

Introduction and Review of Literature

The development and spread of assisted reproductive technology (ART) in the last century has been spectacular and revolutionary but has also posed challenges for health service delivery and society (Fathalla, 2002). ART assists in human reproduction but may not treat infertility. ART in its several forms has often stirred public debates due to ethical, moral, and social issues associated with it. Feminist scholarship has contested the position of ART in society and has expressed divided opinions. Some have opposed ART on the grounds of reinforcing the motherhood ideal, short-term and long-term ill-effects on the bodies of women, its inherent eugenic nature, fragmentation of female body into its parts at the cost of bodily integrity, and commodification and sale of the generative power and organs of the female body. Others have been pro-technology with the belief that technology could liberate women from ‘the tyranny of reproduction’ and have emphasised ‘procreative liberty’, ‘reproductive rights’, and ‘women’s right to self-determination’ (Agnihotri Gupta, 2011; Ainsworth, 2014; Qadeer & John, 2009). For some women ART has been empowering, giving them more control and agentic power to determine their life outcomes; for others ART has resulted in more external monitoring, and right to choose has been reduced to the right to consume (Agnihotri Gupta; 2011). In a globalised world which makes cross-border trade in reproductive health care possible, feminist debates have gained a whole new perspective drawing attention to ‘reproductive stratification’ by ‘race’ and ‘class’ (Ainsworth, 2014; Klein, 2008). Social and legal sciences have been slow at keeping-up pace with the tremendous advances in natural sciences and to address the challenges posed by the ART. Despite perfection of ART by the late 1980s, most practising nations are yet to come up with anadequate regulatory framework to govern its practice (Teman, 2008).

Surrogacy, an extension of ART, involves an arrangement whereby a woman gestates, births and relinquishes the child born to another person or a couple desirous of becoming a parent/s, has attracted much debate. Surrogacy arrangements are of two types depending on the source of female gametes or ova. In 'genetic surrogacy', the surrogate mother contributes her ova and is impregnated through Artificial Insemination (AI) of male sperm in her womb which is a less invasive procedure. Alternatively, ART specialists use 'In-Vitro Fertilisation – Embryo Transfer' (IVF-ET) wherein they fertilise ova of a commissioning mother or a third party donor with male sperm in a laboratory and transfer the resultant embryo/s in the womb of the surrogate mother. In exchange for money or for altruistic reasons, a surrogate mother agrees to carry the pregnancy, birth and relinquish the genetically unrelated child thus born, and all the associated parental rights to the commissioning parent/s (Wilkinson, 2003). This arrangement also referred as 'gestational surrogacy' is more attractive to the people desirous of a genetically linked child, though is complex and requires hormonal manipulation of the women involved.

At present, increasing use of commercial gestational surrogacy (henceforth surrogacy) to realise parenting aspirations has raised concerns. Surrogacy segregates all the essential elements of procreation– the ova, the sperms, and the womb –thereby challenging religious beliefs and normative assumptions of a heterosexual biological 'family', 'kinship' and 'parenting'. It creates scope for multiple sets of parents – the one who gestates and births the child, those who provide the genetic materials, and those who raise the child born (Brinsden et al., 2000; Levine, 2003). While surrogacy provides rays of hope to the people experiencing infertility, the well-being of the surrogate mothers involved is widely debated (Deonandan, Green, & van Beinum, 2012). Evidence across practicing nations indicates that surrogate mothers are often at

educational and economic disadvantage and are resource poor compared to the clients seeking their services, thereby making them vulnerable (Centre for Social Research, 2012; Ciccarelli & Beckman, 2005; Damelio & Sorensen, 2008; Gagin, Cohen, Greenblatt, Solomon, & ItsKovitz, 2005; Pande, 2009^a; Temen, 2001; van den Akker, 2007; Vora, 2009). There is a conspicuous dearth of literature determining long-term impact of surrogacy on the overall health of women and longitudinal data on health outcomes is largely missing (Spar, 2005). Surrogate mothers may not entirely be aware of the complexities of the surrogacy process, and short-term and long-term impact of participation on their health (Damelio & Sorensen, 2008; Unnithan, 2010). Circumstances where commissioning parents in the event of separation, divorce, or death fail to accept custody of the child born through surrogacy endanger child's right to a secure and nurturing environment and a nationality (Tobin, 2014).

Various nations differ in their outlook towards surrogacy ban or regulate its provision based on age, marital status, and sexual orientation of commissioning parents and surrogate mothers. Bulgaria, France, Germany, Italy, Portugal, Spain, Switzerland, and several other nations impose an absolute ban on surrogacy while Australia, Belgium, Denmark, Ireland, New Zealand, and UK only restrict commercial surrogacy. Very few nations like Georgia, India, Russia, Ukraine, and six of the US states permit commercial surrogacy. Policies governing the use of surrogacy in a region contradict with the policies in other resulting in legal plurality. Unequal access to surrogacy services promotes its 'cross-border trade' in the liberal economy of the globalised world. Surrogacy markets have sprung up in the areas where surrogacy contracts are legally enforceable. Aspiring parents often seek cross-border surrogacy services to evade laws in their home countries causing legal dilemmas (Ferraretti, Pennings, Gianaroli, Natali, & Magli, 2010; Spar, 2005).

India with its liberal approach to commercial surrogacy until recently, offered a safe haven to same-sex and heterosexual couples as well as single women and men seeking domestic or transnational surrogacy services and had emerged as a global surrogacy hub (Chang, 2009). ART clinics offering surrogacy services assert that commercial surrogacy creates an avenue for the surrogate mothers to alleviate own poverty and can be an empowering experience (Saravanan, 2010; Vora, 2010). On the contrary, media reports and academic literature have expressed concerns over exploitation and victimisation of poor Indian women in absence of a stringent regulatory measure to govern the practice of surrogacy. In response to these critiques, India prohibited provision of surrogacy services to foreign nationals in 2015 (Government of India, Ministry of Health and Family Welfare, 2015) and later proposed a full ban on commercial surrogacy, permitting only altruistic surrogacy through the Surrogacy (Regulation) Bill, 2016. The bill is a welcome step for the regulation of surrogacy market however; it is currently being debated for limiting access to altruistic surrogacy for the heterosexual married Indian couples. Surrogate mothers held a protest gathering against the restrictive moves from the Indian government (Doshi, 2016; Times of India, 2015b). The issue continues to be debated with limited empirical evidence concerning the practice of surrogacy in India, profiles of surrogate mothers, their experiences of participation in the surrogacy, and implications for family and society to promote evidence-based policy. This study aimed to address this gap.

Surrogacy is a complex social phenomenon with a wealth of Euro-American literature on bio-medical, ethical-moral, legal, and psychosocial implications. This literature is crucial to understand the socio-economic and political contexts in which ART and surrogacy operate. This chapter reviews the multidisciplinary literature

pertinent to anchor this study, aiming to unravel psycho-social experiences of surrogate mothers in India. Since the study primarily focused on the experiences of surrogate mothers and implications for individual and family, this review excluded literature concerning commissioning parents and the children born through surrogacy. The study is grounded in the contemporary practice of surrogacy and does not investigate mythological and epic literature concerning the practice of surrogacy in the ancient India. This chapter situates Indian surrogacy in the contemporary macro-context of the globalised reproductive health-care and the cultural context of the self and the psychological agency of women in India to develop a conceptual framework for the study. The sub-sections include:

- Privatisation of ART in India: Emergence of a Global Market
- Use of ART and Surrogacy: A Quagmire of Challenges
- Implications for ART Practice: Consent, Counselling and Legal Regulation
- Surrogacy in India: An Avenue for Empowerment or Subjugation?
- Psychological Agency of Women in India
- Theoretical Perspectives on Psychological Agency
- Theoretical Framework for the Study
- Conceptual Framework for the Study

Privatisation of ART in India: Emergence of a Global Market

After the birth of Louise Brown –the world’s first baby born through In-Vitro-Fertilisation (IVF) – in July 1978 at the United Kingdom, ART advanced rapidly. Within a decade, first IVF birth through surrogacy was reported in Australia in 1988. Several techniques were developed to address a variety of infertility issues and methods for ovarian stimulation, retrieval of oocytes and cryopreservation of sperms

and embryos were mastered. Techniques to detect genetic anomalies in the embryos before transfer are now nearly perfected (Kamel, 2013). Though originated in the West, ART rapidly spread in Asia with globalisation and integration of the world economy, and is now practised in many nations. In a survey of 16 Asian countries conducted in 1996 India reported practice of sperm donation, ovum donation and embryo donation, cryopreservation of the pre-embryos, surrogacy, and foetal reduction. Other than India surrogacy was practised only in Korea and Thailand (Schenker and Shushan, 1996) and eventually Thailand banned its practice in 2015 for foreign nationals.

India achieved the first scientifically documented IVF birth in August 1986 through a collaborative IVF research initiative between the National Institute for Research in Reproduction (NIRR) and the King Edwards Memorial Hospital, Mumbai. A need to provide subsidised IVF services to Indian population generated interest in ART research. Additionally, Indian Council of Medical Research (ICMR) envisioned acceptance for permanent contraception among the masses by establishing IVF as an easy mode to conceive post tubal-sterilisation (Sama, 2006; Widge, 2002). Following the suit of many other dubious public-private partnerships, researchers trained at the public hospitals in the use of expensive and specialised IVF technology left NIRR to establish a private ART practice (Srinivasan, 2010). NIRR soon discontinued provision of ART mentioning that direct service delivery was not its primary thrust area and lack of funds to support it.

A constant demand for the treatment of infertility and lack of governmental bodies providing it created great avenues for the private practice of ART (Sarojini, 2014; Sama, 2006). In the Indian patriarchal and pronatal social set-up, the motherhood mandate and the preference for a male child were the prominent social

drivers for the demand and growth of ART along with the celebrity status accorded to the successful interventions in media (Srinivasan, 2010). Several other factors fed into the enormous growth of ART industry in India. General Agreement on Trade in Services (GATS-1995) made a direct international trade of goods, services, and people possible (World Trade Organization, 2001) and liberal economic policies made it easier for the doctors trained abroad to import the latest ART equipment and set up clinics in India. Few government hospitals provided ART services but quality of service delivery was poor (Widge, 2002). Provision of ART, which started as a government initiative in India, within two decades became a full-blown private industry (Agnihotri Gupta, 2000) reaching out to rural settings and operating in diverse contexts (Sarojini, 2010). Various players in the ART market now work in unison, refer patients from smaller clinics to speciality clinics and aggressively market ART services with packages and discounts. In the absence of a standardised treatment protocol, practitioners expose people to various treatment plans based on their ability to pay, often trivialise health risks involved and share exaggerated success rates to increase marketability of the ART. Pharmaceutical companies promoting various drugs required for ART and manufacturers of ART equipment too have vested interests in the proliferation of the ART market. Multinational corporations have diverted ART to enormously profitable ventures – research and practice of stem cell therapies. Today, the bio-research industry seeks the consistent supply of unused embryos from IVF cycles for stem cell research raising ethical concerns (Mulay & Gibson, 2006; Qadeer, 2010^b; Sama, 2006; Sarojini, 2010; Sengupta, 2010^a; Sengupta, 2010^b; Srinivasan, 2010).

Figure 1 demonstrates an exponential increase in the number of ART clinics in India. Butler (2003) based on the estimate of Population Council in New Delhi

recorded 60 Indian ART centres operational in 1999; almost all private without any regulatory framework or even discussion about issues associated with ART. Malhotra, Shah, Pai, Pai, and Bankar (2013) analysed data from the National ART Registry of India for three years 2007-09 and reported an increase in ART centres performing IVF from 113 in 2007 to 132 in 2009. In 2015 ICMR published a list of 385 ART clinics enrolled under the 'National Registry of ART Clinics and Banks in India' (Indian Council for Medical Research, 2015).

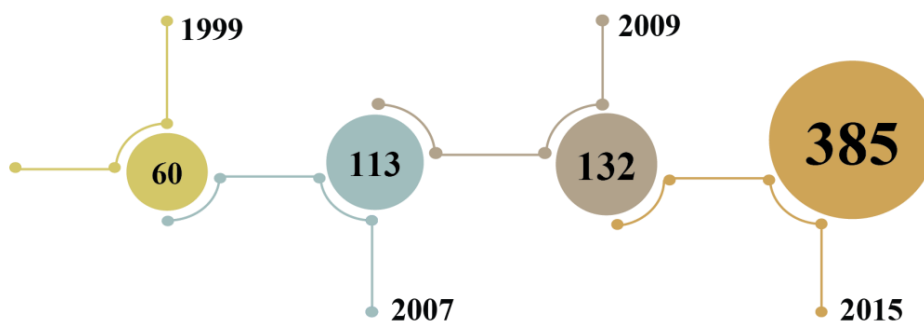


Figure 1. An exponential rise in the number of ART clinics in India.

Note. The data are extrapolations of multiple papers - Butler (2003), Malhotra, Shah, Pai, Pai, and Bankar (2013), and Indian Council of Medical Research (2015).

Figure 1 represents only the number of registered ART clinics by 2015, but the Hague conference report indicated approximately 500 ART clinics operational in India in the year 2010 (Hague Conference on Private International Law, 2012). The number of practising ART clinics in India is likely to be much higher, and under 'The Surrogacy (Regulation) Bill, 2016' (Government of India, 2016) more ART clinics and banks are likely to enrol. Clearly, ART is a full blown industry in India with the involvement of multiple stakeholders purely driven by profits. Minimal registration of ART clinics and absence of robust regulation makes it difficult to estimate its exact size (Sama, 2006).

Cross-border Reproductive Care in the Context of Medical Tourism in India

Several developments in the last decade fuelled medical tourism industry in India. Provisions under GATS facilitated Indian private hospitals treating foreign patients to avail financial incentives including raising capital at lower interest rates and lower import duties on medical equipment. Foreign investments in infrastructure development of private Indian hospitals were incentivised (Mulay & Gibson, 2006; Saxena, 2011). The annual report of the Ministry of Tourism, Government of India 2009-10, recognised medical tourism as a significant segment of the industry and reported various initiatives to the providers of medical tourism services and travel agents and tour operators facilitating medical tourism. The ministry encouraged all the states to promote medical tourism through suitable packages and price banding for various treatments. Ministry of Home Affairs introduced a 'medical visa' for patients and their attendants visiting India for medical care (Government of India, Ministry of Tourism, 2009-10). These provisions substantially shaped infrastructure development of private healthcare sector in India and gave a boost to transnational trade in health care services. Indian private hospitals sought tie-ups with insurance companies abroad which encouraged their clients to avail medical services in foreign accredited Indian private hospitals thereby assuring them of quality care (Mulay & Gibson, 2006; Saxena, 2011). A cross-national study on medical tourism involving India, China, Jordan, and UAE revealed that for medical tourists visiting India, the most important factor for seeking transnational care was high treatment costs in the home country, and the tourists preferred India primarily for the quality treatment at low costs (Alsharif, Labonte, & Lu, 2010).

Cross-border reproductive care is a unique segment of the medical tourism industry which entails seeking ART treatment abroad. Some nations impose a

complete ban on specific reproductive health care services like surrogacy or limit its access to same-sex couples, unmarried and single persons. Success rates for ART procedures vary across practising clinics and some speciality ART procedures might be unavailable at home country due to lack of expertise or if the procedure is considered experimental and does not meet specified safety standards. In addition, there could be an extended waiting period to avail ART, or they may be costly. In these conditions, people tend to seek cross-border reproductive care (Blyth & Farrand, 2005; Cohen, 2010; Ferraretti, Pennings, Gianaroli, Natali, & Magli, 2010).

India provided ART services comparable to world standards at lower costs coupled with a loose surrogacy regulation until 2016, and had emerged as a favoured destination for surrogacy amongst foreign nationals (Chang, 2009; Sengupta, 2010a). In an exclusive report on surrogacy, Law Commission of India (2009) indicated that the cost of surrogacy added up to at least \$70,000 in the USA, and in India, it was as less as one-seventh of this price which drew foreign nationals seeking surrogacy services to India.

The data on the types of visas issued to the foreign nationals by the Government of India during 2010 to 2014 indicates that the number of foreign nationals seeking ART/surrogacy services in India peaked in the year 2012 and dropped after that. It also appeared that people from 67 nations obtained visas to avail ART/surrogacy services in India during 2010-14 (Figure 2). In 2010, ART/surrogacy visas were issued only to the Bangladeshi nationals and in the following years to increasing number of nations until 2013. A sharp decline in the number of ART/surrogacy visas issued and the number of countries granted this visa post-2012 can be attributed to international pressures to regulate transnational surrogacy. The Hague Conference on the Private International Law released a report on international

surrogacy arrangements and indicated 1000 percent rise in the global surrogacy industry from 2006-10. The report expressed the need to regulate the ‘booming global business’ of surrogacy (Hague Conference on Private International Law, 2012).

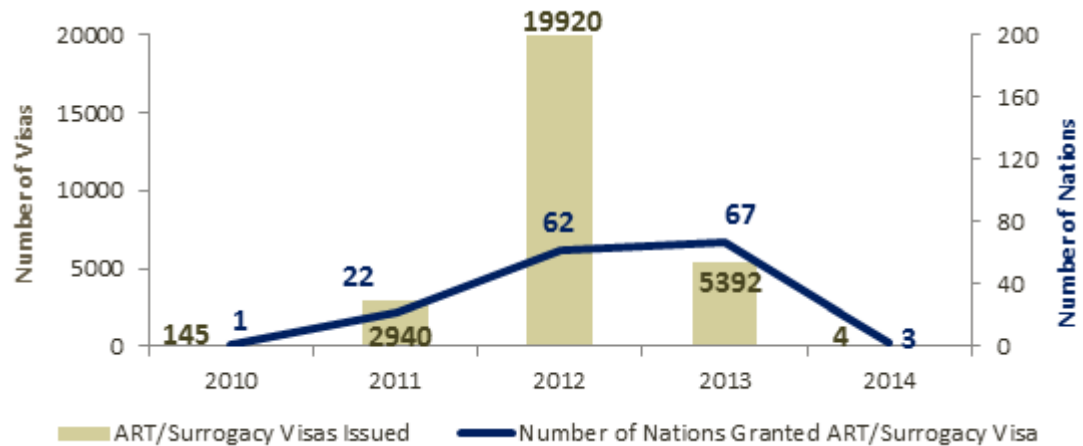


Figure 2. ART/surrogacy visas issued by India during 2010 – 2014.

Note. Data obtained from the Open Government Data (OGD) Platform India¹. Data are available for the period – July 2010 to January 2014.

The report also explicitly stated that in 2010, Consul Generals of eight European countries jointly wrote to IVF clinics in India to cease providing surrogacy services to citizens of their countries without an express indication from the embassy. The government of India in July 2012 released a circular that laid down restrictive guidelines to limit the issuance of such visas and stated medical visa as the only appropriate visa category for surrogacy (Government of India, Ministry of Home Affairs, 2012). Further, the guidelines mandated exit permission from the Foreigners Regional Registration Office against a letter from the ART clinic stating that the child/children born through surrogacy have been duly taken custody of by the foreign nationals and that the liabilities towards Indian surrogate mother were entirely fulfilled. Eventually, in November 2015, Government of India issued another circular banning provision of surrogacy services to foreign nationals and import of human

embryos for any purpose other than research (Ministry of Health and Family Welfare, Government of India, 2015).

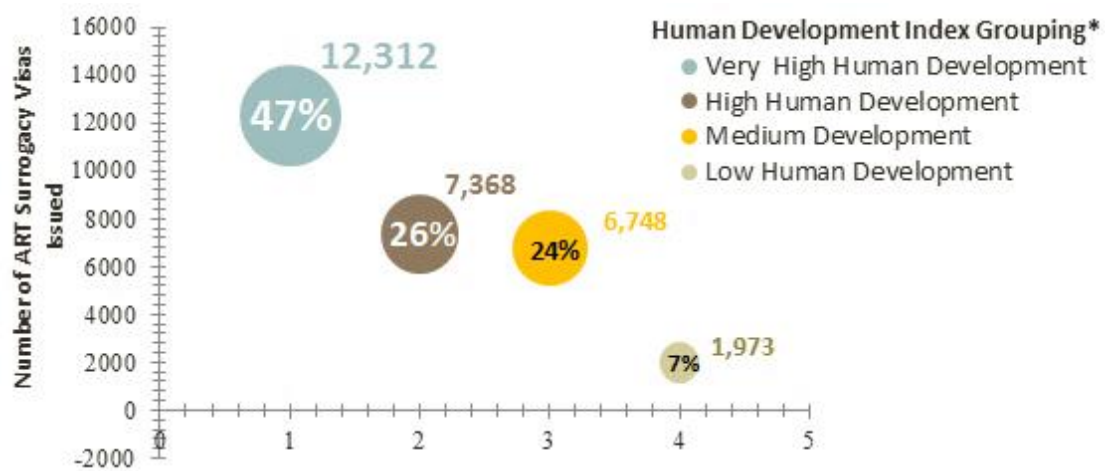


Figure 3. HDI groups and ART/surrogacy visas issued by India 2010-14.

Note. HDI grouping of nations based on 2014 data published on December 14, 2015.

During 2010-14, India issued a total of 28,401 ART/surrogacy visas (Appendix A). The top five nations obtaining ART/surrogacy visas from the Indian government were Bangladesh (16%), France (8%), Malaysia (8%), USA (7%), and Iran (6%). Further analysis by the Human Development Index groups of the nations which received visas (Figure 3) indicated that the majority consumers of transnational surrogacy services in India belonged to nations with very high and high human development index (72%) followed by 24 percent nationals of medium development and 7 percent citizens of nations with low human development. The data clearly indicates differential access to ART/surrogacy primarily limited to the affluent.

Figure 3 only indicates the number of foreign nationals seeking ART/surrogacy services in India, and in the absence of a uniform national registry of ART clinics, the number of Indian nationals availing surrogacy services is not available. Malhotra, Shah, Pai, Pai, and Bankar (2013) reported a threefold rise in the use of surrogacy from 2007 to 2009 though did not reveal actual figures. The Akanksha Fertility Clinic based in Anand, Gujarat alone had attained 1001 births

through surrogacy in the year 2015 and had served people experiencing infertility from 42 nations across the globe (Times of India, 2015a). In the absence of national data, it is hard to estimate the actual economic value of Indian surrogacy industry. Nevertheless, Sama (2012) highlighted media reports estimating the Indian surrogacy industry to be over USD 400 million and Deonandan, Green, and van Beinum (2012) and Howard (2014) stated that India had world's largest gestational surrogacy market worth USD 500 million to USD 2.3 billion. Overall, the data indicate exponential growth of Indian surrogacy industry in the last decade and challenges associated with it merit attention.

Use of ART and Surrogacy: A Quagmire of Challenges

In a review of contemporary scholarship on ART Briggs (2010) argued that these writings on ART fail to question the socio-political and economic environment in which women are increasingly forced to delay reproduction. The easy, celebrity narratives of ART fail to advocate for the social policy reforms for childcare arrangements and family-friendly educational and work places which will enable women to bear children in their twenties. Healthcare providers question the legitimacy of investments in ART in the developing nations like India with limited health care resources and high disease burden, especially, in the view of high treatment costs and low success rates (Butler 2003). In addition, of the 8-10 percent Indian population experiencing infertility, 98 percent suffer 'secondary infertility' which is preventable. A minuscule fraction of Indian population requires treatment through ART and still lesser need IVF and surrogacy (Qadeer, 2009; Sama, 2006). The ART does not cure or even treat infertility; it seeks a technological solution for the social problem of motherhood mandate (Shah, 2010). Figure 4 displays a range of global concerns relating to the use of ART which are discussed next.

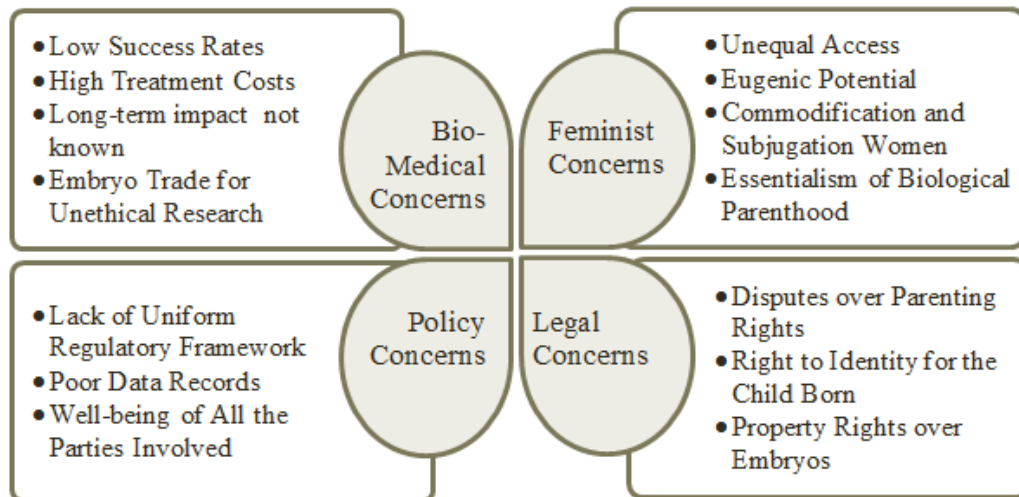


Figure 4. A summary of concerns regarding practice of ART and surrogacy.

Access, benefits and control: ethical and moral dilemmas of ART. The right to reproduce has a long history of political control marked by inequalities of class, gender, nation, race, and sexuality. Feminists argue that both contraceptive and conceptive technologies are on the same continuum as they intervene with the natural hormonal cycle of women, former to control the quantitative aspect of women's fertility and later qualitative in the form of eugenics (Sarojini & Das, 2010). Historically, women's bodies, especially of the women of colour, were subjected to legislative control through population control programmes while White women predominantly continue to undergo invasive procedures to be able to produce children. In doing so, only certain kinds of bodies are considered worthy of reproduction. Neo-liberal globalised market has led to increased yet differential access to ART services in India and elsewhere. Health insurance companies do not cover the costs incurred for ART services limiting its access to the wealthy and marginalise reproductive rights of the poor (Ainsworth, 2014; Briggs, 2010; Mulay & Gibson, 2006; Sarojini, 2010). Many Indian women lack access to high standards of reproductive care during own pregnancies but receive it when they gestate babies for others (Jaiswal, 2012).

Multinational entities invest in bodily products of women from developing countries and underdeveloped areas of Eastern Europe who are vulnerable to the commercialisation of body parts and receive much lower payments compared to women in developed regions for such trade. These entities draw huge profits from the sale of the placenta, ova and extra embryos created during IVF for research and reap profits and benefits which rarely reach to the women involved (Agnihotri Gupta & Richters, 2008). Profit making transnational corporations in the neo-liberal market outsource many forms of high risk and undesirable clinical labour including trade in human organs, clinical trials on subjects and surrogacy to the global north (Vora, 2010). In her reflections on the commercial surrogacy in India, Vora (2009) drew parallels within the large bodies of literature on organ selling and maids, nannies, and domestic workers. She highlighted intersections of class, gender, nationality, and race where certain people are considered more appropriate workers for these devalued forms of work. She critiqued transnational surrogacy in India as a form of neo-colonial exploitation in a globalised world.

Corea (1985) argued, men and women of a particular race may form a highly sought after group for gamete donation because of the highly valued genetic, physical, and intellectual traits. The women from a 'less worthy' race play the role of surrogate mothers or 'incubators' because of their disadvantaged socio-economic status. She critiqued eugenic potential of ART stating, "...when it becomes possible to transfer human embryos routinely from one woman to another; then the way opens up to use Third World women to gestate babies for wealthier Westerners (Corea, 1985. p. 43)." In an ethnographic exploration, Goslinga-Roy (2000) concluded that the racial identity greatly shaped experiences of the surrogate mother she studied. For the white surrogate mother, it was unimaginable to carry in her womb a black child, and she

believed that doing so would threaten her bodily sanctity. She could use genetic disconnectedness to distance the child she carried in her womb only as long as the child was white.

Corea (1985) and Goslinga-Roy (2000) highlighted the eugenic potential of ART at the macro levels of colonial exploitation and racial biases, but the limited empirical evidence available in India suggests that the eugenic notions are further deep rooted in the hierarchical class structure of the Indian society. Sama (2006) in a study involving women undergoing ART found that when donor gametes were used, recipients often desired for the donor qualities 'fair, intelligent, and belonging to the high social class'. Health care providers, who also belonged to the same Indian socio-cultural set-up, held similar opinions like the treatment seekers. One of the service providers reported assuring treatment seekers, "...we are not getting sperms from rickshaw pullers, but from men of good families (Sama, 2006, pp. 321)." The quote aptly demonstrates problematic nature of the eugenic notions associated with the use of ART in the Indian society.

Further, eugenic notions are not only based on racial and class differences but are also related to gender attitudes. Cultural beliefs and social context shape to a great extent image of an ideal child. Expectant parents often visualise their future children with specific traits, but parents conceiving with IVF may also get the opportunity to create 'tailor-made' babies during IVF. It is possible to select gametes from a donor with desired traits, to perform Pre-implantation Genetic Diagnosis (PGD) of embryos for detecting genetic disorders, for sex-selection and the selection of embryos with desired traits (Billitteri, 2015; Butler, 2003). Cultures stressing the importance of begetting a male child may abuse PGD by selective abortion of the female embryos (Ferraretti, Pennings, Gianaroli, Natali, & Magli, 2010). Some private clinics in the

north India were blamed for selective use of sperms with 'Y' chromosomes to ensure the birth of a male child Agnihotri Gupta (2000). PGD has already been used to create 'saviour siblings' who did not carry a disease-causing gene and were suitable to contribute healthy stem cells for the treatment of an older sibling; though successful, the practice was widely condemned (Billitteri, 2015; Srinivasan, 2010). Genetic engineering or micromanipulation to alter the structure of DNA has the potential to replace mutant genes with the healthy ones to prevent 170 inherited diseases, though the use of this procedure is currently limited to experimental research in animal embryos. Scientists and ethicists have appealed for a worldwide ban on genetic modification of human embryos as the technique alters every cell of the resulting child and all subsequent generations. The risks of such alterations can have far reaching impacts which are not yet fully known (Billitteri, 2015).

Ainsworth (2014) highlighted another less discussed perspective linked with the surrogacy and eugenics- that of disability. She contends that in the discussions on surrogacy, no one typically envisions people experiencing disability as intended parents or surrogate mothers. In surrogacy discussions, disability surfaces in association with PGD which allows the selection of disability-free embryos for implantation or selective abortion of embryos with a disability. She further argued that rhetoric equating disability with reduced human value remains unquestioned. Difficult questions like, whether we should permit use PGD for early detection of disability/ selective reduction of embryos/ abortion, whether one can force the surrogate mother to abort a foetus with a disability, can intended parents disown the child born with a disability never surface in the policy discussions. Clearly, access to ART, especially IVF and surrogacy, create ethical and moral dilemmas that can have far reaching social implications and need to be regulated.

Another prominent concern in use of ART and surrogacy is medicalisation of and control over women's bodies. In matters relating to infertility, predominantly women's bodies are medicalised and subjected to various technologies compared to men, and create new power hierarchies through medical control, professional authority and market regulation (Unnithan, 2010). In surrogacy, reproductive technology takes the form of surveillance technology to produce a perfect surrogate child and in the process the surrogate mother ceases to be a person and becomes a commodity. Women's bodies and lives are controlled through high surveillance of their nutrition and daily movement (Ainsworth, 2014; Kessler 2009; Shah, 2010). Women are taught to refer to the self as an 'oven', 'incubator', or a 'hotel room' providing temporary shelter to someone else's child in most surrogacy programs. The biological and physical labour of gestation performed by surrogate mothers is effectively evaded using such 'cognitive dissonance strategies' reducing them to a mere means to an end (Agnihotri Gupta, 2000; Corea, 1985; Tieu, 2009; Vora 2009). In a U.S. based study Berk (2015) revealed that the surrogacy contracts imposed control through three main categories of rules, 'life style rules and behavioural restrictions', 'rules governing breastfeeding', and 'rules governing viewing, handling, and future relationship with the newborn.' As paying party commissioning parents had a great power in determining the controlling restrictions in the contract including the degree of surveillance over the surrogate mothers. Lawyers coached surrogate mothers as well as commissioning parents for emotional regulation and were expected to resolve any breaches in the contract and enforce the agreement rules. Berk (2015) referred to these contractual risk management rules as 'legalisation of emotion,' which whether enforced or not were 'influential and institutionalising'.

Bhardwaj (2013) applied Marx's theory of alienation to surrogacy arrangements she studied in Mumbai. She argued that the women were systematically alienated from 'the product of labour' – the foetus – as the women did not have any rights over the child they gestated for nine months and then relinquished it. The women were required to be detached from the foetus as it was owned by the intended parents. The foetus was more valuable than the labour women performed as it was important for dignified survival of the women. Secondly, women were alienated from the 'labour processes as they did not have any control and rights over the decisions made during surrogacy. Crucial decisions like extent of contact between the intended parents and the surrogate mother, home stay or institutionalisation of the surrogate mother, procedures of foetal reduction, caesarean section etc. were taken by the intended parents. Lawyers who represented commissioning parents screened and counselled prospective surrogate mothers and explained them surrogacy contracts drafted in English in barely 15 minutes. The session emphasised that the child belonged to the intended parents, the surrogate mother must take medicines, keep medical appointments and care for the foetus, must not engage in any acts that could harm the womb, and must keep away dangerous cleaning products and cosmetics. The contract prevented women from seeking services of any other physician, took blanket permission for 'all kinds of surgeries as deemed necessary,' cleared intended parents from any liabilities towards any adversities, and facilitated presence of intended parents in the delivery room violating women's right to privacy. The signed contracts were scanned and mailed to the intended parents but surrogate mothers did not receive any copy of the contract. The surrogacy agents had 'prepared' the prospective surrogate mothers to agree with everything that the lawyer said prior to the visit which nullified validity of any informed consent.

Majumdar (2014) reported that the relationship amongst Indian surrogate mothers and the commissioning parents prevailed on the notions of 'risk' propagated by the infertility clinics and agents. Commissioning parents feared the loss of pregnancy and adverse effects on the health of the foetus which stemmed from surrogate mother's 'class position' as a 'needy' and 'uneducated' woman unequipped to carry the pregnancy to term. This discourse of risk resulted in constant surveillance of surrogate mothers – by commissioning parents in the local arrangements and by the clinic in the transnational arrangements. Commissioning parents blamed surrogate mothers for unsuccessful surrogacy or premature births.

Scholars indicate that in the context of colonial history of India, surrogate mothers are likely to view medical practitioners in an authority position, are dependent on them for information and lack legal representation. The surrogate mother thus may fail to refuse demands imposed on them or to determine work conditions during surrogacy even when commissioning parents may not mean to exploit them. Further, when medical decisions are made weighing monetary costs against the health of the surrogate mothers, conflict of interests are highly likely. As medical professionals become a common party representing both the commissioning parents and the surrogate mothers, in matters of conflict, interests of paying party are likely to prevail (Deonandan, Green, and Van Beinun, 2012; Qadeer 2010^b; Shapiro, 2014). Overall, the literature indicates problematic nature of ART stemming from unequal access to it and control over women's reproductive potential for the benefits to third parties in a globalised neo-liberal market. This literature forms the macro context in which experiences of surrogate mothers in India should be investigated.

Failures, loss and pain: A paradox of IVF and surrogacy. 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 which Franklin (2006) referred as 'paradox of IVF'. She argued that, what people gain in IVF at best is a more nuanced understanding of the reason for their failure to conceive. IVF success rates are low, and ART clinics are inconsistent in their definition of 'success rate' as the attainment of clinical pregnancy following IVF or attainment of a live birth. Moreover, the success rates also vary considerably depending on a multitude of other factors like methods used for embryo transfer and age and physiology of the recipient women (Colin, 2009; Srinivasan, 2010). Malhotra et al. (2013) reported 36.5 percent IVF success rate (pregnancies per fresh embryo transfer) and abortion rate of 5.3 percent in the year 2009 based on the data shared by ART clinics in India but did not report the percentage of live births. More often, success rates advertised by the ART clinics for the treatment seekers can be largely misleading (Mulay & Gibson, 2006; Qadeer & John, 2009; Widge, 2002). ART clinics in India routinely transfer more than one embryo in the recipient surrogate mothers to increase the chances of pregnancy. Health activists have questioned the practice as it often results in multiple gestations with risks of complications during pregnancy and childbirth, pre-term delivery, selective reduction of foetuses, and consequent abortion in some cases. Further, ART clinics tend to gloss over possibilities and risks of multiple gestations, and foetal anomalies (Colin, 2009; Qadeer & John, 2009) and these risks are rarely considered seriously (Fathalla, 2002) compromising the well-being of the surrogate mothers.

International evidence indicates that despite educational intervention, commissioning parents and surrogate mothers were poorly informed about surrogacy, overestimated chances of success and experienced feelings of guilt over failure to conceive, miscarriages and curettage (Brinsden et al., 2000; van den Akker, 1999). The U.S. based surrogate mothers' narratives about pregnancy loss on a surrogacy

support website indicated ‘losses in the hearts’ resulting from the failure to attain pregnancy and ‘losses in the body’ arising from miscarriage and stillbirth. For the surrogate mothers, loss broadly meant their inability to give commissioning parents a child they yearned for, but the intensity of loss experienced by the surrogate mother went unnoticed in the larger narrative of ‘it is not my child’(Berend, 2010). She added that use of technology heightened expectations of success and created a sense of loss upon failure to conceive. The surrogate mothers also mourned the status they earned through self-sacrifice involved in relinquishing the baby they nurtured in their womb. Viewing surrogacy as a ‘planned goal’ made them further vulnerable to the failure. Lastly, the loss was produced through frequent monitoring and eagerness to conceive wherein early testing resulted in false alarms and a normally constituted ‘late period’ came to be viewed as a pregnancy loss. Berend (2010) concluded that the very faith in the technology and numerous possibilities and hopes embedded in it created feelings of loss for the surrogate mothers. The sense of loss experienced by the users of ART needs to be acknowledged (Briggs, 2010).

There is limited evidence about the experience of the sense of loss and coping among surrogate mothers in India which merits attention to inform policy and practice.

Physical and mental well-being of surrogate mothers. Surrogacy is considered inherently unethical on the premise of using reproductively healthy women as a means to an end and subjecting them to several invasive procedures for the benefit of other women and men who are unable to conceive (Agnihotri Gupta, 2000; Corea, 1985). Pregnancy attained through ART involves certain risk to the mother, but there is a conspicuous dearth of studies examining risks to surrogate mothers and egg donors including ovarian hyperstimulation, increased risk of

infertility, breast and or gynaecological cancers, and multiple gestations (Spar, 2009). Awareness about the health risks of ART is low among users, and especially, various ill effects of hormonal drugs used in IVF and egg donation on the health of women and long-term safety of these drugs is yet undetermined (Coeytaux, Darnovsky, & Fogel, 2011).

Surrogacy involves risks of infections and injuries due to surgical procedures, multiple gestation and associated complications, foetal reduction, ectopic pregnancies, bleeding in the first trimester, induced hypertension, diabetes, miscarriage, pre-term delivery, and complications during childbirth and administration of anaesthesia. Women may also experience significant anxiety about medical procedures and may face depression when they fail (Srinivasan, 2010). However, both practitioners and users of ART rarely consider risks to the surrogate mothers seriously (Fathalla, 2002; Qadeer, 2010^b). In a study of 247 Canadian women who underwent 333 consecutive gestational surrogacy cycles Dar, et al. (2015) reported that 10 percent cycles resulted in miscarriages and overall caesarean section rate was 23.3 percent. Health complications were reported in 10 percent women of whom one was severe including caesarean hysterectomy that resulted in severe post-partum haemorrhage. There is no precise data available about medical complications experienced by Indian surrogate mothers though media has reported few unfortunate incidences of the death of an Indian surrogate mother (Times of India, 2012) and an egg donor (The Indian Express, 2016; We.News, 2014) aggravating these concerns.

The majority of the psychological studies in the Euro-American context reported surrogacy (gestational and genetic) as an overall positive experience for the surrogate mothers (Ciccarelli and Beckman, 2005; Jadvā, Imrie, and Golombok, 2015; Jadvā, Murray, Lycett, & Fiona, 2003). The key learnings from these studies were,

- Pre and post birth experiences, quality of relationship of the surrogate mothers with the commissioning parents and the extent to which surrogate mothers' expectations from commissioning parents were met were the key determinants for the psychological satisfaction amongst surrogate mothers. Interaction with commissioning parents and opportunity to see and hold the baby post birth contributed to the satisfaction and the sense of worth amongst surrogates. Post-delivery deterioration of contact with the commissioning parents can result in the feeling of abandonment.
- In the long run, at one year and ten years post surrogacy, surrogate mothers showed normal levels of self-esteem with no depressive symptoms and quality of their marital relationship remained positive over time. One year post-delivery unknown surrogate mothers were less likely to report difficulties compared to known surrogate mothers.

Despite an overall positive experience of surrogacy, these studies also reported some challenges that surrogate mothers experienced. Women experienced conflicts in interpersonal relationships with extended family and friends (Ciccarelli and Beckman, 2005; van den Akker, 2007). Surrogate mothers did experience psychological problems during surrogacy though were not clinically depressed (Jadva, Murray, Lycett, & Fiona, 2003). British surrogate mothers expressed worries about the failure to conceive, inability to cope with emotions, health concerns, feelings of own children, difficulties in relinquishment and commissioning mothers not accepting the baby. Social stigma, maintaining secrecy, physical hardships during surrogacy, time away from own familial obligations, and sense of loss post relinquishment were the challenges reported (van den Akker, 2003). Studies indicated that despite a sense of loss surrogate mothers coped well with the relinquishment (Jadva, Imrie, and

Golombok, 2015; van den Akker, 2003). Temen (2009) revealed that commissioning parents' over engagement and desire to control surrogate mothers created a potential for power imbalance that impacted the surrogate mother in Israel. Contrarily, limited or no participation of commissioning parents dissatisfied surrogate mothers as they carried the burdens of surrogate pregnancy alone.

Ethnographic explorations of surrogacy in the Indian setting have indicated that the ART practitioners almost always mediated the relationship between surrogate mothers and the commissioning parents and there was limited contact between them during and post surrogacy. In case of transnational surrogacy the relationship was further distanced because of the geographical distance and cultural and linguistic differences (Majumdar, 2014; Vora, 2010). Further, in the traditional patriarchal social set-up, surrogacy was a stigmatising experience and Indian surrogate mothers maintained secrecy about their participation in surrogacy (Pande, 2010^b).

This cross-cultural empirical evidence indicates that while surrogate mothers expressed satisfaction for participation in surrogacy, interpersonal relationships during and post surrogacy determined the psychological well-being of the surrogate mothers. Edelman (2004) highlighted that not much is known about the nuances of relationship amongst surrogate mothers and commissioning parents to help mental health professionals understand issues involved in surrogacy. Longitudinal data assessing the well-being of surrogate mothers and commissioning parents are largely missing and availing such data can help identify profiles and circumstances in which problems may arise. Media accounts usually tend to highlight unusual and dramatic aspects of surrogacy and systematic research is needed to document the normative experience of surrogacy.

Empirical evidence regarding how Indian surrogate mothers experience their relationship with commissioning parents during local as well as transnational surrogacy arrangements is relatively limited. Far less is known about the impact of surrogacy on the psychological well-being of Indian surrogate mothers at various stages of surrogacy and their familial lives which are important areas for research. It is crucial to identify potential factors that contribute towards a positive experience of surrogacy as well as those which are limiting in nature. Such data can play a substantial role in the formation of evidence-based policy for safeguarding the interests of women entering surrogacy.

Genes, gestation and nurturing: Kinship and parenting in surrogacy.

Surrogacy shatters the primacy of maternal-infant bonding and challenges the cultural ideal of 'altruistic' motherhood prevalent across cultures when surrogate mothers relinquish the child in exchange for money. Surrogate mothers are thus perceived to be deviant. Many psychological studies in Euro-American context investigated the incidence of psychopathology among surrogate mothers but failed to establish any with inconclusive results. Teman (2008) critiqued these studies as flawed in their normative assumptions of motherhood and family in the western society and concluded that these studies only reflected the sustained interest of psychologists in determining 'otherness' of the surrogate mothers. Temen argued that anthropological studies could offer a more nuanced understanding of the experiences and motivations of surrogate mothers. Similarly, Ragone (1996) claimed that the surrogate mothers display complex and shifting motivations for participation in surrogacy and most of the literature about their motivations oversimplifies such complexity.

Surrogacy has placed mothering ideologies at the crossroads of scientific and cultural realms. The lack of a genetic link with the foetus scientifically defies

maternal identity of the surrogate mothers and the pregnant personhood ascertains it. Surrogacy, therefore, involves balancing of the mother and non-mother identity for the surrogate mothers and commissioning mothers. Several studies indicate that surrogate mothers engage in significant identity formation work and realign their belief systems to make sense of this novel experience in the broader socio-cultural milieu. Empirical evidence across cultures indicates that surrogate mothers actively establish a 'non-mother' identity during surrogacy through cognitive dissonance (van den Akker, 2003) to realign their belief system and establish a 'non-mother' identity during surrogacy which helped them relinquish the child. Levine (2003) reported that when a gestational surrogate mother revealed her shifting perspective about herself from that of a 'mere carrier' to the 'birth mother' during surrogacy on a listserv, other surrogate mothers reminded her of her gestational role and reinforced the parental identity of the commissioning couple. Levine concluded that such socio-cultural organisation of surrogate motherhood effectively overcame in-utero bonding. In an ethnographic exploration of surrogacy in Israel, Teman (2009) revealed a 'dyadic body-project' surrogate and commissioning mothers engaged in to establish an unambiguous definition of motherhood. Surrogate mothers distanced self from the surrogate pregnancy and gave commissioning mothers a sense of centrality in the birth of the child. Teman (2009) concluded that this interactive process of disembodiment by the surrogate mother and vicarious embodiment by the commissioning mother shaped the surrogate identity.

Culture specific notions of procreation, parenting and kinship are often deep-rooted, may not fully match the western scientific knowledge of reproduction, and therefore are likely to be resistant to change. Menon (2004) and Dube (2001) have documented two competing cultural ideologies of procreation in India. Menon (2004)

described that Oriya Hindus in Bhubaneswar believed that both men and women contributed equally to the creation of an offspring and did not reduce the role of women to the mere provider of a womb. Such knowledge, however, is not documented in other parts of India. On the contrary, Dube (2001) revealed cultural conceptions of procreative roles of men and women symbolised as 'seed and earth/field.' In the popular belief blood of the man is thought to create the 'seed' - essence responsible for the creation of an offspring. Paternal blood, therefore, imparts identity to the child. While a male child is believed to pass on father's blood to the next generation, a female child cannot; who instead provides her 'field' to another man to sow his seed and plays an instrumental role in nurturing the child. Dube (2001) points that, coherent accounts of specific contributions of female blood to progeny though present in ancient texts are largely missing in the Indian public discourse. Mothers contribute to the physical traits and temperament of the child, their blood is believed to provide nourishment, warmth, and protection and form limbs of the child, and breast milk nurtures a child after birth. This maternal-child bonding is valorised emotionally and is turned into a moral obligation for the women to nurture and care for children, however, does not give them any rights over the child who becomes the property of the father. Such degradation of maternal rights and the instrumentality of the maternal role are also visible in the surrogacy practice in India.

Majumdar (2014) described Indian surrogacy as an 'alien pregnancy' which was housed in the body of the surrogate mother but was not her own and alienated the commissioning mother because it was embodied by the surrogate mother. She reported that ART clinics in Mumbai discouraged emotional attachment between the surrogate mother and the foetus to ensure relinquishment but expected surrogate mothers to care for the foetus as their own to ensure its survival. Similarly, Pande

(2010^a) revealed that ART practitioners in Gujarat constantly appealed surrogate mothers to engage in motherly acts of nurturance to ensure adequate foetal care during gestation. Simultaneously, they stressed the lack of a genetic link between surrogate mother and the child and used various metaphors to reinforce the instrumental role of the surrogate mothers. Conflicting maternal and the non-maternal role of the surrogate mothers ensured the success of the surrogacy program. However, Pande (2009^a) also reported the ways in which surrogate mothers subtly resisted such subjugation. Surrogate mothers she studied reinforced their own maternal identity through the labour of gestation and shared bodily fluids like blood and breast milk which they claimed were more intense and stronger than the genetic ties commissioning mother shared with the baby. At the same time, surrogate mothers used patrilineal and patrilocal cultural notions to justify relinquishment of the child stating it was the property of its father and when they compared relinquishment with giving away of a daughter in her marriage. Further, surrogate mothers and the commissioning parents used 'kin labour' to manage anxieties associated with global inequities in the context of surrogacy. They referred to each other as sisters, maintaining extended contact after the birth of the child by sending letters and sharing photos of the growing child. Some commissioning mothers allowed the surrogate mother to breastfeed the baby, exchanged gifts and also made payments and purchases for the surrogate beyond specifications made in the contract. For the surrogate mothers, kinship ties with the commissioning mother became a key way to prevent reduction of surrogacy to a purely commercial and disposable transaction, and the commissioning parents erased the guilt of possibly exploiting the vulnerability of the surrogate mother. When the commissioning parents severed these kinship ties out of the fear of surrogate not relinquishing the child, surrogate mothers considered their

kin labour wasted. Pande (2015) concluded neither genes nor gestation in itself defined kinship but so did the narratives and rituals associated with the surrogate pregnancy.

Overall, cross-national empirical evidence suggests that traditional notions associated with reproduction, parenting, family and kinship remain resistant to change among the users of ART. Hammons (2008) evaluated 14 judicial verdicts in the U.S. involving four types of ART – genetic surrogacy, gestational surrogacy, egg donation and IVF to explore the extent to which ART had changed the societal understanding of motherhood. Her study was based on the premise that judicial decisions reflect contemporary social understandings and also have potential to transform social expectations through verdicts. She concluded that courts were reinforcing traditional social norms about motherhood giving primacy to the biological motherhood over social motherhood. Hopes of the feminists for ART paving the way for new forms of the family remain a distant dream.

Implications for Practice: Consent, Counselling and Legal Regulation

Implications for informed consent. Academic discourse challenges validity of the informed consent of the surrogate mothers primarily on three grounds, long-term impact of surrogacy on the lives of women is not known, women may fail to estimate extent and nature of commitments during surrogacy and the coercive power of money and familial obligations may push women into surrogacy.

The evidence concerning long-term impacts of surrogacy on health, relational complexities and social outcomes is not entirely understood, and the limited evidence may not be readily available to the surrogate mothers. The consent provided under these circumstances may not be fully informed (Coeytaux et al. 2011; Palattiyil, Blyth, Sidhva & Balakrishnan, 2010; Tieu, 2009). The surrogate mothers are

subjected to various medical treatments which have a potential adverse impact on their health but are rarely involved in any decision making.

Van den Akker (2003) reported that surrogate mothers in Britain were well informed about the medical and practical aspects of surrogacy but knew little about legal, psychological and social aspects. They relied on the agencies and clinics for information and engaged in own research. Qadeer and John (2009) and Tieu (2009) argued that it might be difficult to understand fully what the experience of surrogacy would entail and emotions one may experience after relinquishing the child. Changes in the daily routine and diet and disruption of normal familial roles and responsibilities may be difficult to predict, may adversely affect psychological health of surrogate mothers, and should be prevented and redressed (Deonandan, Green, and van Beinum; 2012). Furthermore, 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 and physical and psychological health (Palattiyil, Blyth, Sidhva & Balakrishnan, 2010).

Significant financial incentives may push women to trivialise risks and disregard adverse health outcomes of surrogacy when viable alternatives to generate comparable income are absent (Shapiro, 2014). When altruistic surrogacy involves a close relative or friend, it might be difficult to provide a genuine informed consent. In complex familial settings possibility of women being pushed in surrogacy to help other family members or to meet financial need can not be denied (Tieu, 2009).

Deonandan, Green, and van Beinum (2012) suggest that a medical model of informed consent may be limited to communication of medical risks and benefits and may not cover socio-emotional risks and impacts of participation in surrogacy. Individualistic medical model of informed consent could be expanded to

accommodate family members and significant others. Surrogate mothers should be made aware of the risks of multiple gestations; foetal reduction and abortion, and ART practitioners should involve them in determining the number of embryos to be transferred in their womb, for the consent to be fully informed. While the Surrogacy Regulation Bill (2016) acknowledges the need for informed consent of surrogate mothers, empirical evidence regarding its practice is largely missing and constitutes an important dimension for surrogacy research.

Implications for counselling. A surrogacy arrangement can be deemed successful only when it is a satisfying experience for the surrogate mother. Counselling of all the parties involved can greatly enhance success of surrogacy by enabling stakeholders to understand enormous complexities involved before taking it up (Shapiro, 2014). Counselling support to resolve interpersonal conflicts and emotional challenges during surrogacy is necessary and further research is needed to determine frequency and components of therapeutic support required for surrogate mothers (Ciccarelli & Beckman, 2005).

Despite general agreement about the importance of counselling, limited empirical evidence available suggests inadequacy of counselling support provided to the surrogate mothers across the practicing nations. In a survey of six ART clinics and two facilitating agencies in Britain, van den Akker (1999) reported that counselling was largely voluntary for the participants and there were no counsellors specifically trained to provide surrogacy counselling. In another study by van den Akker (2003) involving British 23 surrogate mothers, post relinquishment emotional support provided by agencies, clinics, medical practitioners and counsellors was reported to be inadequate. Levine (2003) shared that the surrogate mothers in the U.S. articulated the need for a smooth transition and a sense of closure for themselves, their families,

and commissioning parents post relinquishment. They also shared the need for their own children to understand that the surrogate children were not their siblings and they themselves could not be given away. Pashmi, Tabatabaie, and Ahmadi (2010) reported that more than half of the surrogate mothers studied in Isfahan were dissatisfied about counselling and found it insufficient and limited in scope. Another study involving 12 gay Australian men seeking surrogacy services in India reported dissatisfaction amongst participants for the lack of emotional support and counselling during surrogacy. Participants also mentioned that medical practitioners were insensitive in the event of a miscarriage (Riggs, Due & Power, 2015). Quality of counselling offered to the Indian surrogate mothers is thus questionable.

Implications counselling, support counselling and therapeutic counselling recommended for people experiencing infertility (Bagshawe & Taylor, 2003) can be extended to surrogate mothers. Implications counselling could help involved parties understand effects of treatment on self, family, and children. Support counselling can assist them to connect with a support group offering emotional support before, during, or after participation in surrogacy and therapeutic counselling could focus on effects, consequences and treatment resolution. The quality of counselling support available to the surrogate mothers in India, if any, is highly questionable. In a broader context of general apathy towards the provision of quality mental health services in India, provision and quality of counselling support for the surrogate mothers needs to be investigated. Relevant components from the three successful counselling models presented in Table 1 can be adapted to develop contextually relevant counselling guidelines for the Indian surrogacy programmes.

Table 1*A Comparison of Counselling Component in Three Surrogacy Programmes*

Israel ¹	Netherlands ²	Canada ³
Commercial Surrogacy	Altruistic Surrogacy	Altruistic Surrogacy
Four Stage Counselling Model	Psychological Screening	Screening
<ul style="list-style-type: none"> • Stage 1: providing information and emotional support and facilitating decision making • Stage 2: clarification of mutual expectations and establishing clear communication patterns • Stage 3: support to cope with the emotional and interpersonal difficulties that may arise during the surrogacy process and stress reduction • Stage 4: Preparing the surrogate mother for birth and relinquishment of the baby, union of commissioning parents with the baby and any referrals for further support 	<ul style="list-style-type: none"> • Personality test • Complaint and quality of life test • Relational and sexual wellbeing test <p>Legal Screening</p> <p>99 items list to check views on:</p> <ul style="list-style-type: none"> • Course of action in case of multiple gestation /congenital disabilities/complications during pregnancy and delivery • Agreements about smoking, drinking and working, expected support from commissioning parents • Visiting lawyers, completing adoption formalities for the child, preparation of a will to cover all eventualities, compensation for the medical costs <p>Discussion of Practical Issues</p> <ul style="list-style-type: none"> • Disclosure to others/ to the child born through surrogacy • Conflict of interests 	<ul style="list-style-type: none"> • Attitudes towards multiple gestations, foetal reduction /medical termination of pregnancy for foetal anomalies, attachment with foetus, future relationship with parents and the child • Availability of support network • Expectations as a surrogate mother, issues of trust and control and detachment or over-attachment during surrogacy • Potential plan for birth and relinquishment <p>Counselling for Undesirable Outcomes</p> <ul style="list-style-type: none"> • Chances of cycle failure, miscarriage, ectopic pregnancies, foetal anomalies, complications of pregnancy, potential for bed rest, and antepartum hospitalisation • Number of embryos to transfer with risk of multiple gestations • Nutrition and lifestyle issues during pregnancy <p>Post-partum Counselling</p> <ul style="list-style-type: none"> • Pregnancy and birth experiences and potential depression • Future contact with commissioning parents and disclosure to the child born through surrogacy

¹Gagin, Cohen, Greenblatt, Solomon, and Itskovitz-Eldor (2005). ²Dermout, van de Wiel, Heintz, Jansen, and Ankum (2010). ³Dar, et al. (2015).

Implications for the regulation of surrogacy. Most nations practicing surrogacy are grappling with the complex dilemmas posed by surrogacy and lack effective regulatory framework; others have imposed a blanket ban on its practice. At the macro level, Ramskold and Posner (2013) articulated the need for an evidence-based international legislation to govern the practice of surrogacy and proposed an international regulatory framework independent of the nations practicing transnational surrogacy. They add that ART clinics practicing surrogacy should avail international certification guided by the International Health Regulations 2005 or the World Health Organisation. A separate convention for the effective implementation of international surrogacy guidelines can be formed under the Hague Conference on Private International Law and the World Organisation for the Cross-Border Cooperation in Civil and Commercial Legal Matters.

Spar (2009) highlighted that many path-breaking technological revolutions came to be legally regulated effectively and argued that it is possible to regulate surrogacy effectively. She articulated the need to recognise surrogacy as a commercial relationship to address international trade in ova, sperms and wombs and asserted that failure to recognise surrogacy as a profit-making enterprise or business has resulted in underregulation of surrogacy. She recommended forming rules governing surrogacy transactions, regulations for preventing abuse and a global framework for regulation of cross-border trade as a way forward. Many scholars express similar views and caution against patronising laws controlling women's bodies and legislation that limits access to ART based on identity. At the same time they also recognise exploitative potential of surrogacy and the need to form policies for responsible regulation ART and associated industries. Such policies could be based on the core principles of humanity, equality of power, reproductive autonomy and health, non-discrimination,

clarity, and justice. Instead of imposing legal restrictions to enter surrogacy they recommend creating enabling conditions leading to a positive surrogacy experience and minimising the exploitative potential of surrogacy (Ainsworth 2014; Coeytaux, Darnovsky, and Fogel, 2011; Ramskold and Posner, 2013; Shapiro, 2014; Wilkinson, 2003). A 'soft-law' approach is recommended by Damelio and Sorensen (2008) for the regulation of surrogacy aimed at protecting the vulnerable surrogate mothers from harm while giving them freedom to enter paid surrogacy contracts. Under this approach several hours of multi-session surrogate education course with modest time gaps between sessions to facilitate reflection is mandatory for entering paid legal surrogacy. Gabry (2012) advocated for the well-defined surrogacy contracts that predetermine legal parentage before the beginning of the surrogacy process.

Several scholars also argue for legalisation of paid surrogacy, genetic as well as gestational; offering commissioning parents and surrogate mothers right to choose what works best for them. They advocate monetary compensation to surrogate mothers to recognise women's labour which has been historically unrecognised, undercompensated and undervalued and for the challenging and risky work surrogate mothers undertake (Agnihotri Gupta, 2011; Ainsworth, 2014; Anleau, 1990; Qadeer 2010^a, Qadeer & John, 2009; Ramskold & Posner, 2013; Shapiro, 2014). 'Fair Trade International Surrogacy' was advocated by Deonandan, Green, and van Beinum (2012) who made a case for standardisation of surrogacy fees wherein prices for surrogacy would be set to a fair price in regional or local context.

In the Indian context, Qadeer (2010^a) recommended to fix the compensation for commercial surrogacy as one universal value and argued that surrogacy whether commercial or altruistic must cover compensation for adverse effects of health complications and medical negligence, and compensation to the family of the

surrogate in the unfortunate event of her death during surrogacy. She suggested that such compensation should cover costs for all the medical expenses, life insurance, counselling and legal costs, travel charges for psychological evaluation, and health insurance for the surrogates family; and surrogate mother should be paid separately for caring for the baby.

Srinivasan (2010) emphasised the need for an informed public debate on various matters including whether surrogacy should be banned or regulated, whether efforts should be directed at standardisation of the treatment protocols for safety, should treatment seekers be counselled for all the options including adoption, should sale of ova be compared with organ sale and be banned, and how to determine permissible extent for PGD and if abortions can be allowed in the IVF process. Shah (2010) argued for the need to regulate ART citing the absence of standardised treatment protocol and drugs, lack of documentation systems, sparse knowledge about side-effects of the treatment amongst patients, the gimmicks of ‘success rate’, and other malpractices. She also emphasised the need for empirical evidence about women entering surrogacy arrangements and factors critical for ensuring their well-being in the burgeoning ART industry to inform policy. This study aimed to address such empirical gaps to inform policy.

Surrogacy in India: An Avenue for Empowerment or Subjugation?

Evidence across practicing nations indicates that surrogate mothers are often at educational and economic disadvantage and are resource poor compared to the clients seeking their services, thereby making them vulnerable (Centre for Social Research, 2012; Ciccarelli & Beckman, 2005; Damelio & Sorensen, 2008; Gagin, Cohen, Greenblatt, Solomon, & ItsKovitz, 2005; Pande, 2009a; Temen, 2001; van den Akker, 2007; Vora, 2009). In the macro-context of poverty and the colonial history of India,

Vora (2009) condemned Indian surrogacy as a form of neo-colonial exploitation in a globalised world. ART clinics offering surrogacy services on the other hand assert that surrogacy creates an avenue for women to alleviate poverty and can be an empowering experience (Saravanan 2010, Vora 2010).

Anleu (1990) and Tieu (2009) suggested that altruistic surrogacy within the family may involve a higher risk of oppression of women as when a close relative or a friend is involved it might be difficult for the surrogate mother to provide a genuine informed consent. In the complex familial settings possibility of women being pushed in surrogacy to help other family members experiencing infertility or to meet the financial needs cannot be denied. A couple of decades ago, prior to the boom of commercial surrogacy in India, Agnihotri Gupta (2000) reported that surrogate mothers were always related to the couple seeking her services indicating the possibility of their subjugation at a familial level. Similarly, Indian egg donors were reported to be pressured by family members to donate eggs for the close relatives experiencing infertility (Agnihotri Gupta & Richters 2008). The Centre for Social Research (2012) reported that the husbands coerced surrogate mothers in Anand, Jamnagar, Surat, Mumbai, and Delhi for participation in surrogacy though the report did not present empirical data to validate the claim. The psychological agency of women entering surrogacy continues to be debated amidst paucity of Indian empirical evidence. Concerns about socio-economic injustice through which surrogacy arrangements thrive although valid often fail to acknowledge ways in which women exercise agency in seemingly oppressive conditions. Fixmer-Oraiz (2013) and Markens (2011) reported that the popular discourse on surrogacy portrayed Indian surrogate mothers as victims of poverty pushed into paid surrogacy. Scholars are

increasingly questioning such a portrayal of poor women in the third world as passive acceptors of subjugation lacking agency.

Recent ethnographic studies of surrogacy in India have revealed the agentic role of the surrogate mothers. Forde (2016) and Deomampo (2013) reported that participation in surrogacy was a conscious decision for the women in Mumbai and most of them were far from the image of victimised women– neither economically desperate nor pushed into surrogacy by their in-laws. Instead, women asserted their participation in surrogacy to their disapproving husbands. Forde (2016) however argued that despite asserting participation in surrogacy women relied on the traditional gendered virtues of submissiveness and self-sacrifice to make sense of their participation in surrogacy. Surrogacy was seen as maternal self-sacrifice towards the fulfilment of the moral obligation to secure future of their children and not as a pursuit of economic rewards. Further, women stressed that the decision to participate in surrogacy was often a ‘joint decision’ made by consensus with family members allowing them to shift the responsibility of decision making to the close family members and evade the stigma for participation in surrogacy. Deomampo (2013) reported that the surrogacy agents in her study as a group put forth organised efforts to negotiate with fertility specialists their demands for better wages for self and ensured consistency in amounts paid to the surrogates. One also played an advisory role to resolve any familial conflicts of the surrogate mothers and challenged the male authority when required. However, the agents also further reinforced inequality in the surrogacy industry by opposing entry of new surrogate mothers as ‘surrogacy agents’- a threat to their power position – and limited opportunities for upward mobility for other women. Vora (2010) through her empirical work at a Delhi-based clinic revealed that surrogate mothers projected the surrogate child as a divine gift they gave

to commissioning parents – something which only God could give and denied their disposability. Despite the ‘gift’ narrative, surrogate mothers considered surrogacy as a form of undesirable work, unless economically necessary. In another ethnographic account based in Gujarat, India Pande (2009^a, 2010^a) viewed surrogate mothers’ claims over maternal identity through the labour of gestation and shared bodily fluids as mild ‘everyday forms of resistance’ to patriarchal social set-up where children are considered the property of the father. Further, a surrogate mother viewed the limited role of her spouse in the assisted reproduction as his emasculation. Ruling out any spousal contribution helped some surrogate mothers have sole claim over the money they earned through surrogacy. Surrogate mothers denied disposability by highlighting personal attributes for which commissioning parents selected them as a surrogate over other prospective surrogate mothers. In doing so, they resisted the commercial and contractual nature of their relationship. Pande acknowledged that while these discursive practices helped women resist disposability, the same practices simultaneously reinforced gender hierarchies and also prevented women from negotiating a better pay for surrogacy. Husbands and in-laws viewed surrogacy as a moral obligation and duty of women towards their family. The surrogates too did not question self-sacrificing and selfless image imposed on them and their desires to be helped by a white couple in the long run further reinforced racial and class subjugation.

This empirical evidence suggests that surrogacy can be both empowering and exploitative and specific contexts and factors which can facilitate or impede empowerment of Indian women participating in surrogacy need to be investigated. Such knowledge can guide standardisation and regulation of surrogacy practices in India aimed towards ensuring the well-being of surrogate mothers. The next sections

review the literature on the psychological agency of Indian women and theoretical perspectives on the self and agency to form a base for the conceptual framework of this study.

The Indian Self and the Psychological Agency of Women in India

The primacy of culture in shaping human behaviour and development cannot be overstated (Shweder, Goodnow, Hatano, LeVine, Markus, & Miller 2006, Miller 2006). Application of Euro-American individualistic thought often fails to capture local realities in the non-western cultures. Individualistic conception of agency frames agents as individual actors and when applied in the settings where self is constructed in relation to the others does not yield a coherent account of the actions agents engage in. Roland (2001) asserted that radically different cultural/ psychological worlds do exist. Based on his psychoanalytic work in the U.S., India and Japan, Roland (1988) proposed a tripartite model of self composed of the familial self, the individualised self and the spiritual self. Roland explained the ‘familial self’ as the inner psychological make-up of the Asian men and women which facilitates their effective functioning within intimate hierarchical familial and social relationships. He proposed further sub-organisations of the familial self marked by ‘symbiosis-reciprocity’ wherein intimate relationships are intensely emotional, interconnected and interdependent allowing affective exchanges through permeable ego boundaries and maintenance of a highly private self. High levels of empathy and receptivity towards others are developed where self is experienced as a highly relational and contextual ‘we-self’. Feelings of honour and reputation derived from a sense of belonging to a family and other groups, hierarchical relationships and idealisation of elders promote self-esteem which Roland refers as ‘narcissistic configurations of we-self regard’. Adherence to traditionally defined reciprocal responsibilities and obligations and

social etiquette respecting hierarchy in public relationships indicates a ‘socially-contextual ego-ideal.’ ‘Superego’ of the familial self-structures aggression and sexuality according to the hierarchical familial and social relationships. ‘Modes of communication’ always operate at least at two levels and highly contextual cognitive and ego-functioning marks the familial self. He suggested that such a familial self grows in individuation when it comes into contact with global civilizational forces and social change and referred to it as an ‘expanding self’.

An increasing body of literature indicates co-existence of both individual and relational dimensions in the Indian self. A sense of duty and obligations towards others in a hierarchical social set-up binds the Indians self. In this duty based system values of deference, loyalty and subordination to superiors, in turn, yield nurturance and care from superiors (Mascolo, Misra, & Rapisardi, 2004; Menon, 2011). Indian people predominantly display tendencies of familism, preference for hierarchy, and maintenance of the personalised relationship. A mix of both interdependent and independent modes of self-construal is highly prevalent (Mishra, Akoijom, & Misra, 2009).

Chakkarath (2005) stated that life span development model of the *Hindu* psychology based on the fundamental assumption of ‘transmigration’ of human soul through the cycle of birth, death and rebirth views life as a suffering lead by *karma* - accumulation of good and bad deeds of the individual. 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. The biological and social conditions an individual experiences are considered results of one’s own accumulated *karma* and are thus

perceived as being just. The *Hindu* life span developmental model involves four life stages each with specific developmental goals,

- *brahmacharya*: begins with schooling and aims at knowledge acquisition, developing a character, preparing to be responsible
- *grihastha*: begins with marriage and aims at serving God, sages and ancestors, enjoying worldly goods, and begetting a male child
- *vanaprastha*: begins when children attain adulthood and aims at gradual withdrawal from family life for contemplation and meditation
- *sannyasa*: the final stage of life aimed at mental renunciation of worldly ties, contemplation and meditation

Thus the life of a *Hindu* self primarily involves following a set code of conduct and practicing discipline and self-regulation to attain the ultimate goal of salvation *anasakti* - detachment/ indifference. A moral duty based order helps in maintaining social order through management of interpersonal relationships and complete detachment is presented as a developmental goal only in the last stage of human development. Chakkarath (2005) builds on the works of Sinha and Tripathi (1994) and Mascolo et al. (2004) and states that Hindu Indians are likely to be individualistic at a motivational level focusing on self-fulfillment and independence and collectivists at the behavioural level thus appearing dependent. He recommends that the studies of 'self' must consider the impact of affective, behavioural and cognitive concepts from indigenous psychology on human development.

Feminist literature concerning Asian women for long has failed to acknowledge such a radically different cultural world of the Asian women. Mohanty (1988, 2002) argued that the category of 'third world women' is often treated as a homogeneous entity by the feminist scholars who analyse experiences of the 'other'

from their own middle-class lens and thus universalize 'oppression' of women. In doing so, they often cast 'other' as a victim of varying contexts like patriarchy or the capitalist economy in the paternalistic light and downplay 'agency' of the concerned women by viewing them as passive acceptors of subjugation. Chaudhary (2012) suggested that the representation of Indian women as a homogeneous category is problematic in the context of regional, linguistic, ethnic, religious, social, familial, and life stage diversity; and demanded that their experiences must be studied with keen attention to their subjective position in the familial and social hierarchy. She proposed that the interconnectedness may allow for flexibility in relationships where women negotiate their agency within familial and social spaces. Ganesh (1999) stated that Indian women actively construct their own realities through the attainment of negotiation skills which are central to their 'capacity to adjust'.

Menon (2011) revealed that fulfilling duties and expectations of others might generate a sense of satisfaction among Hindu, Indians and agency thus takes the form of catering to the needs of the significant others. Ethnographic explorations of the Hindu Gujarati women by Raval (2009) indicated that agency for these women involved negotiation within the context of their familial roles rather than resistance when faced with conflicts. Personal desires in the conflict were rarely self-centred, revolved around the needs or well-being of their children and were resolved by thinking through the situational demands for optimising the benefits for their children. Conflicts between own desires and expectations of others were settled by active negotiation with the family members rather than passive acceptance of the role-based social ideals. She concluded that the internalisation of others' needs perhaps came to be experienced as personal needs.

It thus appears that agency viewed from an individualistic lens often regards Indian women's compliance to the social roles or primacy to the needs of their kin as 'victimisation' and fails to recognise the constructive potential of negotiations in which women engage in. Ganesh (1999) therefore identified exploration of the nature of agency exercised by Indian women and the active processes of negotiation they engage in as productive endeavours for future research. Such an approach according to her shall widen the concept of 'agency' from the present bipolar discourse to include a more nuanced understanding of the day-to-day negotiations of women in patriarchal setup.

Ahearn (2001) advocated the need to distinguish several forms in which agency is manifested including agency of power, agency of intention, complicit agency, oppositional agency and so forth. She also proposed that multiple forms of an agency may guide a single action. Therefore, acts of acceptance, accommodation, ignorance, resistance or protest are manifestations of the agency. This study questioned the unilateral view of surrogate mothers in Gujarat as 'victims' and explored the exercise of agency with keen attention to the contexts which enabled or limited the agency of surrogate mothers.

Theoretical Perspectives on Psychological Agency

Ahearn (2001) contended that socio-cultural approaches which neglect multiplicity of motivations driving human actions equate agency with 'free will' or 'resistance' and are too narrow in their scope. She articulated the need for a broader definition of the agency that acknowledges implicit assumptions about the personhood, desire, and intentionality of the agency. Building on the multidisciplinary works Duranti (2004) examined how agency is enacted and represented in language and provided a working definition of agency as,

“the property of those entities (i) that have some degree of control over their own behavior, (ii) whose actions in the world affect other entities’ (and sometimes their own), and (iii) whose actions are the object of evaluation (e.g. in terms of their responsibility for a given outcome)”
(Duranti 2004; p. 253).

He stated that all the languages have multiple ways of representing agency as well as mitigating agency and thus offer linguistic framework choices to speakers where they can mention or omit the agent responsible for an event. He added that there is cross-linguistic evidence on the use of impersonal, passive like and passive constructions as a means of agency mitigation and to avoid blaming specific parties, of course, neither all passive constructions can be assumed to purely serve the purpose of agency mitigation nor is it the only way of mitigating agency. Frie (2008) argued that equivocal definitions of agency and parsimonious explanation of its nature and processes involved limit its application to the lived experiences of agents and conceptualised agency as, “a situated and emergent process of reflection, informed by personal history, and fundamentally embedded in our biological and socio-cultural contexts (Frie 2008; p. 224)”. He proposed that agency is a fluid and dynamic process situated in changing contexts. Humans reorient their actions through the imaginative capacity to alter their experiences and in effect may change their contexts.

Relationships with others are inevitable in social world and agency emerges with experiences of the self with the others. This emphasis on the relational perspective of agency is also stressed by Sugarman (2008) who stated that agency continually develops through self-revelation in the context of various relations individuals experience in their lives. He accorded special significance to the distinction between 'functional' and 'personal' relations proposed by Scottish philosopher Johan

MacMurray. A functional relation is instrumental as it is motivated by some common goal which once 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. This distinction between functional and personal relations is of relevance for this study as ethnographic evidence on surrogacy across cultures has demonstrated that commissioning parents are likely to conceptualise their relationship with the surrogate mother as a functional one, whereas surrogate mothers tend to accord a personal value to it. The differences in the individual orientation are likely to be stark especially in the transnational surrogacy arrangements.

Theoretical Framework for the Study

The cultural psychology perspective to individual development by Shweder et al. (2006) and Miller (1997) forms the theoretical framework for the present study. Such an approach is especially suitable to study the experiences of surrogate mothers for the following reasons:

- it gives scope to recognise surrogate mothers as 'agents' who 'intentionally' participate in surrogacy and thus moves away from the 'victim' discourse
- it allows framing of agency in a relational context wherein surrogate mothers in the context of their family relations could be conceived as agents

Central to the popularity of cultural psychology perspective is the claim that culture and mind are intertwined and "make each other up". It recognises the presence of certain core mental structures which are universal yet dynamic, taking differential form in the context of the customs, traditions, practices, shared meanings, and perspectives of a specific cultural community of which an individual is a member.

Cultural psychology thus studies what individuals belonging to a specific cultural community know, think, want, feel and value and therefore do as beneficiaries and perpetrators of a cultural tradition (Miller, 1997 and Shweder et al., 2006).

Shweder et al. (2006) defined culture as the symbolic (mental) and behavioural (practice) inheritance of a self-perpetuating community in a historical context. The symbolic inheritance refers to the implicit and explicit knowledge and normative beliefs of a cultural community about 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. Shweder et al. (2006) argued that culture is an 'intentional world' as its members actively perpetuate mentalities and practices which they perceive to be 'right, normal, and beneficial' in some respect. These valued mentalities and practices of a cultural community become an integral part of the psyche of community members through the processes of socialisation. Therefore, cultural psychology regards contexts and meanings as an integral component of the human psyche rather than as external factors exerting influence on it. Shweder et al. (2006) added that the transformative capacity of the human mind turns the self-conscious and deliberate processes into a routine and mundane and thereby increases the efficiency of an individual. As a consequence, cultural mentalities that determine individual actions in daily lives are not readily available in the form of awareness. The concept of 'custom complex' represents the intimate association between a mentality and one or more practices associated with it and also forms a unit of analysis in the studies of cultural psychology. Cultural psychology aims to capture behavioural origins of mental functioning and mental base of cultural traditions and practices in specific cultural communities through the use of custom complex (Shweder et al., 2006). This cultural

psychology perspective forms the base for exploring the exercise of agency by Indian surrogate mothers in this study.

A large body of literature in cultural psychology is devoted to the understanding of the self as an agent in the socio-cultural context and is reviewed by Shweder et al. (2006). Relevant to the focus of this study is knowledge about the understanding of selves as relational agents summarised by Shweder et al. (2006) as,

- self in relation to others determines the individual experiences and the self cannot be abstracted from the social context
- self is experienced by accommodating with others and creating and fulfilling obligations to become part of various interpersonal relations
- such an interdependent sense of self, calls for the agency in the form of high degrees of self-control directed towards personal desires and goals and emotions that may conflict with expectations of others, self-discipline, adjustment, and attending to the situational demands.

It, thus, appears that psychological 'agency' of relational selves' takes a distinctive form which when evaluated from a Euro-centric perspective would be misinterpreted as a lack of agency or victimisation. It also applies to the surrogate mothers in India who are often portrayed as victims of various contexts. However, recent literature about the agency of Indian women though scarce, demonstrates the differential exercise of agency in a relational context. The cultural psychology perspective, therefore, is useful as a theoretical base to understand the 'custom complex' of the agency of surrogate mothers in Gujarat who are a part of the larger Indian culture. Figure 5 depicts a prediction of an intimate association between symbolic inheritances (mentality) of the broader Indian cultural community with one of its behavioural inheritance (practice) as an exercise of 'agency' by a subgroup of

women participating in surrogacy in Gujarat. Mentalities are predicted based on the existing literature in cultural psychology that spells out in detail psyche of individuals in the relational worlds. When relationships are central to the meaningful existence of an agent, behaviour of such an agent is likely to be directed towards forming and nurturing of social relations to derive a personal sense of well-being. However, this certainly does not mean that such an agent ceases to be an individual. The exercise of agency by a relational self is situational and dynamic in nature. It means that exercise of agency may vary depending on the social standing of the individual in a specific situation, gender, relative place of the agent in the social hierarchy, and duties and obligations of the relationship in question. Thus, the exercise of the agency would invariably take several forms a few of which are predicted in the Figure 5 based on the literature about the agency of women in India.



Figure 5. A predictive model of the customs complex of agency of the Indian self.

Conceptual Framework for the Study

The conceptual framework for this study (Figure 6) draws on the cultural psychology perspective of individual development by Shweder et al. (2006). It demonstrates the course of surrogacy as an intentional action that takes place in the macro context of

poverty, global economy, and incongruent ART laws that promote trade in reproductive health services at the national and transnational levels. In line with the mounting evidence which indicates that women in India exercise agency within a relational context, the research views a surrogate mother in the context of her family relations as a primary 'relational agent'. Such an agent is a self-reflective being who interprets her world and through her imaginative capacity makes plans for the future. Futuristic plans are oriented towards some form of change to meet her needs in the context of her family relations. Participation in surrogacy is conceived to be an intentional activity which comes into being after much deliberation and is oriented towards the attainment of some specific goal in the future. During surrogacy surrogate mothers are exposed to a new set of circumstances, people, and ideologies and need to adapt themselves to such changes. They may experience several barriers as well as facilitators during this process towards the attainment of their goals. Role ambiguity and relational ambiguity are examples of such barriers whereas celebration of customs like '*shreemant*' (baby shower) may contribute towards a sense of satisfaction.

Surrogate mothers actively construct their experiences in several forms representing varying degrees of agency throughout the process of surrogacy. The exercise of agency takes place in diverse situations in the context of several interpersonal relationships during surrogacy. The character of the situational and relational context may determine how the agency is exercised or in which form it is manifested. Such a complex process of exercise of agency, however, may not occur at a conscious level. The predictive model of a 'customs complex' of agency in the Indian context represents the underlying mental foundations that may guide the practice of agency.

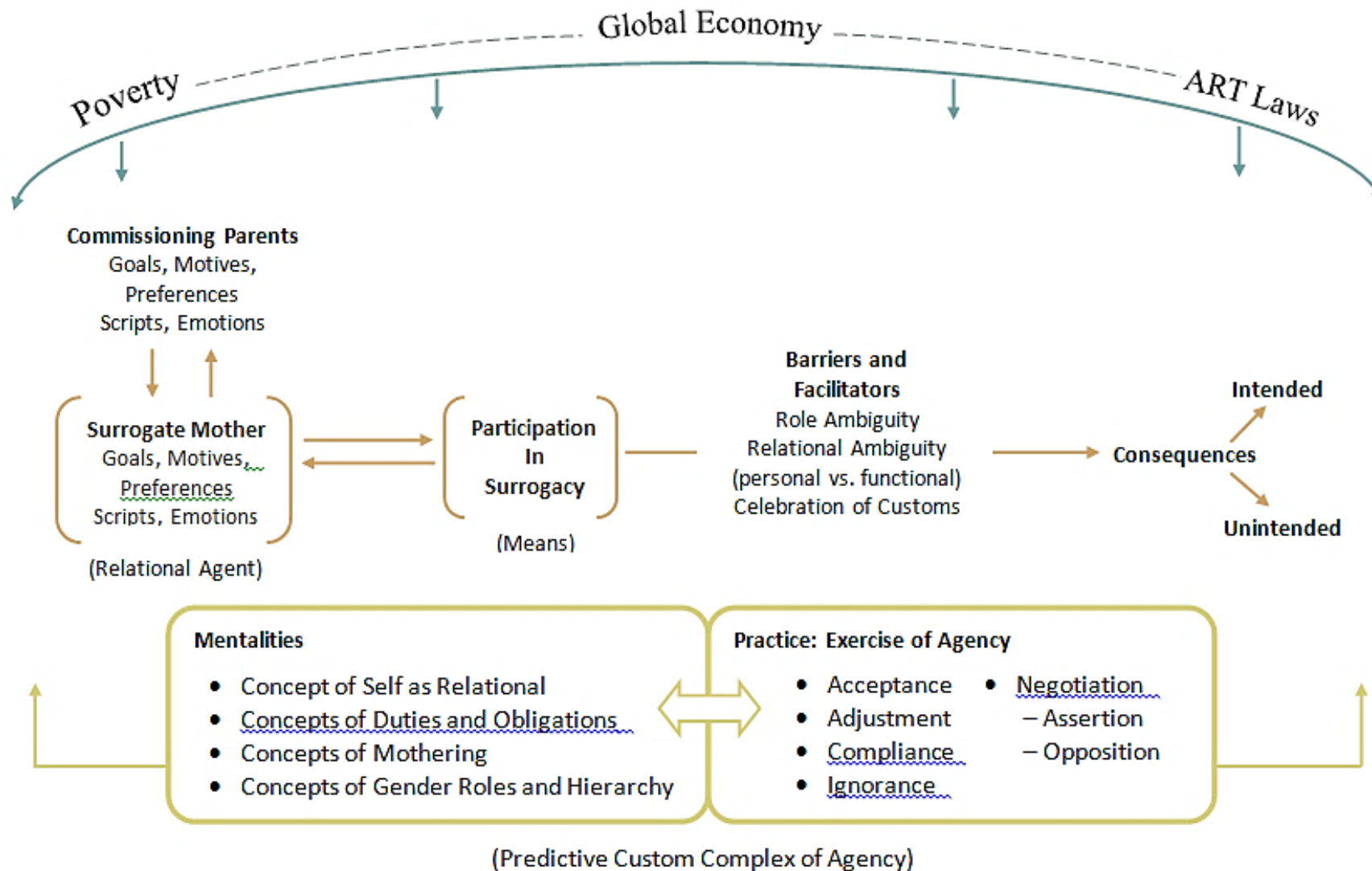


Figure 6. The conceptual framework for the study.

At this juncture, it is important to define conceptualisation of ‘agency’ for the proposed research. Based on the different theoretical perspectives and empirical evidence, the proposed study conceptualises agency as,

- an emergent and developmental process
- which is negotiated in the relational and socio-cultural context
- wherein agent orients intentional, imaginative, and reflective capacities towards the change
- aimed at the attainment of some specific goal/s in the future

Significance of the Study

- The study documents the experiences of surrogate mothers in the Indian context, which remains a relatively unexplored arena.
- The study contributes to the understanding of the exercise of agency by surrogate mothers and generates a 'custom complex' of agency in the context of surrogacy in India
- The findings are useful to inform surrogacy policy and practice in the Indian context.

Research Questions

- What are the experiences of surrogate mothers participating in surrogacy in Gujarat?
- How is the maternal identity of surrogate mothers constructed in the context of surrogacy?
- How do surrogate mothers negotiate ‘agency’ in the process of surrogacy?
- How does participation in surrogacy influence the lives of surrogate mothers and their families?