogacy and requested her husband to seek approval of her mother-in-law highlighting hierarchical nature of the family relations. Kalika expressed that it was unimaginable for her to participate in surrogacy without the consent of her mother-in-law. Interestingly, while Kalika tried 'assertion' with her husband, she insisted 'approval' of her mother-in-law and this time formed an alliance with her husband to convince her. This indicated careful management of the interpersonal relationships to attain personal goals.

The situation became only more complex when Kalika's confidence wavered after obtaining approval from her mother-in-law. What seemed a distant dream to Kalika so far had now become a reality; and forced her to weigh benefits and costs of participation in surrogacy. She was worried over possible health consequences and labour pains but was assured of a caesarean section delivery by her sister. Thought of separation from her children and husband for nine months during surrogacy rattled Kalika, who had never lived alone without her family. She was also concerned about

the well-being of her children in her absence. Kalika then doubted her ability to manage surrogacy endeavour and refused to participate in surrogacy.

At this juncture, Kalika's husband, aware of the enormous monetary gains involved in surrogacy, insisted that Kalika must stick to her original decision to participate in surrogacy. He coaxed her into surrogacy promising that he will take utmost care of the children and would visit her regularly at the ART clinic. Kalika then firmed up her mind and attained surrogate pregnancy in her second attempt of the embryo transfer. It took her considerable time to adjust to the new setting and at times she even regretted her decision to participate in surrogacy. Kalika's narrative vividly portrayed the inter-personal conflicts women must navigate in a hierarchical familial set-up as well as intra-personal conflicts they must resolve as agents in pursuit of individual goals embedded in the familial context. The decision to participate in surrogacy was a complex exercise, the intricacies of which were rarely overt.

The narratives of women unravelled complexities of the decision-making to participate in surrogacy for the Indian women based in Gujarat, India. The Indian society in the influx of social change has brought Indian men and women, especially urban, in the contact zone of a global civilisation creating scope for the development of an 'expanding self' – marked by growing individuation (Roland, 2001). The profile of the women entering surrogacy indicated that 64 percent women had separated from a traditional joint family household and moved into a separate living space with their spouse establishing their own nuclear household. A few even reported marrying by own choice against the will of their family members departing from the traditional norm of 'arranged marriage.' It is not surprising then to find that a majority of women in this study based in Gujarat – an Indian state with high international out-migration

and diaspora – took initiative to participate in surrogacy playing a lead role in the decision-making process.

But was the decision-making process straightforward for these women?

Hardly so. The narratives of women indicated that for most of them the process was a complex one, full of interpersonal and intrapersonal conflicts marked by the struggles of striking a balance between their core ‘we-self’ and their pursuit of this novel form of work – surrogacy. Women held on to the traditional psychological makeup of the ‘familial self’ and were primarily motivated by a strong sense of duty and obligation towards improving life outcomes for their children through surrogacy income. This was indicated in numerous narratives like that of Sargam’s justifying her participation in surrogacy. As Menon (2011) and Raval (2009) have observed, fulfilling duties and expectations of others possibly generated a sense of satisfaction among women and agency took the form of catering to the needs of the significant others, especially children. Well-educated children were seen as a financial asset for a secure old age with reciprocal care from children.

Women and their spouses alike appeared to derive a sense of self-esteem from family honour reflected in their fear of stigma for participation in surrogacy – largely construed as a form of immoral sex-work in general public opinion. The stigma also stemmed from women’s transgression from the traditional role of managing childcare and household; increased earnings of the women through surrogacy were perceived as a threat to the traditional hierarchical family structure where the male breadwinner of the family is viewed as an authority. Women then strategically used assertion and negotiation to seek spousal approval for participation in surrogacy. In addition, women’s concerns about the approval of the elder family members, despite many of them establishing a nuclear household indicated their deference to the highly affective

intimate hierarchical family relations. Chaudhary (2012), Ganesh (1999) and Raval (2009) have proposed that in the patriarchal hierarchical family setting, interconnectedness allows women to experience flexibility in relationships and women actively negotiate their individual goals rather than resistance when faced with conflicts. Irrespective of whether the women perceived their participation in surrogacy as an individual, mutual or spousal decision, the decision was shaped by various actors. Different individuals assumed a lead role at unique junctures during decision-making.

Evans and Nambiar (2013) have recognised collective action as a potentially empowering tool to enhance agency of women both in the household and public domains. They added that collective action can empower women to access assets and resources, enhance decision making power, challenge the social norms and behaviours and also bring about policy changes. Kalika's ability to form alliances in pursuit of her goals can be viewed as a form of collective agency in the familial context. There were other instances of collective action in the data wherein women in the context of family came together to attain their goal of participation in surrogacy. In one instance, two young couples in a joint family household together strategically mitigated anticipated opposition of the eldest woman in the family for participation in surrogacy. Participant observation also revealed an instance wherein surrogate mothers and surrogacy agents formed an alliance to maximise monetary gains from the commissioning parent of a surrogate mother. Pande (2009a) in another ethnographic study of surrogacy in Anand, Gujarat revealed that surrogate mothers worked together to have a clause added to the surrogacy contract wherein commissioning parents were made responsible to pay the agents' commission for introducing women into surrogacy which was originally deducted from the surrogate

mother's earnings. All these instances indicated that women were able to effectively use collective agency in order to attain favourable outcomes. Such collective action of the surrogate mothers however is missing from the policy discourse on surrogacy in India.

Contrary to the reports of Agnihotri Gupta (2000) and Agnihotri Gupta and Richters (2008) revealing that the surrogate mothers and egg-donors were often related to their service seekers and possibly experienced coercion; 85 percent women in this study played an active role in the decision-making to participate in surrogacy. A lot has changed over the last decade with the commercialisation of surrogacy services in India, which has widened the pool of women who can provide surrogacy services beyond ones' kith and kin thereby reducing the chances of coercion in the hierarchical family setting; albeit with the new avenues of exploitation in the commercial market space which need to be further investigated to inform policy. Restriction on commercial surrogacy at best can discourage women's participation in surrogacy out of the economic desperation but fails to ensure their well-being under the altruistic guise.

Overall, it appeared that the majority of women exercised psychological agency though control over the decision to participate in surrogacy may not necessarily yield a positive outcome for the women. The collective voices of women are missing in the policy discourse and there is a need to create opportunities for the surrogate mothers to participate and shape the Indian surrogacy policy.

Nature of women's agency in the context of surrogacy. Narratives of the women were further analysed with an aim to explore the nature of psychological agency exercised by women. It involved exploration of the various agency practices women engaged in to overcome barriers and attain specific goals in the course of

surrogacy while they interacted with stakeholders in varying contexts as displayed in Figure 33.

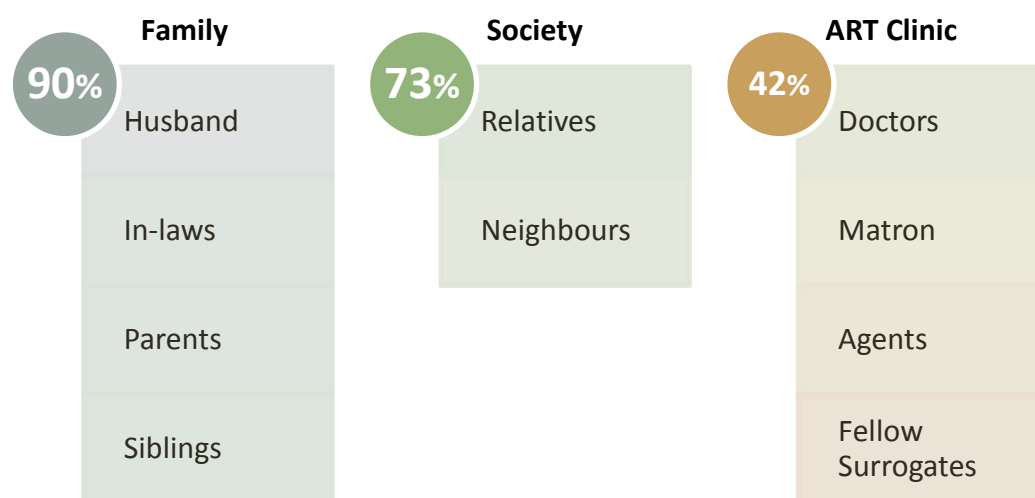


Figure 33. Contexts in which women exercised agency.

Note. N = 41 surrogate mothers

Figure 33 indicates that most women exercised agency in the context of family (90%) and society (73%). Lesser women (42%) indicated exercise of agency at the clinic, which could have resulted from the authority and power position held by other stakeholders in the clinical context (Deonandan, Green, and Van Beinum 2012, Qadeer 2010^b). Ahern (2001) has highlighted that agency may take several forms beyond ‘resistance’ which need to be recognised. During surrogacy, women engaged in varied agency practices in the context of family, immediate society and the clinical setting. Figure 34 portrays definitions of the six ‘agency practices’ which were developed from the inductive analysis of the women’s narratives as well as from the contextual understanding gained through participant observation. The definitions were modified throughout the analytical process to reflect the full range of behaviours women engaged in towards attainment of specific goals. The practices included, ‘ascertaining facts’, ‘selective disclosure’, ‘assertion’, ‘negotiation’, ‘request’, and ‘persuasion’.

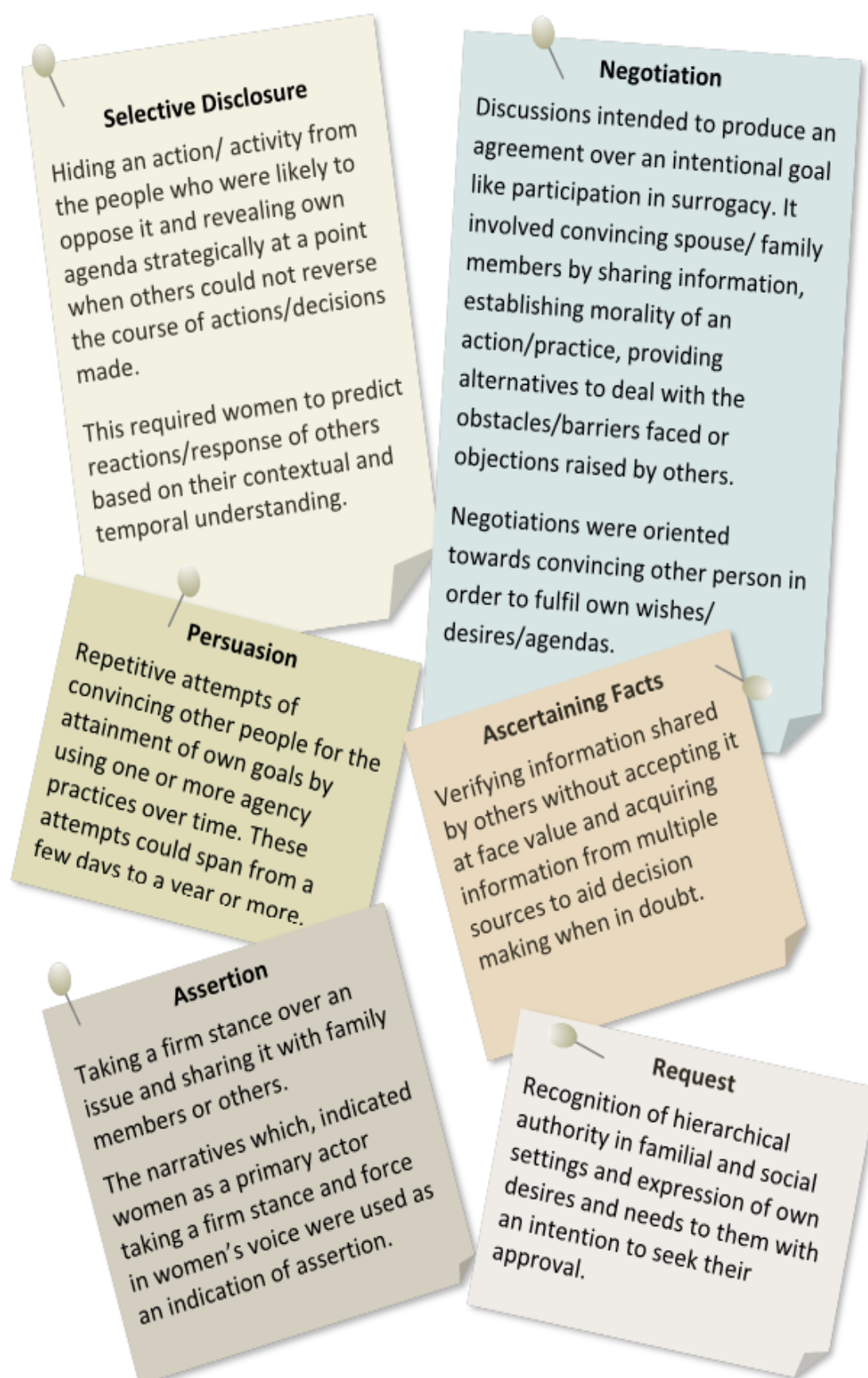


Figure 34. Definitions of women's agency practices in the context of surrogacy

Each of these ‘agency practices’ are first described in detail with an aim to portray their nature in the greatest detail possible. Following this, agency practices used by women are compared using two parameters, the perceived role of women in the decision-making to participate in surrogacy (self decision, mutual decision, spousal decision) and the extent of surrogacy participation (first-time surrogate mothers and repeat surrogate mothers).

Selective disclosure. Use of this practice appeared most frequently in the narratives irrespective of the role they played in the decision to participate in surrogacy. In the hierarchical familial set-up in India where elder members hold considerable authority over family decisions, selective disclosure permitted participants – usually the youngest adult women at the bottom of the family hierarchy – to manipulate situations in their own favour. Women utilised contextual knowledge to recognise likely opponents in the family and concealed their endeavours in pursuit of personal goals. Selective disclosure involved revealing crucial information at a strategic juncture when others could not reverse the decisions and actions of the women. Amongst the 68 percent women who reported an individual decision to participate in surrogacy, two reported secretly initiating hormonal treatment without the knowledge of their spouse and revealed it only at the time of embryo transfer when spousal consent became absolutely necessary. A few women (4) took their spouse in confidence but revealed participation in surrogacy to extended family members at a strategic juncture – after confirmation of the surrogate pregnancy – when the decision could not be reversed. Nikita (30 years) a mother of three sons shared that when she embarked on her surrogacy journey, she lived in a joint family household. The family was headed by her mother-in-law with her three sons and their wives and children living under the same roof. It was a difficult life in poverty for her.

She learnt of surrogacy from her sister-in-law (derani) and viewed it as an opportunity to buy a separate household of her own. At the time of interview Nikita was working as a nanny at the ART clinic and had established her independent household. She revealed,

When we decided to do it, my brother-in-law, his wife, my husband and I decided that for now we will not disclose anything to my mother-in-law, we will tell only once it is done. My (pregnancy) report was confirmed. Then they shared it with my mother-in-law. They explained to her that our standard of living was poor, and it was not a bad (immoral) work. Then she agreed.

Pachi jyare karwanu nirnay karyo tyare me, mara diyar-derani, ne hun ne mara var ame evu nirnay lidho ke mari sasu ne hamana kasu batawanu nathi, jyare thai jay tyare bataweesu aapde. Maro report aai gayo tyare pachi ae loko ne mara sasu ne waat kari, samjhaywu ke aapdi paristheeti aawi che. Ke awi rite kai khotu kaam nathi. Toa pachi mani gaya.

Nikita's narrative is an exemplar of collective agency wherein younger members of the household came together and made a decision to participate in surrogacy without seeking approval of elders. They selectively disclosed their surrogacy endeavour only after Nikita's successful attainment of surrogate pregnancy when the decision to participate in surrogacy could not be reversed.

Selective disclosure was also an effective practice to counter anticipated stigma for participation in surrogacy. Despite spousal approval, women anticipated familial resistance for surrogacy participation due to associated stigma and health risks. In order to evade such resistance and stigma women made false claims about their long absence from family and disclosed their surrogacy endeavour only to select family members (Figure 35).

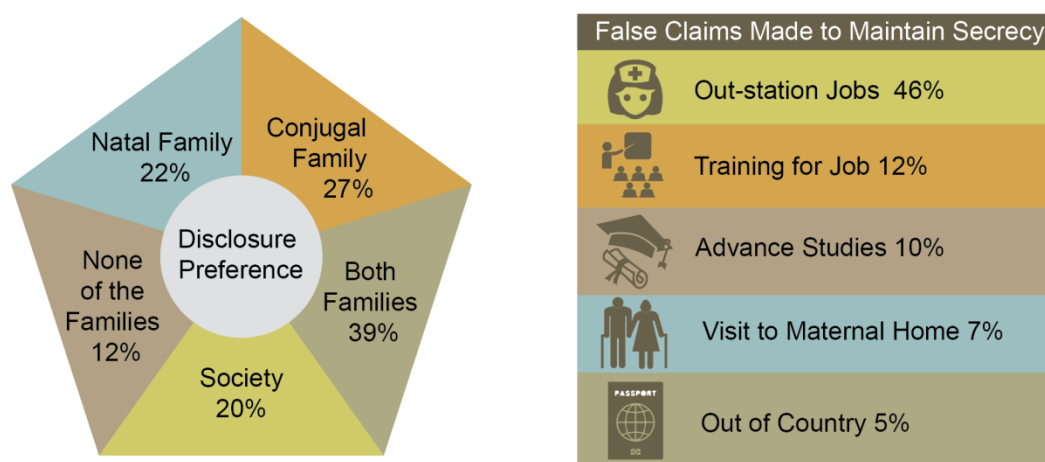


Figure 35. Preferences for selective disclosure of surrogacy endeavour.

A large majority of women (88%) had disclosed their surrogacy to at least one family member. Of these, nearly half (47%) were introduced to surrogacy by their kith and kin. Relatively fewer women (20%) openly disclosed their surrogacy endeavour to society. They did so when several other women from their villages had already participated in surrogacy. Few (12%) shared that no one other than their spouse and the surrogacy agent knew about their participation in surrogacy. This is of concern as in the absence of social support system family provides a protective net to individuals in difficult circumstances. In addition, spouses influenced the decisions pertaining to disclosure and pressurised women to maintain absolute secrecy about surrogacy. Two women also reported unique use of selective disclosure –to evade mandatory spousal consent for participation and to subvert social stigma. These unique cases summarised in the Boxes 6 and 7.

Box 6. Evading Rules: Selective Disclosure of Marital Status

Nipa (35 years) had separated from her alcoholic spouse who spent all his earnings in gambling. She along with her two children lived with her parents and her brother. A couple of years post separation, on insistence of her in-laws, Nipa reconciled the differences and moved back with her critically ill husband to care for him, who died soon after. Barely literate and never employed, Nipa worried for the future of her children.

She then accepted a proposal for remarriage from her brother-in-law who promised to care for her children; only to realise soon that his income was irregular and inadequate to support a family of four. Nipa proposed participation in surrogacy to her husband but he refused equating surrogacy to infidelity and stating that he did not want to live with the shame of being a dependent on his wife's surrogacy earnings.

While he took up short-term migration to work as an agricultural labourer, Nipa in his absence began hormonal treatment for surrogacy. In order to evade mandatory spousal consent, she never revealed her remarriage at the ART clinic and claimed being a widow by sharing death certificate of her former diseased husband. Circumstances only got more complicated when Nipa's second husband arrived at the ART clinic searching for her. By then, Nipa was through with her embryo transfer awaiting confirmation of her pregnancy. Her husband argued with the medical practitioners demanding Nipa's discharge from the clinic so that she could return home with him. The medical practitioners refused and proposed that he could take Nipa home only if he could repay all the money commissioning parents had invested in Nipa's treatment so far. Out of any money to pay for the medical expenses incurred, Nipa's husband kept a tight vigil on her for over 15 days until the pregnancy test results were disclosed. To Nipa's dismay, her embryo transfer failed amidst protest, verbal abuse, and constant surveillance stemmed from the suspicion of infidelity by second husband. After few months, Nipa returned for another treatment cycle with the consent of her husband.

Nipa's use of selective disclosure to evade rules of the clinic, a rare and extreme case, glaringly highlights need for a robust regulatory framework.

Box 7: Circumventing stigma through selective disclosure in print media

Bhagwati (35 years), a mother of three and a second time surrogate mother, hailed from a small village near Anand. Having dropped out of the high school, Bhagwati supported her indebted family of six through her meagre monthly income of Rs. 1500 she earned by working at a local dairy. Her husband cultivated their mortgaged barren farmland and on some of the difficult days even sold his blood to meet daily living expenses. For Bhagwati, surrogacy certainly seemed a solution to all her hardships. Being hopeful about a good future, she barely anticipated social stigma she and her family would face for her prolonged absence from family during her institutionalisation for surrogacy. Bhagwati contemplated ways to circumvent stigma and did something which was unthinkable for most other surrogate mothers. She gave an interview for a photo story to be published in a local newspaper disclosing her participation in surrogacy. Bhagwati's disclosure of her surrogacy was thought through and strategic. In her words,

“Initially, I maintained secrecy about it, but everyone started accusing that I had eloped with some other man, that I left my husband and my children. Once, Doctor announced that someone was to visit for interviews saying, ‘in case no one knows and if you are unwilling (to disclose your participation in surrogacy) don’t give interview, it will appear in newspaper along with photos.’ I purposely gave the interview, everyone in my village then knew that I participated in surrogacy. School teachers at the village read it and convinced other villagers that surrogacy is a moral work, there is nothing wrong, and that I did well for my children.”

“Pahali wakhat baddha thee chupawyu hatu pan ghare baddha evu kahata hata ke ae toache ne koi ne lai ne bhagi gai, ene chodi ne jatee rahi, chokrao chodi didha. Pachi ek diwas doctor ae kidhu ke koi interview lewa aawana che toa koi ne problem hoy, koi na Janata hoy ane interview nahi aapwu hoy toa tame na aapsho ena photo paper ma aawana che. Toa me Jani joi ne j me interview aapyu, photo aapyo paper ma. Toa pachi mara gaam ma baddhu Jahir thai gayu k eke surrogate mother bani che. Pachi gaam ma school me shikashk loko ne waachyu ne toa kidhu ke aa baydi ne kasu khotu nahi karyu, saaru j karyu che ene chokrao mate.”

Bhagwati's cleaver use of selective disclosure to evade stigma was unique and questioned generalisation of Indian surrogate mothers as passive acceptors of subjugation.

Ascertaining facts. A primary barrier women faced prior to participation in surrogacy was determining authenticity of the surrogacy process. Majority of the women (85%) personally confirmed authenticity of the surrogacy process and did not accept information provided by agents at face value. Ranjana (30 years) a first-time surrogate mother shared, “I could not trust it. (People) were saying (they) involve (women) in immoral work. It must be a shoddy clinic to pay like this. Therefore, I told her (agent), first I will see (the clinic) and then I will come (for surrogacy).”

Mane ekdam saachu natu laagyu, etale mane em kaheta hata ke awara dhanda karawe. Awaru dawakhanu hashe toa ae rite paisa aapta hashe. Etale me emane kidhu hun pahele jowu ane pachi j hu aawu.

Heena (36 years) a first-time surrogate mother demanded that her agent provide a documentary proof of the money paid for surrogacy services. She shared, “I told the agent, ‘show us whatever documentary proofs that you have.’ He then showed us newspaper. He also showed bank passbook. Initially my husband thought 3.5 lakhs is impossible, who will pay so much but after the agent showed (the documents) he believed it.”

Me kidhu ke bhai, tane je hakikat tari jode koi dakhlo je tyanu weetyu hoy ke tane je proof hoy te tu bataw. Pachi paper hi batawyo. Ane bank wala ni je chopadi hati ae batawee. Etle ene em ke sada tran laakh rupaya toa na hoy ke, kon aape che em ke, emane yakeen nato. Etale pachi batawyu ne tyare emne yakeen thayu.

Women visited the infertility clinic with (49%) or without their spouse (34%) to ascertain the asexual nature of surrogacy and some (11%) acquired the information they needed from other surrogate mothers or family members who had experienced or were informed about surrogacy. A few women (6%) in addition to enquiries with

others also relied on media publications for information on surrogacy. The women who made a first visit to the surrogacy clinic without their spouse, preferred to understand the procedures before initiating a discussion with their spouse. Narratives of six women did not indicate use of the practice ‘ascertaining facts.’ For three of these women surrogacy was initiated by others, two reported not thinking through their participation in surrogacy much, and one trusted surrogacy agent who was known to her.

Women who were in the immediate need of money opted for egg donation which ensured instant payments compared to the nine month long period of surrogacy. Women utilised these short egg donation stints to familiarize themselves with the clinic and learn about surrogacy experiences of other women. Only after gaining confidence in the authenticity of clinic operations did they entered surrogacy.

Majority of the women (85%) were far from being gullible and preferred to take an informed decision to participate in surrogacy demonstrating agency. However, it is important to note that women were predominantly concerned about determining the morality of surrogacy and rarely used the opportunity to investigate the impact of surrogacy on their health, thereby limiting the empowering potential of their agency.

Assertion. Narratives of more than half of the women (59%) indicted use of ‘assertion’. Women practiced assertion in various contexts and situations to serve specific purposes (Figure 36) although it was predominantly used in the familial context. Only a couple of women used assertion consistently across multiple contexts. In the familial setting, women practised assertion to ensure their participation in surrogacy as well as for determining the use of income they earned through surrogacy. Hiteshi (35 years) a twice surrogate mother shared how she remained firm on her decision to participate in surrogacy despite the resistance of her spouse. She separated

from her spouse temporarily and asked for a divorce unless she was allowed to participate in surrogacy. In her words, “I wanted to be (a surrogate) but my husband refused. We quarrelled a lot and separated from each other. Then I stipulated, ‘only if you allow me to become a surrogate mother, we will live together otherwise we should divorce. Then he signed (the documents) and cried a lot.’”

Mane lagyu ke banwu joiae pan maro husband na j padata hata. Ame be jan bahu jhagadya pachi ek beeja thi alag thai gaya. Pachi hu sharat kari ke mane mother banwa dewi che toa aapde beo rahishu saathe nahi toa aapde chhuta thai jaiae. Pachi emne sahi kari ane pachi bahu radya ae.

Assertion		
Family	Society	ART Clinic
<ul style="list-style-type: none"> Decided to participate in surrogacy against spousal/ familial objections (9) Initiated hormonal treatment without spousal consent (2) Deserted reluctant spouse for participation in surrogacy (3) Determined utilisation of money earned through surrogacy (3) 	<ul style="list-style-type: none"> Disclosed participation in surrogacy and took firm stance against stigma (8) 	<ul style="list-style-type: none"> Sought travel allowance for ET (1) Refused participation in egg donation (1) Demanded treatment for weakness, stretchmarks, dark circles (3) Stayed at home during surrogate pregnancy (3) Ventured out of surrogacy house (3) Determined mode of delivery (2) Determined mode of payment (1)

Figure 36. Manifestation of assertion in the context of surrogacy.

Jagruti (38 years) a mother of two and a first-time surrogate mother almost threatened her husband of infidelity if she was not allowed to participate in surrogacy.

She shared telling her husband, “Wives of other people elope. If I am living with you and I don’t get good food to eat, then even I will chase other (men). I will live with some rich man. Instead of that it’s better that we live separately for nine months (of surrogacy) it’s not bad”.

Ke lokonee baydio bhagi jay che. Ke tamara ghar ma ho toa amne saru khawanu na male toa amari bhi pachi bahar j najar pohochse. Ke ame bhi koi rupiyawla ni ghare jata rehsho. Ena karta nav mahina tame ane ame alag rhishu, tema kai fer na hoy.

Both Hiteshi and Jagruti exerted considerable pressure on their spouses to seek their approval for surrogacy and these were unique instances. The normative pattern for women practicing assertion was to state firmly own desire for participation in surrogacy. Women also practiced assertion for the utilisation of money earned through surrogacy. Reshma (35 years) a second time surrogate mother when probed about who controlled utilisation of the money she earned through her first surrogacy said, “of course, I decide. No one in my family asks for money to spend. I independently searched and bought a house. It’s in my name.”

Mare j nakki karwanu ne? Mara ghar ma thee koi em na kahe ke bhai lai mane aap, pahu karwu che evu kai nahi. Ae mari rite j makan joi ne me mari rite j lidhu. Mara nam thee j che makan.

A few women (8 %) also disclosed their surrogacy to society and challenged the stigma associated with surrogacy. Dhara (25 years) a second time surrogate mother revealed that she kept a life-size photograph of the baby born through her first surrogacy in her home. She proudly shared with everyone that she was her surrogate daughter. Dhara said, “I am not scared of anyone. What will they think? (I ask them)

‘Will you pay money to run my house? No one utters a word (against my participation in surrogacy)!’

*Mane toa kase koi ni beekh bhi na lage. Koi shu wichar karwana? Tame
aapwa aawana amari ghare paisa? Koi nam j na le ne!*

Very few women (10%) reported episodes where they were assertive at the surrogacy clinic. Three women reported asking doctors for treatment towards specific symptoms they experienced during surrogate pregnancy like weakness, stretchmarks and under eye dark circles. One woman was scared of labour pains and specifically asked for a caesarean section delivery. Few others violated restrictions over mobility by venturing out of the surrogate hostel or going back home without seeking permission of the medical practitioners only to return after a couple of months. Participant observations at the surrogacy clinic revealed that one of the women (other than the 41 interviewed) turned down the proposal for egg donation prior to participation in surrogacy. One of the surrogate mother availed travel allowance for her visits to the clinic for preliminary check-up and embryo transfer. Figure 37 presents excerpts from the narrative of Yashashree (26 years) a first time surrogate mother and the most assertive woman interviewed who openly challenged medical authority and planned to confront her commissioning parents when they visited for lack of contact during surrogacy.

Almost all women complied with the rules that imposed restrictions over mobility, life-style and diet during surrogacy. Limited assertion by the women at the clinic could be most likely attributed to the fear of pregnancy loss propagated at the clinic and authority position of medical practitioners who were also directly disbursing payments to the surrogate mothers.

Demanded Medical Treatment	<p><i>"I had an itchy belly and had developed dark circles too. I told madam, 'My body was not like this. I did not have any blemishes over my body, and after coming here I got all this. You treat me and get back my body to the normalcy the way I was when I came (here).'"</i></p> <p><i>"Mere ko pet main bahot khujali aatee thi aur dark circle bhi pad gaye the. Maine bola madam mera sharir aisa thode hi na tha. Mere sharir me toa ek bhi daag nahi tha aur idhar aake mere ko sab aisa ho gaya hai, toa aap mere ko pura mai jaisi aai thi waisa ilaj mujhe kar ke dena."</i></p>
Flouted Mobility Restrictions	<p><i>"Once I went home I was reluctant to return. Whenever I looked at my children, my husband, I felt like I don't want to go, I don't want to go (at the ART clinic). Like this I stayed back at home for two months."</i></p> <p><i>"Ek baar ghar gai thi ne toa ghar se aane ka mann nahi kar raha tha, bacche log ko dekh ke, gharwale ko dekh ke bilkul mann peeche ho raha tha ke, nahi jana hai, nahi jana hai aisa. Aisa karte karte toa doa mahina rah gai ghar."</i></p>
Planned to Confront Commissioning Parents for No Contact	<p><i>"When commissioning parents visit I will question them even if they feel bad or good. Even if (our) neighbour is ill, don't we at least ask, what happened? Are you sick?" Now that your child is in my womb, how much you should enquire about me? You should ask me 'Do you eat food on time? I hope, you don't have any problem.' Why she cannot ask such things in general? She does not ask anything; what should I interpret from that? Everyone says all people here are like this. But I said, 'that's how other people think, but I think differently. I want to know why (there is no contact from the commissioning parents)? It is important (for me) to ask.'</i></p> <p><i>"Jab partiwale aaenge tab yah sawal toa unse karna hai bhalehi ab unko bura lage, chahe accha lage. Bajuwala bhi bimar ho jata hai toa apne itana toa puchate hai ne kya hua? Tabiyat kharab hai aapki? Ab toa aapki santan hai mere pet me, aapko toa kitana mere bare main puchana chahiye? Ek baar mai jawab dete dete thak jaavu lekin aapko puchana chahiye ke bhai aap time se khana khati ho? Kuch aapko problem toa nahi hai? Aisa waisa toa puch sakti ho na? Wo kuch nahi puchati iska matalab kya nikalneka baba? Sab log bolte hain ke yahan pe toa sab log aise hai. Par maine bola vo sabki soch hai, meri soch kuch alag hai. Mere ko aisa hai ki kyon aisa? Puchana jaruri hai na."</i></p>

Figure 37. Use of assertion by a surrogate mother in the clinical setting.

Negotiation. Women who played a lead role in the decision to participate in surrogacy, once convinced about its authenticity, initiated a discussion with their

spouse about their desire for participation. Women negotiated their participation not only with their spouses but also with the extended family members. The negotiations involved discussions intended to obtain an approval for participation in surrogacy. The agentic role that women played in the negotiation process was evident through their use of action verbs like, '*samjhan padi*' (explained), '*manaya*' (convinced), '*kidhu*' (told), '*bataywu*' (showed), '*waat kari*' (discussed), and '*fuslaya*' (lured).

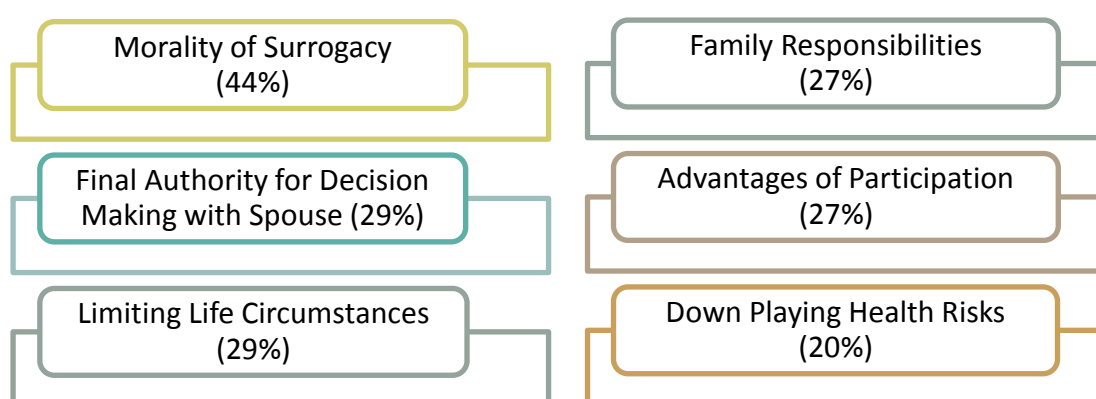


Figure 38. Themes women used for negotiations to participate in surrogacy.

Women anchored their negotiation around one or more of the six core themes presented in Figure 38. Women reiterated the asexual nature of surrogacy and thereby the morality of surrogacy work which they intended to engage in. They emphasised the role of medication in the conception and convinced their spouse and family members to visit the clinic. Women emphasised limiting life circumstances and at the same time helped their spouse visualise better life outcomes that could be attained through participation in surrogacy. They explicitly pointed out poverty; inflation, low wages, and living in a rental accommodation as primary push force for their desire to undertake surrogacy. Women highlighted their economic responsibilities towards family, especially related to children, for example, giving them a quality education, buying a home for them, and saving money for their marriage.

Chitra (25 years) and her husband were agricultural labourers with three children. Chitra, a first-time surrogate mother shared,

I explained to my husband, we don't have anything (savings), and in this (surrogacy) we get salary of Rs. 3000 per month and then 3.25 lakhs. I said, even if we work in the fields all day for nine months will we be able to save so much of money? And, we have three children to educate, should I go?

Me mara gharwala ne samjhan padi ke aapdi pase kasu che nahi ane aawi rite aam che ke tran hajar pagar male ane tran pacchis male aapne. Me kidhu aapde aakho diwas nav mahina sudhi aapde ubha rahiae kheti ma toa pan aapda paisa ubha thwana? Aa trn jana ne janwana che, toa hun jawu?

At times women also used collective action by engaging family members or agents in convincing their spouse for at least an exploratory visit to the infertility clinic. During such a visit, medical practitioners explained medical procedures to women, their spouse and family members and also facilitated their interaction with other surrogate mothers. Men usually approved their wife's participation in surrogacy after a visit to the clinic and discussion with the medical practitioners.

Narratives of women indicated that negotiation was a complex process wherein women displayed an acute awareness of the contextual realities and were able to exert subtle pressure on their spouses to seek approval for surrogacy. The negotiations were temporal in the sense that women grabbed specific opportunities for negotiation and withdrew their efforts when they sensed that the negotiation might not succeed. Nikita (30 years) a domestic help and her husband an auto-rickshaw driver had two children. Nikita, having completed two surrogacies shared her memories of the time when she convinced her spouse for her participation in surrogacy.

It almost took two to four months. At times I would broach the discussion, at times I would back out when he was not ready, at times we would argue and he would accuse me that I was greedy for money. Then at times, we would face (adverse) situations where I would highlight to him that we could have avoided it by participation in surrogacy. I used such opportunities to highlight if we do surrogacy and buy our own house, we need not put up with demeaning treatment by other family members. Only after as much explanation did he agree.

Lagbhag be char mahina toa gay ahata. Amuk wakhat waat chedu, amuk wakhat na, kem ke chedu toa na game, amuk wakhat toa jhagado bhi thai jay ke tane paisa joie che aam tem Jhagado thai jaay. Pachi amuk wakhto evi paristheeti aawi jaay to ahu kahu ke jo surrogacy karai hate toa aavu na thay ne? Amuk wakhte kai paristheeti aawi jaay ghar ma rehwanu na male, ghar ma be bhai ma jhagada bhi thay, to ahu emne kahu ke jo aapde surrogacy karaiye toa aapdu ghar thai jaay, toa aapde koi nu sambhadwu pade? Evi rite kari ne pachi samjhai samjhai ne pachi mani gay ahata. Lagbhag tran thi chaar mahina toa thaya hata j. Tyar pachi aaya."

These narratives of women indicated that women were far from passive in the process of decision making to participate in surrogacy. Instead, they used various strategies to convince their spouses and family members once they themselves were determined to participate.

Request. Along with tireless negotiations, women strategically emphasised that the final decision regarding their participation in surrogacy remained with the husband and they will not override it. Only after investing considerable efforts in negotiations, women requested their spouses to permit their participation in surrogacy.

Isha (30 years) a former homemaker and a first-time surrogate mother revealed that when she first discussed participation in surrogacy, her husband rejected it outright and verbally abused her. Isha then lured him stating that if they earn some good amount through surrogacy, they would be able to purchase a house and lead a good life. She convinced her spouse for an initial visit to the clinic and assured her husband that she would not participate in surrogacy against his will. Isha shared, “I said, (you) see it, only if you find it all right send me.”

Me kidhu, Jowo, saru lage tamne toa mokljo. Nahi toa kai nahi.

Rukshar (36 years) a former nurse-aid was determined to participate in surrogacy and convinced her spouse stating, “You come along with me. If you are not convinced, see it yourself. See other women (surrogate mothers), see the clinic and meet the Madam (Doctor) there. If you find it trustworthy then you send me.”

Tum saath chalo mere. Tumko nahi acchha lagta, tum apani najar se dekho.

Koi ladies ko dekho, waha pe dawakhana dekho, waha pe madam se milo.

Aapko sahi lage toa mujhe bhejna.

Further, once the husband agreed, some women sought permission of the older family members showing deference to authority. Surbhi (34 years) a former nurse shared, “All my family members discussed it and then with everyone’s consensus I did this (surrogacy),”

Amara family member ne baddha ne waat kari ane baddha ni sahamtee pachi main aa karyu.

Women mentioned requesting medical practitioners for their preferred delivery mode – natural labour or a caesarean section delivery – according to own comfort levels. Women also sought free medical treatment for the health ailments their children experienced and asked for fortified foods for self with flavours of their

choice. Pooja (39 years) a former homemaker and a first-time surrogate mother shared her plans of requesting the doctor to avail extra payment from the commissioning parents. Pooja revealed that because she was 39 years old, well past the upper age limit for surrogate mothers, this was her first and the last chance to earn money through surrogacy. She shared, “I will speak with madam (doctor). That this is my last chance, please tell commissioning parents to be considerate.”

Waat karish hu madam jode barabar? Ke maro chello chance che madam.

Partywala ne kaho ke kai samjhe.

Women also requested for relaxation of rules controlling their mobility during institutionalisation and at times ventured out of the surrogacy hostel. Experienced surrogate mothers requested permission for short visit to their home occasionally which was approved by the medical practitioners.

Persuasion. It appeared that the decision to participate in surrogacy was rarely spontaneous and was deliberated over time. Women’s attempts at convincing the spouse for participation in surrogacy involved use of a combination of agency practices over time which lasted anywhere between a few days to several months. Temporal indications were especially evident in the descriptions where women narrated how long it took them to convince their spouses and significant others for participation in surrogacy. One exemplar narrative with explicit temporal dimension included,

Husband said you can go on your own. I am not bothered, I will not sign; I am not supporting you, and do whatever you want. I am not permitting you (to participate in surrogacy). Every day, I would lecture him for hours. With great difficulties I managed to convince him, then he said yes.

Gharwala ne bola ke tu ja sakti hai lekin tu kar, mere se koi len den nahi hai.

Mai sign bhi nahi karunga, mai tere saath nahi, tere ko jo chahe wo karle,

mai tere ko raja dene wala nahi hun. Harroj main ek ghante, dedh ghante,

aadha ghante unase lecture kartee thi. Bahu musibato emane manawama

mane bahu takleefo padi. Pachi emane haa padi che.

Nevertheless, once determined to participate in surrogacy women did not give up despite spousal resistance. Women instead used various strategies to negotiate their participation in surrogacy. Narratives of women indicated that, superficially it may appear that women did not have a say in the decision making process, but in fact women played a significant role in shaping decisions of their spouses. Women were clear about their own interests, goals and pursuits and used several agency practices to influence decisions of their spouses over time demonstrating psychological agency.

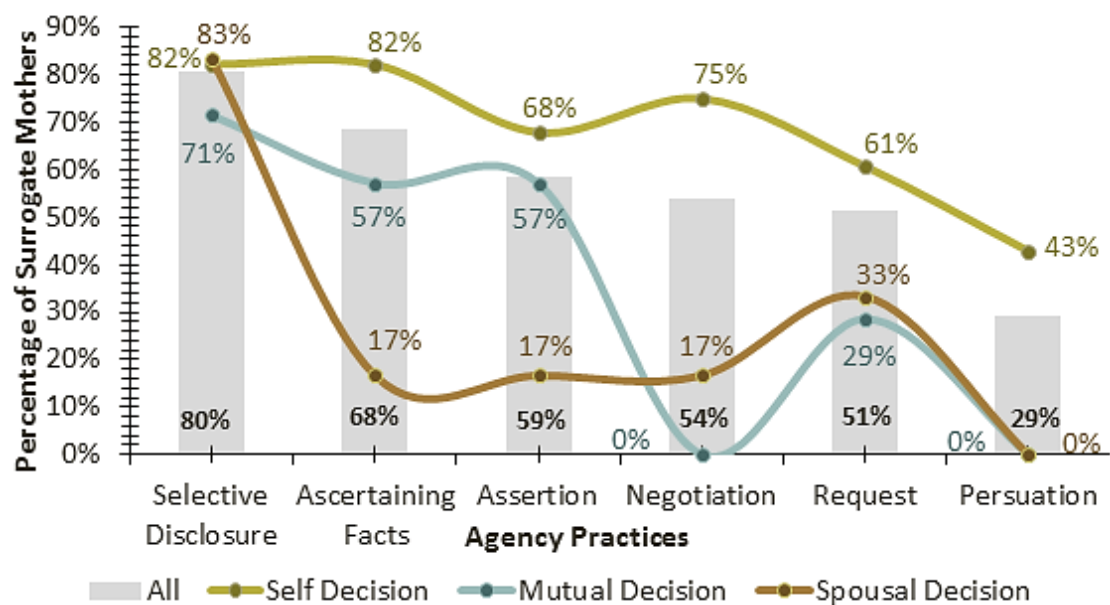


Figure 39. Use of agency practices by women based on the type of decision making to participate in surrogacy

Figure 39 indicates extent of use of various agency practices among women and compares it by the women's perceived control over the decision to participate in surrogacy. For this analysis women were categorised in the three groups - women

who reported an individual decision to participate in surrogacy (28), women who reported participation in surrogacy as a mutual decision between them and their spouse (7) and the women for whom participation in the surrogacy was a spousal decision (6). Overall, 'selective disclosure' was the agency practice reported by a large majority of women (80%) followed by 'ascertaining facts' reported by 68 percent women. More than half of the women reported using 'assertion' (59%), negotiation (54%) and 'request' (51%) to attain their goals. Narratives of a small number of women (29%) reported 'persuasion' wherein they used a combination of agency practices over prolonged time in pursuit of their goals. Novelty of the surrogacy process and stigma associated with it could have led to higher reports of agency practices 'selective disclosure' and 'ascertaining facts'. The data indicated that contrary to the image of third world women as passive acceptors of subjugation which has also been questioned by scholars of Asian origin (Ganesh, 1999; Menon 2011), women demonstrated the practiced psychological agency in seemingly oppressive conditions.

It appears from the Figure 39 that the use of agency practices was reported the most by women who individually took the decision to participate in surrogacy. It is likely that women who were independent decision makers had to counter the resistance of their spouse and family members and resorted to use of various agency practices. 'Ascertaining facts' was reported the most by women who were individual decision makers. It also appeared most frequently in these women's narratives compared to other agency practices. Factual information about surrogacy was crucial for these women to better negotiate participation in surrogacy with their spouses and family members. Women therefore could have heavily relied on 'ascertaining facts.'

Use of ‘selective disclosure’ and ‘request’ was lowest amongst the women who reported that the decision to participate in surrogacy was mutual between them and their spouse. These women could have received significant spousal support and might have been more open about their surrogacy endeavour. However, narratives of women also indicated that when social awareness about surrogacy was high in the villages they came from, it significantly reduced stigma associated with surrogacy and facilitated disclosure. Narratives of none of these women indicated use of ‘negotiation’ and ‘persuasion’ in absence of spousal resistance for participation in surrogacy. When women and their spouses both were favourable to participation in surrogacy and when women had an equal say in the decision, women could have experienced lesser interpersonal conflicts leading to absence of ‘negotiation’ and ‘persuasion’ in their narratives.

The women who participated in surrogacy on the insistence of their spouse reported use of ‘selective disclosure’ most frequently (83%) followed by ‘requests’. It is alarming as when women were subtly coaxed or coerced into surrogacy, their spouses might have pressurised them to maintain secrecy about surrogacy. In such circumstances, women may lose significant social support and any adverse outcomes of surrogacy on these women cannot be redressed.

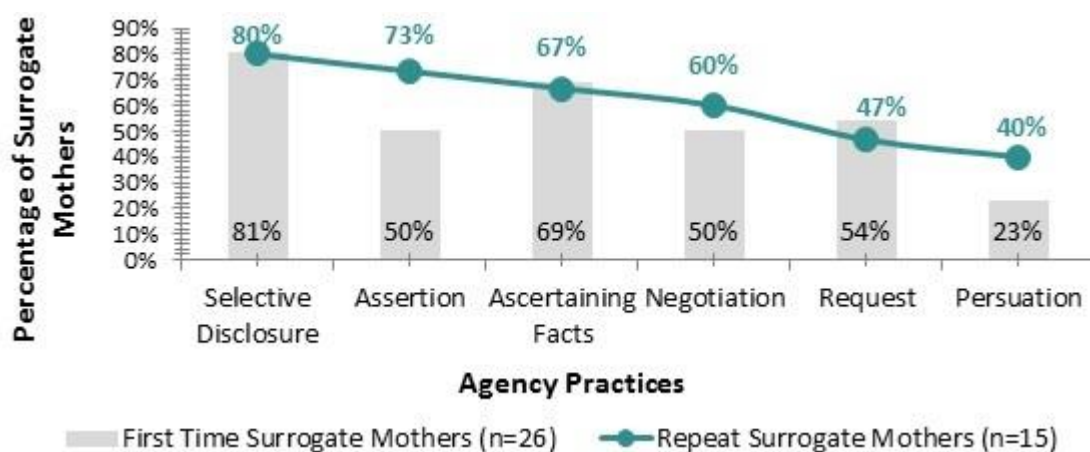


Figure 40. Comparative use of agency practices amongst two groups of women.

A prominent difference in the use of agency practices ‘assertion’, ‘negotiation’, and ‘persuasion’ was visible amongst the first-time surrogate mothers and repeat surrogate mothers. Higher percentages of repeat surrogate mothers reported use of these agency practices compared to the first-time surrogate mothers. Narratives of the repeat surrogate mothers indicated that once they gained familiarity with the surrogacy process, they were far more confident of their second time participation in surrogacy. This was reflected in higher percentage of repeat surrogate mothers using ‘assertion’ in their interactions with spouse, family members, and medical professionals at the infertility clinic. Similarly, familiarity with the surrogacy process could have facilitated use of ‘negotiation’ and ‘persuasion’ with others by the repeat surrogate mothers. Another plausible reason for this difference in use of agency practices could be increased status of women resulting from economic contributions they made to their families. A positive surrogacy experience may lead women to repeat their participation in surrogacy and may facilitate exercise of agency.

A custom complex of psychological agency of women in India. The contemporary cultural psychology perspective to individual development Shweder et al. (2006) formed the theoretical framework to explore the exercise of psychological agency by women in the context of surrogacy in India. Central to the popularity of this perspective is the claim that culture and mind are intertwined and "make each other up" (Shweder et al., 2006. p.724). They defined culture as the symbolic (mental) and behavioural (practice) inheritance of a self-perpetuating community in a historical context. They proposed that the symbolic inheritance refers to the implicit and explicit knowledge and beliefs of a cultural community about persons, society, nature, the divine, and what constitutes 'normal' or the ‘appropriate’ ways of life. Whereas, behavioural inheritance refers to the institutionalised practices in the realms of family

and community life spread across socio-economic and political spheres. The concept of 'custom complex' represents the intimate association between a mentality and one or more practices associated with and also forms a unit of analysis. Figure 41 presents the custom complex of the psychological agency of women in the context of surrogacy in India based on the analysis of the narratives.

Figure 41 presents a custom complex of the psychological agency of women in the context of surrogacy in India. Mentalities were predicted based on the existing literature in the cultural psychology that spells in detail the psyche of individuals in the relational worlds and include patriarchy, gender roles, duties, hierarchy, context sensitivity, and individuation. The specific agentic practices of women as derived from their narratives and observed during fieldwork were interpreted using this existing knowledge of the underlying mentalities of an Indian self.

The behavioural outcomes of women during the course of surrogacy were predominantly shaped by the mentalities associated with social norms of patriarchy, gender roles, duties and obligations towards others, hierarchy, context sensitivity and individuation. Women's self-interests were deeply influenced by the needs of their children. Nevertheless, women navigated their goals against resistance of others and their selection of specific agency practices was informed by their understanding of the contextual realities. Women largely confirmed with the social role ideals, with few exceptions, and yet subtly influenced others for the attainment of own goals.

Patriarchal mentalities which determined family honour based on the chastity of women in the family were manifested in the great emphasis men and women led on determining asexual nature of surrogacy. The concerns about 'safety' of surrogacy processes were limited to sexuality and hardly any women reported being concerned about adverse health outcomes of surrogacy.

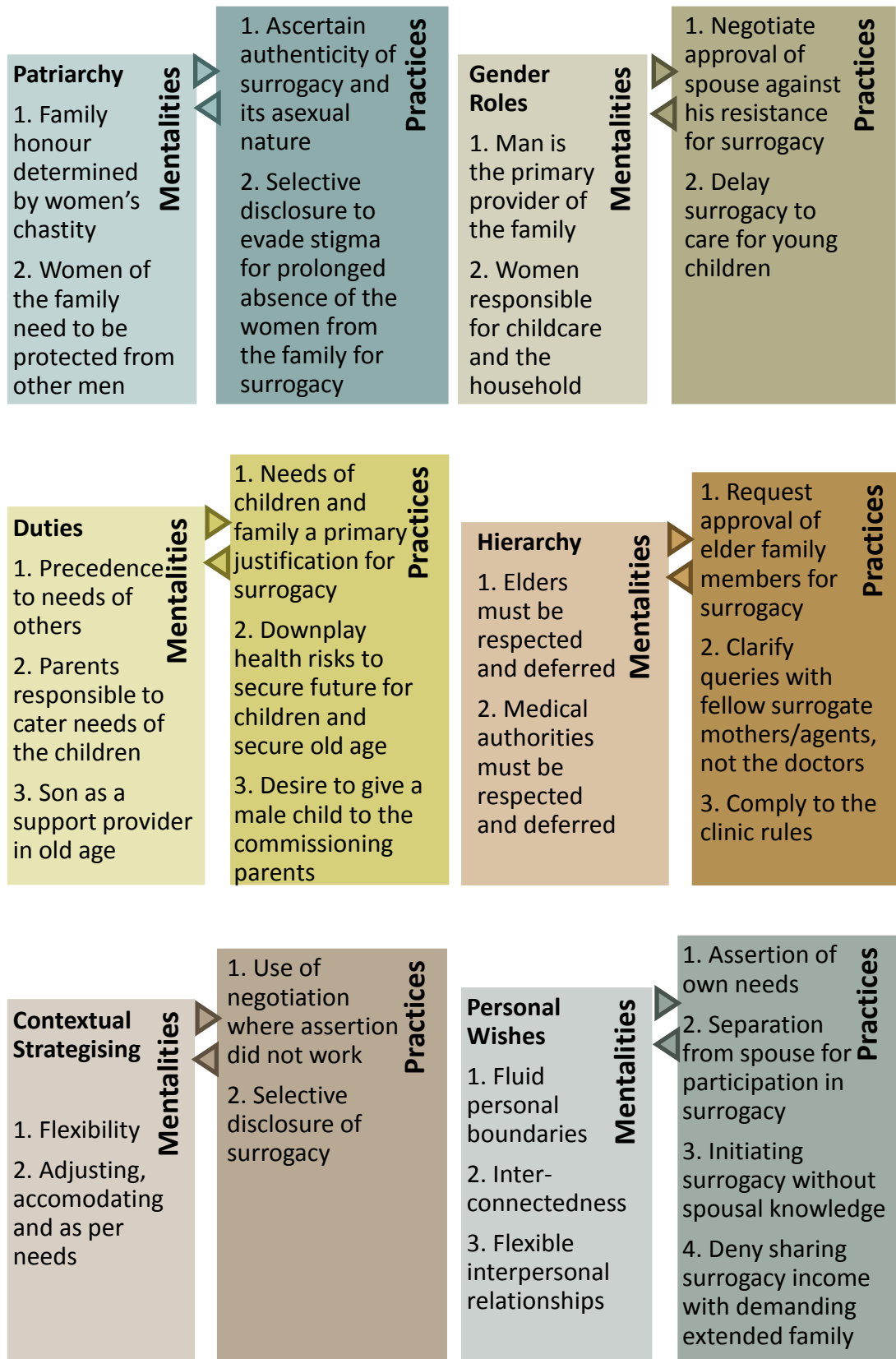


Figure 41. A custom's complex of women's agency in the context of surrogacy.

Women and men alike were concerned about stigma associated with prolonged absence of women from the family and preferred to maintain secrecy about participation in surrogacy, with few exceptions. A couple of women expressed disclosing their participation in surrogacy to society and asserted that it was their individual choice.

Women revealed that childcare and household chores were considered primary responsibility of women and in absence of alternative childcare arrangements their spouses resisted participation of women in surrogacy. In a couple of cases, women explicitly expressed that their spouses were threatened by the possibility of increased power women may have in the household through the enormous monetary gains they could make in surrogacy which resulted in spousal resistance. Women nevertheless persuaded their spouses for approving their participation in surrogacy and delayed participation by a couple of years by the time their children could be left in the care of others.

Women viewed catering to the needs of children as their primary responsibility and expected reciprocal care from them in the old age. Desire to provide a stable life by buying a home and by providing a quality education to their children, especially sons, were predominant motives articulated by women for participation in surrogacy. Women reported overcoming their fears for participation in surrogacy by focusing on the needs of their children and imagining a bright future for them. Even the possibility of death during surrogacy was justified as a sacrifice for their children. Other worries expressed regarding participation in surrogacy too revolved around safety and wellbeing of children during institutionalisation for surrogacy. The norm for son preference also manifested in the form of a desire to give a male child to the commissioning parents.

The emphasis that women lay on respecting hierarchical relations was evident in their efforts to seek approval of the elder family members for participation in surrogacy. Despite living in separate nuclear households, women sought approval of their in-laws for participation in surrogacy with few exceptions, wherein women chose to reveal their participation in surrogacy to elders in the family only after attainment of the pregnancy. Women also perceived medical practitioners as superiors and showed deference to them. Women relied more on the fellow surrogate mothers, surrogacy agents and hostel wardens to acquire any information they needed.

Women's choice of specific agency practices was informed by their contextual awareness. It was reflected in the combination of agency practices women used and use of varied strategies with varying people. In the decision making process to participate in surrogacy, at times women took the lead and at other times they followed the lead of their spouse or other family members and surrogacy agents.

Narratives of women also indicated a high degree of individuation reflected in their perceived primary role in the process of decision making. One woman demanded separation from her husband for participation in surrogacy. A couple of women initiated hormonal treatment for surrogacy without the knowledge of their spouses and a few kept their demanding extended family members seeking share in the money earned through surrogacy at bay. The overall expression of agency by the surrogate mothers was highly contextual and complex.

Key Takeaways

Psychological Agency of Women in the Context of Surrogacy in India

- The narratives of women revealed complexities of the psychological agency of women in the context of surrogacy in India. Most women (85%) appeared to have some control over the decision to participate in surrogacy. Sixty eight percent women reported the decision to participate in surrogacy as an individual decision, 17 percent perceived it as a mutual decision and 15 percent revealed that it was a spousal decision.
- Despite playing a lead role in the decision making women faced considerable spousal resistance for the reasons – fear of stigma, possible distortion of family life, adverse health outcomes, and perceived threat to the male authority in the family due to financial independence of women. Women nevertheless used various agency practices to gain approval of their spouses and extended family members for participation in surrogacy.
- The predominant agency practices women used in the context of surrogacy included, ‘ascertaining facts’, ‘selective disclosure’, ‘assertion’, ‘negotiation’, ‘request’, and ‘persuasion’.
- Women’s use of agency practices was complex and highly contextual. They held on to the traditional psychological makeup of the ‘familial self’ and were primarily motivated by a strong sense of duty and obligation towards improving life outcomes for their children through surrogacy income.
- Women’s concerns about the approval of the elder family members for surrogacy, despite many of them establishing a nuclear household indicated their deference to the highly affective intimate hierarchical family relations.

- Irrespective of whether the women perceived their participation in surrogacy as an individual, mutual or spousal decision, the decision was shaped by various actors. Different individuals assumed a lead role at unique junctures during decision-making while women negotiated their participation with the family members.
- Women formed alliances in the familial setting to utilise collective power in pursuit of their own goals either to seek approval of the male family members or to override decisions taken by men. Women used collective agency in the clinical setting to negotiate their goals with commissioning parents and medical professionals.
- Maximum women (90%) practiced agency in the context of family, 30 exercised agency in the context of immediate society (73%) and 42 percent women reported agency in the clinical setting. Authoritative power position held by medical practitioners in Indian society could have restricted expression of women's agency in the clinical setting.
- Use of agency practices was reported the most by women who individually took the decision to participate in surrogacy. It is likely that women who were independent decision makers had to counter the resistance of their spouse and family members and resorted to use of various agency practices.
- All the women used a combination of agency practices however; the specific agency practices they used differed amongst the three groups – those who reported individual decision, mutual decision, and spousal decision to participate in surrogacy.

- Ascertaining facts' was reported the most by women who were individual decision makers; possibly because factual information about surrogacy was crucial for these women to better negotiate participation in surrogacy with their spouse and family members.
- Use of 'selective disclosure' and 'request' was lowest amongst the women who reported that the decision to participate in surrogacy was mutual between them and their spouse. These women could have received significant spousal support and might have been more open about their surrogacy endeavour.
- The women who participated in surrogacy on the insistence of their spouse reported use of 'selective disclosure' most frequently followed by 'requests'. It is alarming as their spouses might have pressurised them to maintain secrecy. In such circumstances women may lose significant social support and any adverse outcomes of surrogacy cannot be redressed.
- Higher percentage of repeat surrogate mothers reported using 'assertion' in their interactions with spouse, family members, and medical professionals at the infertility clinic compared to first time surrogate mothers. Familiarity with the surrogacy process and/or increased status in the family through the money earned in the first surrogacy could be plausible reasons for this difference.
- Women's agency practices appeared to be associated with traditional patriarchal mentalities, gender roles, and a familial self that valued duties, hierarchy, and context sensitivity.

Surrogacy Outcomes and Future Plans of the Women

This section briefly analyses narratives of the women who had completed at least one surrogacy successfully (15) a year prior to the interview. The analysis aimed to determine positive impact of surrogacy if any on the lives of women and their families and explored future plans of all the 41 women interviewed.

Surrogacy outcomes. When asked about impact of surrogacy on their lives, women who had completed at least one surrogacy shared their experiences of utilisation of the money earned through surrogacy and positive changes in their status in the family.

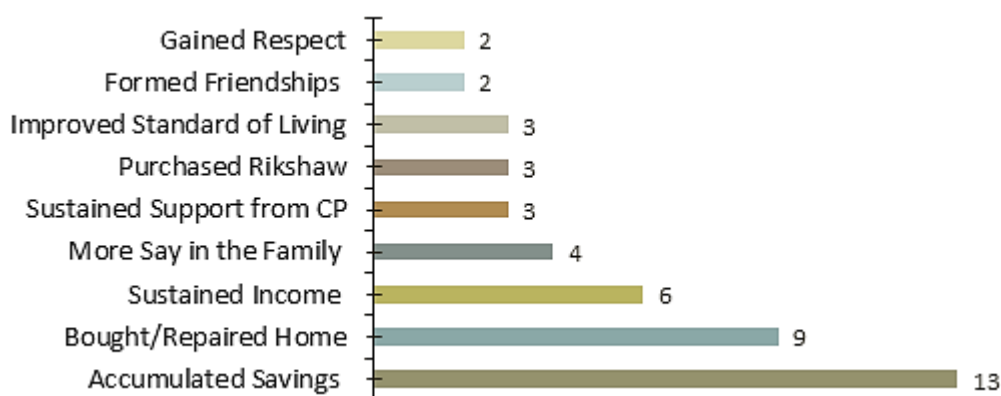


Figure 42. Positive impact of surrogacy on the lives of women.

Note. N=15.

Figure 42 indicates that participation in surrogacy helped majority of the women alleviate poverty to some extent. Most of the women (13) stated that they invested at least a part of their surrogacy income in some form of savings giving them a sense of security. Women intended to use the savings for providing a quality education to their children. One reported enrolling her son in an engineering college and another proudly shared that her sons excelled in studies at a boarding school she managed to enrol them. Almost all the women had shared that one of their primary motivations for participation in surrogacy was to achieve a sense of stability by

purchasing a house. Not all but many (9) women were able to realise this goal. Three women reported buying an auto rickshaw as a means of regular income generation for their husband. Material gains acquired through surrogacy income raised day to day standard of living for 3 women.

Pipasa (25 years) a second time surrogate mother gained confidence in her ability to independently run her household through surrogacy income without relying on the spousal earnings. In her words,

Before participation in surrogacy, I was dependent on my husband's daily wage to feed everyone. After I became a surrogate my life improved, irrespective of his earning, I can run my household, no problem. Life is better now. I bought a CNG (auto rickshaw) on own; I know that every day I will get Rs. 200. So far I was never able to save and worried for day to day earnings as I had no savings. Therefore life now is better compared to before.

Jyare surrogate bani nahi hati tyare ghar ma mane kevu hate ke chalo, aaje gharwala jashe ane kamai ne lawashe toa ame khai shaku. Ame je bani ne gaya te saru jindagi thai gai, je jaay ki na jay ame ghar chalai laish, kai wandho nahi. Ane pahala karta atyar ni jindagi sari kahway. Hawe me jate CNG lidha. Mane khabar che mane roj sanj ne saware basso rupaya aawshe. Pahale bachat kya thati hati? Pahle toa ae tension hati ke aaje malshe ki na male kem ke bachat nahi ane etale pahala karta atyare jindagi sari che."

Nikita (30 years) reported beginning her surrogacy journey with a round of egg donations followed by two surrogacies and then additional three rounds of egg donation. Thereafter, the medical practitioner advised her against further egg donation and Nikita took up work as a nanny for children borne through surrogacy at the clinic.

Extent of her engagement in ‘reproductive labour’ is indeed alarming and needs scrutiny, though Nikita expressed her satisfaction in following words,

Surrogacy has had a positive impact on my family and the children. I am able to run my household and nurture my children well working here (as a nanny). All three sons of mine are studying in a hostel (boarding school). I have bought a home and a new CNG rickshaw. Compared to before, my life has improved a lot.”

Surrogacy karaya pachi mane mare ghar ma mara chokrao ma baddhu saru j thay che. Ane aawi rite kaam waam karine mane mara ghar nu mara chokrao nu palan poshan sari rite kari shaku chu. Mara chokrao trnyo tran hostel ma bhane che. Ane mare ghar kari lidhu ane rickshaw navi CNG lidhi che.

Pahala karta mara ghar ma kafi sudharo che.”

After completing one or two rounds of surrogacy, some women (6) took up paid work at the ART clinic mostly as nannies or became surrogacy agents and earned commission for introducing new women into surrogacy. Women reported satisfaction for the continued income they earned through their association with ART clinic. However, despite such satisfaction expressed, further research is needed to identify possible pitfalls and long term impacts, positive or negative, of prolonged association with ‘reproductive labour industry’ on the lives of the women.

Other than the material gains, women reported improvements in their personal lives in the form of increased say in the family matters (4), respect in the family or in the rare case in society (2), and sustained contact with the commissioning parents (3) and the fellow surrogate mothers (2) who became friends. These new relationships gave women a sense of personal fulfilment. Rukshar (36 years) a twice surrogate

mother shared that her extended family respected her for supporting the household and the education of her children through surrogacy. In the words of Rukshar,

Now our nephews respect me more. My husband has irregular earnings. So, nephews admire me saying ‘our aunt is equipped to take care for her children’s future. Not only she bought a house, she went again (second surrogacy) for her children, otherwise who goes and gets own belly slit within 11 months? Therefore, aunt deserves respect. Do we have capacity to educate our children in affluent colleges?

Mare jeth na chokrao ma maro wadhare maan thayu. Mara gharwala kamawe na kamawe evu kai magajmari hoy. Toa aa loko em kahe ke amari kaki ketali sari che ke chokarao nu toa dhyan bhawishy ma rakhi shake che. Ek makan toa banavyu biji feri pan chokarao mate gai ne, nahi toa biji feri kon agyar mahina ma pet chirawa jaawe? Etale kaki j saara kehway ne? Ke chokrao ne etlu hifi college ma bhanawanu ke thodi aapdi takat che?

Increased agency of women following surrogacy in the context of family was evident in an impromptu conversation I had with the husband of a surrogate mother who had completed two surrogacies and was working as a nanny at the ART clinic. Despite the material gains resulting from his wife’s surrogacy income, the husband expressed dissatisfaction about the absence of his wife from home while she worked as a nanny at the ART clinic. When nudged, whether he would like her to get into another surrogacy he reacted, “No, no. She will become a millionaire. Then she will tell me that she is earning money and feeding me. She doesn’t obey me! Don’t you know she had deserted me? Fortunately she returned.”

*Na, na! Ae toa karodpati thai jashe. Pachi mane bole ne hun paisa
kamaweene tane khwadavu chu. Ae thodi j sambhade che maru! Tamne toa
khabar j che ne jati raheli te? Ae toa naseeb saru ke pachi aawi gai.*

The conversation indicated that women may gain considerable power in the household and might be assertive through the economic independence they achieve through participation in surrogacy. One of the best practices at the clinic made it mandatory for the women to have an independent bank account which they did not share with anyone. The surrogacy payments were deposited only in this individual bank account of the women enhancing their control over the money they earned in surrogacy to some extent. Systematic post-surrogacy counselling may greatly enhance women's agency and their access and control over resources.

Future plans of the women. When probed about post surrogacy plans, majority of the women expressed desire to continue their participation in paid workforce (66%) either as domestic helps, nurse aids, nurses and teachers (39%) or in the form of 'reproductive labour' to repeat surrogacy and nanny jobs at the ART clinic (27%). The data indicates desire of women for economic independence and a glaring need for creating skill building opportunities and broadening the livelihood options for women.

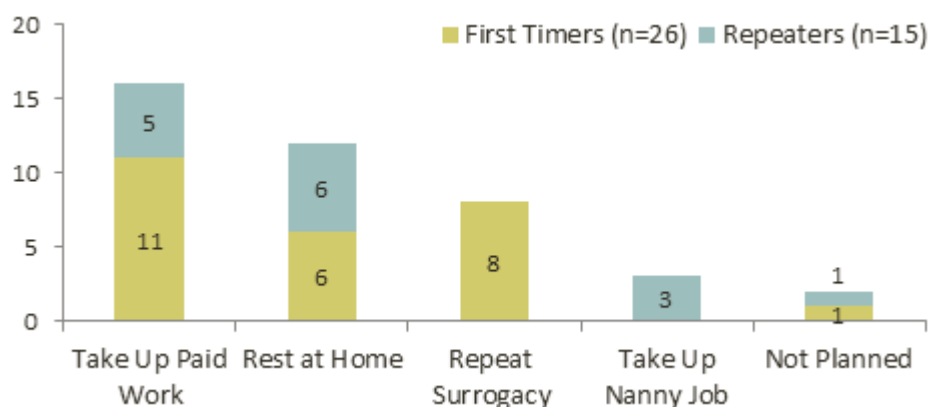


Figure 43. Future plans of women post surrogacy.

Key Take Aways

Surrogacy Outcomes and the Future Plans of the Women

- Amongst the 15 women who had successfully completed at least one surrogacy, a large majority were able to attain stability in the form of savings and material possessions that improved their quality of life. These women successfully attained the goals they set out in their minds while they decided to participate in surrogacy – purchasing a house, accumulating savings, providing quality education to the children, and acquiring an improved status in the family and at times in the society.
- Women reported a sense of economic independence and improved say in the matters concerning their family. At the same time, it appeared that some women were likely to experience resistance of their spouses who saw independence of women as a threat to their power position in the family.
- In the absence of other viable income generation opportunities, women were likely to prolong their engagement in the ‘reproductive labour’ in the form of repeated surrogacy and egg donation stints. Further research is needed to identify possible pitfalls and long term impacts, positive or negative, of prolonged association with ‘reproductive labour industry’ on the lives of the women.
- Majority of the women aspired for economic independence evident in their desire for the continued participation in the paid workforce post surrogacy. There is a need to ensure access to a range of skill building and livelihood opportunities for women other than the ‘reproductive labour’.