

# Commercialisation of the female body

As wombs become 'stock-in-trade'

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## Abstract

This study has focused on the approach of the Indian government with additional voices from women's rights activist and researchers. The study has investigated how the surrogacy industry is approached and dealt with within the political economy sphere. It presents an exemplifying case of how business based on bio-medical advancements and globalisation is dealt with on a national level. The main research question is *How is commercial surrogacy produced and approached as a social problem by the Indian government?* It uses 'What's the problem represented to be'- method and a theoretical framework of gendered international political economy. The Indian government label and frame commercial surrogacy first and foremost as a medical issue. The labelling is a consequence of the government's categorisation of commercial surrogacy as a source for foreign exchange revenue. A complication of this framing is weakening of the surrogates bargaining position. Commercial surrogacy is only categorised as a social problem when the process is not smooth; that is when the commissioning parents are not pleased. The Indian governments policy, proposed and implemented, regarding commercial surrogacy forms discursive complications that can be harmful for surrogates.

Key words: surrogate motherhood, assisting reproductive technologies, social policy, problem representation, feminist economics

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## 1. Introduction

Surrogacy is a rapidly growing business in India with varied social and economic consequences and challenges. The development of biotechnology and cutting edge biomedicine is stretching the imagination of our society, creating opportunities and tools that were not imaginable only a few decades ago. Such new technologies alter existing income opportunities, giving rise to new ones that may affect larger economic structures. As a new social phenomenon, gestational surrogacy challenges conventional assumptions on family and the exchange of services. At present there is no national register on surrogacy and no available official statistics in India but based on anecdotal evidence and media reports a sharp raise is estimated (SAMA 2012:7). Building on a qualitative explorative case study with India as an exemplifying case, I will focus on how surrogacy as a new social phenomenon is received, perceived and dealt with, especially from the point of view of the government.

Surrogacy is a challenge to many of our assumptions about family, parenthood, about what you can buy and pay for, babies, parental rights et cetera. The spread of surrogacy poses questions about how to define *parent* and what obligations they have towards their children. Is surrogacy a service that we as a society should expect or is it greater enhancing the power structures in society based on gender, ethnicity, class and cast? Women's role in South Asia is not constant, in the last few years' reports about an increasing sex ratio with fewer girls per boys along extreme and extensive sexual violence is a part of the situation in India today. This is nothing new, women's roles have changed throughout history and will continue to do so. This is reflected in what part women play in the economy, what work is seen as female and who does what in the household.

This study springs from an interest in how India as a society deals with the new business of commercial surrogacy and how various discourses shape the establishment and framing of it in the Indian economy. The interest is based on a curiosity of what claims and assumption that are made about surrogacy as a social problem in India today and how they affect the legitimacy of the demand the surrogacy business is built on. The study was shaped by my two month long fieldwork in Mumbai and New Delhi in the spring of 2014 along with the input I got from my supervisor and several students and professors at Tata Institute of Social Sciences. The interviews with my informants also contributed to the focus of the study and to deepening my interest in surrogacy as a phenomenon.

## **1.2 Focus and objective**

This study focuses on the approaches of the Indian government with additional voices from women's rights activist and researchers. The objective is to investigate how commercial surrogacy has been received and institutionalised in the Indian society. India is one of the few countries that allow this business to develop and are taking measures to incorporate it in the official economy. This study will contribute to research on surrogacy in India by studying how the surrogacy industry is approached and dealt with within the political economy sphere. It is an exemplifying case of how this particular type of business based on medical advancements and globalisation is dealt with on national level.

This study does not collect any material produced by the surrogate mothers themselves. The primary focus is to study how the political and public sphere has taken on the issue. Surrogate mothers have limited political agency and voice for several reasons, the economical strain they are often in and their vulnerability in the society at large and in relation to the clinic and the commissioning parents in particular (SAMA 2012:40 CSR 2013:40). It is hard to find any campaign or space in the national debate where surrogates have expressed their opinion nor have surrogates, as far as I know, been invited/taken part in the formulation of the government documents presented in my analysis. Nothing points to that the surrogates themselves have played an active part in shaping or controlling neither the institutionalisation nor the political and societal approaches towards the business they are a part of. There are several groups that participate in framing surrogacy as a social problem however this study wishes to lift the actor with a social and societal responsibility, appointed by the people, the government

## **1.3 Research questions**

How is commercial surrogacy produced and approached as a social problem by the Indian government?

- How is commercial surrogacy categorised, labelled and framed by the Indian government?
- From a feminist perspective, what are the discursive complications and dilemmas produced by this problem representation?

## **1.4 Commodification of the human body - Contextual insights**

Presented in this section is contextual insights connected to the surrogacy business in India. These insights are to be seen as a part of the analysis.

### 1.4.1 Economic context

India is known for being a recipient of outsourcing from the global North foremost of information technology functions like software maintenance and telemarketing. Recently, medical services have become a player in the outsourcing market, which attracts foreigners and gives way to an emerging industry in India. International travelling for medical treatment has traditionally been undertaken to seek more advanced technology or experts travelling to countries with leading medical centres (Horowitz 2007). In parallel to this international medical travelling a stream consisting of travellers, often from the global North, seeking cheap medical care in the global South has emerged (ibid.).

During the last decade India's trade deficit has steadily increased except for a minor decrease in 2009-2010 (Department of Commerce (DC), Government of India 2013:28). In 2012 the current account was -4.7% of the GDP (World Bank 2014). However service exports plays a major role in Indian exchange revenue as it stands for 40% of all exports and is a major force in Indian growth (DC 2013:XV). During the last decade the increasing surplus from trade in services has helped to keep check on the current account deficit by offsetting a major part of the deficit accruing from the merchandise side (ibid.). Medical tourism is categorised as a deemed (National Health Policy 2002:34). This means both that health care providers catering to medical tourists are eligible to apply for fiscal incentives and subsidies but also that medical tourism contributes to minimising India's trade deficit (National Health Policy 2002:34, DC 2013:XV).

Medical tourism is when travellers seek a price or a treatment/setup of care that they cannot access at all or not access in a, for them, agreeable way where they reside (Horowitz 2007). There are several reasons why people become medical tourists, lower prices is one and to get treatment that is restricted or illegal in their home countries is another (ibid.). Insurance companies in the US have become interested in medical tourism and reimburses some out of country treatment in order to lower costs (Horowitz 2007, York 2008:99). Using *medical tourism* can be controversial and has been contested as tourism implies amusement while enjoyment only sometimes is a part of the travel. The term is argued not to reflect the reality of the traveller/patient however the term is used to separate it from the traditional form of medical travelling<sup>1</sup> (Horowitz 2007). It is the term used in literature on this phenomenon in several disciplines and will therefore be used in this study as well.

#### Medical tourism and India

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<sup>1</sup> The common and traditional form of travelling for medical purposes is to seek care that you cannot receive in



Ten years ago, in 2004, estimated that 1.2 million patients travelled to India for health care (Horowitz 2007). In 2007 India along with other Asian countries like Malaysia, Singapore and Thailand was considered as well established medical tourism destinations (ibid.).

The most prominent advantages India have as a medical tourist destination is the high level education of medical practitioners with a large English speaking population along with the competitive prices on premium treatments (Hazarika 2010:248) The price of treatments in India is around one-eighth to one-fifth of that in western countries (ibid.). The government of India has been promoting the country as a global health destination in several manners. The government encourages medical facilities to provide services for foreigners in the National health policy (ibid.). In order to facilitate the industry a separate visa category for medical tourists was created that allow foreign patients and their families to stay in India up to 12 months (ibid.). In the National Health Policy 2002 urban medical institutions are proclaimed as service production units and important sources for foreign exchange earnings (Government of India 2002 in Reddy and Qadeer 2010:70). The Finance Minister, Jaswant Sing in 2003 announced in his annual budget speech that India was going to become a global health destination (Reddy and Qadeer 2010:70). The Indian government invests in infrastructure, tourism and treats medical tourism as a trade in hopes of earning foreign exchange (Reddy and Qadeer 2010:71). Also financial incentives like low interest rates on loans, low import duties on medical equipment for hospitals that treat foreign patients are tools used to promote medical tourism (CSR 2013:33f). The Ministry of Tourism is working with hospitals to attract patients and between 2005 and 2008 the yearly number of foreign patients coming to India increased from 150000 to 450000 (Chinai & Goswami, 2007 in CSR 2013:33f). One of the initiatives that opened up for India as a medical tourism destination was the Ninth Five-Year Plan 1997-2002,<sup>2</sup> that allowed and encouraged non public financing of health care, with that private health care insurance was introduced and the commodification of health services in India started (Reddy and Qadeer 2010:70). The government is promoting investments in sectors that are supportive to the medical tourism industry along with subsidising the private medical sector (Reddy and Qadeer 2010:72).

Insurance companies in the global North sees medical tourism as a way of lowering costs, while the uninsured in the global North see medical tourism as an opportunity and the countries, from where the medical tourists travel see it as a price control mechanism of medical services (Reddy and Qadeer 2010:74). Along with major hospitals of the global North paring up with hospitals in the global South

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<sup>2</sup> Since independence the Planning Commission of India has developed, executed and monitored the Indian economy through Five-Year Plans. The Five-Year Plans is a tool for handling and planning the economy and to promote a balanced and effective use of the countries resources.

the signs of a global liberal trade and globalisation in medical services becomes clear (ibid.). The international surrogacy industry has been referred to as the ultimate outsourcing (Shetty 2012).

There have been voices that have problematized the process of opening up and subsidising the private medical care sector that have made health services an instrument for market expansion and financial gain (Reddy and Qadeer 2010:70). Reddy and Qadeer claim that as business interest was given a place in the national health policy the principle of equal access to health care was undermined and the medical services for the poor and the better off was completely separated (ibid.). They claim access and treatment of Indian citizens is divided in two parallel systems as the medical industry is using public recourses, diverting them from the public health system to the private hospitals focusing on international patients. Government hospitals are encouraged to work on their private facilities in order to attract medical tourists but because of the low levels of public investment that can only happen at the cost of the facilities for the poor (Reddy and Qadeer 2010:71). Reddy and Qadeer claim that the focus on increasing revenue through medical tourism is contradictory to creating a strong public health care sector (Reddy and Qadeer 2010:74). Finally argues that polarisation of health care provision rooted in social and economical marginalisation is the outcome of globalisation and a progressive liberalisation of trade in health care services in the ASEAN region (Reddy and Qadeer 2010:69).

India is becoming one of the most popular countries for fertility tourism (Smeardon 2008 in CSR 2013:33). The unregulated fertility industry in India as an integral part of the medical marked with a special focus on medical tourism (SAMA 2012:7). Commercial surrogacy was in 2011 estimated to generate \$2.3 billion per year (Gupta 2011). After this section on medical tourism it is important to point out that surrogacy is not necessarily a part of the medical tourism industry but can be a purely domestic arrangement carried out in India, with commissioning parents and surrogates all being Indian nationals (Pande 2010:974).

#### **1.4.2 Physical context - The body**

In 1994, ten years after the first gestational surrogacy in the world succeeded in the US, the process was first preformed in India (CSR 2013:33). In 1997 the first commercial surrogacy arrangement was conducted (ibid.).

### Surrogacy and its different forms

The term surrogacy is used to describe when a woman is carrying a child that from conception has been intended to be raised by others than her. The conventional form of surrogacy, *traditional surrogacy*, means that a woman, the surrogate, is inseminated with the intended father's sperm. A second form of surrogacy, *gestational surrogacy*, is made possible by In vitro fertilisation (IVF). IVF is when egg and sperm is collected from two individuals and is used to create an embryo in a laboratory that is thereafter placed in the carrying mother's womb. In gestational surrogacy doctors use the eggs and sperm from either the intended parents or donors/sellers. This makes it possible to have a birth mother that is not genetically related to the child. Commercial surrogacy can be either traditional or gestational but refers to an agreement where the women carrying/delivering the child is paid by the commissioning parent(s). Altruistic or gift surrogacy is when the woman carrying the child is not paid.

This study does not separate traditional from gestational surrogacy. Most of my material concern gestational surrogacy. It should be mentioned that traditional surrogacy is less invasive as IVF is not used which means no fertility drugs for the surrogate as no embryo is placed in the uterus. Gestational surrogacy takes a long time of preparations and heavy medical intervention as it involves IVF (CSR 2013:20). That the surrogate is not connected to the baby genetically can mean that she carries a child that is quite a lot bigger than children from her own eggs. Not only because the surrogate during this pregnancy is fed while during her other pregnancies might have been malnourished but also because the egg and sperm can be from taller and different proportioned people. There are arguments that the lack of genetical connection makes it easier for the surrogate to complete her part of the deal and not feel as sad or wanting to keep the baby while others claim there is attachment to the children indifferent of genetical bond (CSR 2013:42).

### The surrogates

In the United States a typical payment for a surrogate ranges between USD 20,000 and USD 25,000. (CSR 2013:31) Studies show that Indian surrogates mothers earn between USD 3275 to USD 6551 (CSR 2013:151)<sup>3</sup>. The payment can depend between area, clinic, fairness of the surrogates' skin and education level along with other factors (CSR 2013:130). The age of women that were surrogates in one study was between 21-34 while in an other study 66 % of the surrogate mothers were between 26 to 30 years (SAMA 2012:34, CSR 2013:42). In the same studies the surrogates had prior

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<sup>3</sup> However most of the women whose monetary compensation these numbers were based on had not given birth yet and therefor not received their final payment. These numbers should only be seen as an indicator as different studies show that there are huge variation in the cost of surrogacy and the pay for the surrogates. Compare these numbers presented in SAMA (2012:7) to see contrast.

employment as housemaids, in factories or beauty parlours and as garment workers if not standing without work; several of the surrogates had multiple ways of earning income often seasonal and/or informal work (CSR 2013:45, SAMA 2012:40). More than half the women earned more than INR 3000 (USD 49) per month while the rest earned less, in their prior employment (CSR 2013:46). In a study on commercial surrogacy in Gujarat taken place between 2006 and 2008, thirty-four out of forty-two surrogates interviewed said to have a family income close to the poverty line (Pande 2010:974). Instability in employment and rising living expenses along with the amount and that it is paid in a lump sum, these women state is why they have chosen to become surrogate mothers (CSR 2013:46, SAMA 2010:50). The surrogates usually live in slum areas where basic facilities like clean water and toilet facilities are insufficient (CSR 2013:54). The clinics, the commissioning parents or the agents decide the amount of salary the surrogate receives; the surrogates rarely have the information or the position to negotiate it (SAMA 2012:134). This is one of the indicators that the surrogate's position in the decision making in the arrangement is inferior to that of the clinics, commissioning parents and the agents (SAMA 2012:137).

There is not much known about the long term health affects of surrogacy in the case of Indian surrogates. However it is important to point out that surrogacy involves hormone injections and sometimes several embryo transfers in order to become pregnant which makes the time the surrogate spend on the surrogate arrangement longer than nine months. The IVF procedure is extensive both in time and by including many steps of procedure.

### **1.4.3 Legal context**

Surrogacy is not prohibited in India. The need for regulation is put forward as the number of problematic cases are increasing of cross-border surrogacy arrangement with unsolved questions about the children's citizenship and the parentage status along with concerns about the health and rights of the surrogates (Rengachary Smeardon 2013:187). This section presents the legal context of surrogacy in India and provides an initial presentation of the policy used as material in this study. Policy is a tool and a product of the government and the legal context is crucial in this study as the research questions focus on the government.

#### **Existing regulation in India**

The Draft Assisted Reproductive Technologies (Regulation) Bill 2010, hence the draft bill, includes surrogacy regulation and is pending with the Indian national parliament (Rengachary Smeardon 2013:187). On state level, Maharashtra has a bill pending but it has not been released to the public

(Rengachary Smeardon 2013:188). In place are guidelines put forward by the government, the Ministry of Health and Family Welfare, the national academy of medical science and the India council of medical research (ICMR) (ibid.). These guidelines have no legal status.

The Ministry of Home affairs sent a message, hence the circular, to the Ministry of External Affairs concerning the type of visa should be granted foreigners coming to India for surrogacy arrangements (Rengachary Smeardon 2013:189). The circular states medical visa as the proper category (ibid.). It regulates surrogacy as it states the conditions under which foreign nationals can be granted medical visas for surrogacy (ibid.). The circular can be read as a whole in Appendix 1.

The ICMR lies under the Ministry of Family Health and Welfare stands behind the creation of the draft bill. The ICMR coordinates and promotes biomedical research in India. The Ministry of Health and Family Welfare is the responsibility of the Minister of Health and functions on jurisdiction of the government of India. The Ministry of Home Affairs have jurisdiction from the government of India and the Minister of Home Affairs is the agency executive. The Ministry is responsible for the upholding of internal security and domestic policy. Even though a Joint Secretary of the Ministry of Home Affairs signed the circular it is difficult to know who took part in the decision-making leading to the circulars release.

### Baby Manji – India's first public surrogacy case

Surrogacy arrangement depends on the contract between the commissioning parents and the surrogate. There have been several cases of surrogacy where the contract has not been enough to full fill the initial wishes. The most famous case in India was Baby Manji's case in 2008. A Japanese couple came to India and made a surrogacy arrangement with a clinic and a surrogate. When the child was born the commissioning parents had separated and as the contract stated that in case of a separation the husband would care for the child himself Baby Manji did not have a legal mother as neither the surrogate, the egg donor nor the commissioning female parent was bound by the law to recognise the child as hers. There was no legal framework to settle the parentage or nationality of the child nor was the contract legally binding with regard of parental rights (Points 2009:4). The problem in the Baby Manji case was that the commissioning father was at first not allowed to bring her to Japan as Indian law prohibits single men from adopting. Surrogacy poses challenges to the legal system, as the existing definitions of family, parents and citizen are not applicable to the situations created through commercial surrogacy arrangements. The nationality of the child is an issue as many of the commissioning parents go to India because surrogacy is not legal in there home

countries nor do they accept the parental rights of the commissioning parents over the child. The law presumes just two parents, which complicates surrogacy as there are so many people involved in creating a child and not just two as the law presumes.

### ***1.5 Demarcations of the study***

The focus of this study is the Indian government. Left out are the approaches and framings of the surrogates, children born through surrogacy and the commissioning parents, domestic and foreign. In the early stages of my study the ambition was to incorporate several groups active in surrogacy but in the end the government focus was allowed to have a dominant position. A reason for leaving out the voices of surrogates is that in the work of NGO's the surrogates' voices are limited to interviews done at clinics or from contacts through the clinic and mostly taken place during pregnancy, while the surrogates are still bound to a contract, as getting access and trust from surrogates to talk about their experience pre birth is difficult (CSR 2013:84, Sandoval 2010:70). This is in my view problematic as the surrogates are dependent on the clinics. In my encounter with surrogacy I had questions about the scale and speed of the expansion of the sector along with who was making money out of this global gendered division of labour and who was the loser. However as there are neither national nor state level registers this idea was put aside. It would also have been interesting to have made a comparative case study and incorporated Thailand that also are renowned for medical services and where several surrogate cases has received media attention in the last years<sup>4</sup>.

This study does not focus on the commissioning parents but the government. That is the reason that this group does not get a thorough presentation nor a problematization concerning the difference between domestic commissioning parents, and foreign commissioning parent. However as parts of my material only concerns foreign commissioning parents this group are more visible in my analysis. My experience and position limits the approaches towards this subject and is one of the reasons this study will not be focused neither on ethics and moral nor try to evaluate the benefits/disfavours of commercial surrogacy itself.

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<sup>4</sup> In the summer of 2013 media all over the world paid attention to an Australian couple that allegedly took one of their twins born through surrogacy, leaving the second twin, a child with Down Syndrome and severe heart condition, to be cared for by the surrogate mother. Also a case with a Japanese 24-year old man is believed to have fathered over ten children through surrogacy in Thailand and have been accused of human trafficking. Both cases, accessed 13th of August 2013, <http://www.bbc.com/news/world-asia-28686114>, the second case, accessed 13th of August 2013, <http://www.bangkokpost.com/learning/learning-from-news/425502/surrogate-update-wed-dna-tests-indicate-single-father>

## **1.6 Disposition**

After a short introduction the aim and focus of the study was presented with the research questions; followed by contextual insights divided in three parts, economic, physical and legal. The final section of the introduction chapter is a discussion on the demarcations of the study. The second chapter concerns methodology. It presents the design of the study, the collection and selection of data along with discussions on reliability and criticism of the sources. One section is dedicated to discuss and explain the method of analysis called '*What's the problem represented to be*'. The second chapter closes with ethical consideration. The third chapter is called *Surrogacy as a problem* and presents the analysis. The first section lifts current research on the surrogates, their bodies and the practice of commercial surrogacy along with a study of policy responses to surrogacy in the US. Following this is a theoretical discussion on Bacchi's discursive approach to social problems and central concepts in gendered international political economy. The third section presents the results from the application of '*What's the problem represented to be*'-method, answering the first of the sub-questions. The second sub-question is attended in the fourth section by applying the gendered international political economy framework. The study is finished with a concluding chapter that sum results and shortly discusses future research.

## **2 Methodology**

In this chapter the design and methodology of this study will be presented and discussed along with thought on reliability and source selection.

### **2.1 Design of the study**

This study is a qualitative, exploratory, single case study of how the surrogacy industry is received and framed on a national level. The design is suitable because it concerns a new and unresearched phenomenon.

The primary reasons for doing a case study of India is, firstly, because most research on surrogacy has focused on the global North, foremost the USA, secondly, India is in a favourable position to investigate as a policy is pending and there have been several high profile cases in the media, thirdly, India is one of the largest economies in the region with an expanding service sector and increasing trade deficit. This study also has an explanatory ambition but it is a secondary aim and should be regarded as an addition rather than a focus. An assumption that underlies the method of this study is that some problem representations are beneficial for members of some groups at the expense and even harm of others (Bacchi 2009:15,44f). It rejects that capitalism or patriarchy explain everything

about exploitation and claim that there is a need for policy analysis that investigates problem representations in order to make it possible to intervene and reduce harmful effects (ibid.). I believe this to be true and see it as a major reason to investigate policy in the manner of this study.

This study will investigate the sub questions;

- How is commercial surrogacy categorised, labelled and framed by the government?
- From a feminist perspective, what are the discursive complications and dilemmas produced by this problem representation?

The answer to these questions will be found by using two documents produced by the Indian government along with interviews with women's rights activists and researchers along with prior research. The first document, which is the draft bill, is presented in short in the section on legal context. The second document is the circular, also first presented in the section on legal context. In the presentation of the analysis references are used instead of quotes. However as I am using discourse analysis and because my ambition is to be transparent the circular can be found in Appendix 1. The most frequently referenced chapter of the draft bill, chapter 7, page 25-29, can be found in Appendix 2. In depth data is provided by five interviews with women's rights activists and researchers who have a position, involvement or stake in the issue of commercial surrogacy. The views and remarks by my informants will be incorporated in the analysis of the documents.

*'What's the problem represented to be'*- analysis is foremost used to answer the first sub question; *How is commercial surrogacy categorised, labelled and framed by the government?* Gendered international political economy is as theoretical framework foremost used to answer the second sub question; *From a feminist perspective, what are the discursive complications and dilemmas produced by this problem representation?* However the frames are closely connected, compatible and interact in the analysis. Bacchis' aims of highlighting and changing policy that is harmful to certain groups of people is in this study interlaced with the feminist political economics' commitment to challenge gendered structures in order to promote gender equality and form a theoretical starting point (Rai 2013:3).

### Who I am and why that matters

That this study is based in a social constructivist view of research and knowledge implies that knowledge is created and not discovered by people. The study draws from discourse analysis



because it recognises the creation of value through language however a material and physical experienced is also recognised and a part of the analysis. I have a theoretical base in feminist theory and rely in my analysis of the work of feminist researchers. My position is presented because a part of this study is to evaluate the policy proposals concerning surrogacy in India. As policy research is inevitably political and as evaluation is with out doubt coloured by the presuppositions, background and values by the researcher my situation is relevant (Bacchi 1999:10).

Eldén calls discourse analysis a methodological consequence for assumptions of postmodern and poststructuralist theories as it centres on the text and the creation of the text (Eldén 2005:63). This study uses discourse as a method and has a postmodern approach. The reflexive ambition of the study indicates the critical view of objectivity that is harboured in the postmodern approach. The approach can also be found in the assumption that phenomena, such as commercial surrogacy, can be framed in many different ways by a society, and that non of these ways are more true or correct than the other; only that some might be harmful to some people while others are not.

I have chosen to focus my study on a phenomenon which I myself, nor anyone who I know have taken an active part in. My experience with India is limited. I have spent time twice, the first time for two month's of internship, the second for field research for this study in Mumbai and New Delhi. This study has been designed with reflection of my position as a female student from the global North, educated in a Eurocentric tradition.

## ***2.2 Data collection***

I searched and downloaded both the draft bill and the circular from the website of the ICMR. The interviewed material comes from interviews with researchers and women's right's activists whom are active in the public discussion of commercial surrogacy or whose work is connected to surrogacy. The interviews complement the documents that represent the governments framing of commercial surrogacy as they help to point towards silences in the documents. Material from the interviews also contributes to the analysis by explaining and lifting the context of commercial surrogacy in India.

The interviews was recorded and transcribed in full. When preparing the interviews being up to speed on the work of my informants and background information about their areas was a goal. In consistency with constructivist approach, the interview situation is seen as a conversation between two people and the participants collectively construct the information and knowledge that come out of the interview. I call my interviews discursive interview and find my guidance for form and execution in Kvale and Brinkmann (2009). The interviews are semi structured and adapted after the

informants' involvement and connection with surrogacy. A semi structured design allows for more follow up questions and pay attention to specific experiences of the informants that was not known before hand and it served the purpose of exploring further the approaches and view of the issue of surrogacy. That in turn, suits the purpose of the interviews well as the interviews centred on the informants experience with, and engagement in surrogacy and as I had a wish for the informants to talk freely. Also the questions were adapted to every interview. An example of an interview guide is presented as Enclosure 1. The informants chose the place of the interview as to make it easy and comfortable for them. The interviews took place at their place of work or on one occasion in the home of the informant.

### ***2.3 Methods of selections***

The selection of documents coming from a governmental source concerning surrogacy was limited as the issue is quite new and there is little policy that concerns surrogacy. The draft bill and the circular were chosen because they are the only outspoken, national level, policy or proposed policy that directly deals with commercial surrogacy in India. The circular was selected as material as it is the only official document specifically regulating a part of the surrogacy process.

Selection of the informants was done using snowball effect, complemented by contacting people whom have made statements in media, published studies or written academic articles on surrogacy. Contact was also made through teachers, fellow students and workplaces of informants. The informants were contacted through e-mail and on several occasions also by phone. Originally I wished to do more interviews but out of the 25 persons that I approached the final number of interviews were six where five were suitable as material. One of the informants had been attacked during data collection for a study on surrogacy and had received a lot of what she referred to as hate mails. I mention this to point out the sensitivity of the issue. This can of course be a reason that it was difficult for me to arrange interviews but foremost I believe it was not in the interest of the approached informants to talk to a student. The informants are one documentary filmmaker, three researchers, and one advocate and women's rights activist. They are all women. Through out the analysis the informants are referred to as I1, I2, I3, I4 and I5.

### ***2.4 Reliability***

Reliability in qualitative studies can always be questioned when applying a framework constructed for quantitative studies. What strengthens the reliability in this study is the central position theory has and how theory is an integrated part of the study. My ambition is to clearly state my position in the academic world, my relation to the topic of my study and how I have made interpretations.

Transparency is something that I have strived for and that reflexivity should be present throughout the study to support the reliability of the result. By using developed analytical tools the possibility of good intersubjectivity increases (Bergström and Boréus 2005:352). *'What's the problem represented to be?'* provides an open yet detailed and clear tool in analysis as it is based in six questions with instructions on how to answer them in practice.

## **2.5 Criticisms of sources**

The creation process of the draft bill is not clear. It would contribute to the analysis if more were known about how it was created. This draft bill is relevant to use as a representation of how the government is framing and dealing with commercial surrogacy even though we would like to know more of its creation. Because it is possible to download from a government web page we know something about its origin and we know that it has been created under the supervision of the government. As the sampling is strongly affected by the fact that there are only a very small number of policy documents, statements and reports by the government on surrogacy it is important to reflect over their origin.

The informants in this study are not representative of any group. They were picked for their engagement and interest in surrogacy. This is an element that can be critiqued however they are presented as voices from the civil society and should be considered to be just that. Different voices could lift silences in the documents or pinpoint other framings.

Prior research of surrogacy in India gives witness to the difficulties to access people involved in surrogacy. For this reason several studies have small groups of respondents and affected the outcome of the studies. There are also big gaps in the research on surrogacy in India, in particular on how it have been promoted along with the physical effects the practice have on the surrogate's bodies. Parts of the prior research referred to in this study are focused on the USA. This research is still relevant as surrogacy has been a business there for a longer time than in India. Even so, it is important to reflect over and highlight that it is made in a different context.

## **2.6 What's the problem represented to be?**

Policy is created in order to deal with social problems or to prevent them from rising. By using Bacchi's *'What's the problem represented to be'*- method one can answer questions about how the authors frame and label a particular phenomenon. Since the research questions in this study concerns how the government have framed and is dealing with commercial surrogacy Bacchi's method offers a critical way of analysing this. The method was designed not only to be critical but

also to help view policy in different light and pinpoint alternative representations. This is the methods strength; in particular identifying silences in the policy that is crucial when we do not know under which circumstances the policy was constructed. Studying the frames used in reproductive politics is an important part in understanding how our society reacts and deal with developments in reproduction and biomedicine (Markens 2007:182). Markens shows, with her US focused study, very clearly why a social constructionist approach to analyse social problems is suitable as she identifies two very different ways of defining the problem with surrogacy and legislative solutions which shows that social problems are not fixed (2007:173).

The material will be analysed with a method called '*What's the problem represented to be?*' developed by Carol Bacchi, a Canadian policy researcher working in Australia. The method is based in discourse analysis and is to be applied on policy. This approach consists of six questions that to a certain extent complement and overlap each other. The questions are;

### **1, What's the 'problem' represented to be in a specific policy?**

The first question is a clarification exercise to locate the representation of the problem in the policy (Bacchi 2009:2f). This includes looking at the proposed intervention, as the intervention is the key to how the problem is represented (Bacchi 2009:3). For example if a policy dealing with getting more women into the labour market suggests vocational training the 'problem' or reason for the low participation of women in the labour market is seen to be women's lack of training.

### **2, What presuppositions or assumptions underlie this representation of the 'problem'?**

The second question is set to uncover deep-seated presuppositions by investigating binaries, key concepts and categories that are operating in the policy (Bacchi 2009:7). A binary assumes an A/not-A relationship, for example male/female, healthy/sick, public/private, one side of the binary is excluded from the other and there is a hierarchy where one side of the binary is privileged and considered more important than the other (Bacchi 2009:7). Binaries simplify complex relationships (ibid.). Key concepts are seen as relatively open ended, that is, they can be filled with different meanings which makes them contested as the meaning of concepts can be different depending on political vision (Bacchi 2009:8). Given categories should be noted but not accepted and their function and meaning in the light of the problem representation should be recognised (Bacchi 2009:9).

### **3, How has this representation of the 'problem' come about?**

Non-discursive practices behind and the history of the problem representation are looked into with the help of this question (Bacchi 2009:10). It lifts competing problem representations and illustrates that the problem representation is not fixed but floating (ibid.).

**4, What is left unproblematic in this ‘problem’ presentation? Where are the silences? Can the problem be thought about differently?**

Forth question is considering the limits of the problem representation being investigated by pinpointing the silences in the policy.

**5, What effects are produced by this representation of the ‘problem’?**

Fifth question assists in critically assessing the effects that the problem representation creates. These effects are subtle and are to be understood through poststructuralist discourse theory and feminist body theory (Bacchi 2009:15). There are three types of effects that we are looking for in our analysis, discursive effects - limits imposed on thought and speech, subjectification effects – what subjects positions are available in the discourse and lived effects – material impact (ibid.).

**6, How/where has this representation of the ‘problem’ been produced, disseminated and defended? How could it be questioned, disrupted and replaced?**

The last question pays attention to how the problem representation became dominant and the possibility to challenge the policy if it is seen as harmful (Bacchi 2009:19). The six questions should also be applied to the studies own problem representation (Bacchi 2009:2).

The answer to these questions will, as suggested by Bacchi, be presented together as they overlap each other (Bacchi 2009:100f). Bacchi’s method is presented in two books which both have acted as guides, *Women, policy and politics, the construction of policy problems* (1999) and *What’s the problem represented to be?* (2009). Both books draw on Bacchi’s own research and is completely focused on western countries and Australia.

## **2.7 Ethical considerations**

Gestational surrogacy is a phenomenon that is ethically controversial, prohibited in many countries around the world. Commercial surrogacy is a sensitive issue as have been and will continues to be reflected over and kept in mind throughout the study. I am aware of the stigma women who have been surrogates live and that the business is frowned upon for exploiting people in harsh circumstances. I received guidance from my supervisor at TATA Institute Of Social Sciences and also discussed my approach with other faculty members that have supervised master students

researching surrogacy. This was very helpful and necessary as this is the first study I am conduct in India.

I did inform my informants at my initial contact with them of the purpose of the interview, my position and affiliation. The interview also started with a short orientation describing the purpose of the interviews. My intention was to be as clear as possible with the aim of our interview even though while the data collection was carried out the focus of the study was slightly shifted. All informants are anonymous.

### **3. Surrogacy as a problem**

This chapter hosts the large part of the analysis and presents theoretical framework along with key studies on commercial surrogacy.

#### **3.1 Current research**

Commercial surrogacy as a phenomenon can be traced long back in history but gestational surrogacy came with the development of IVF in the 1970's. Research and debates on the phenomenon within and across different disciplines have been undertaken since. Surrogacy is and has been most common in the US foremost the state of California, influencing the research on the issue. However in the last years as surrogacy has increased in India, scholars have done research on the subject from several disciplines and angles (Pande 2010, Sandoval 2010, SAMA 2012, CSR 2010). The phenomenon has been discussed from identity standpoints (Pande 2010) and legal standpoints (McLahlan and Swales 2009) as well as the medical risks for all involved (Nakash and Herdiman 2007). This section presents research on surrogacy both in the US and India.

##### **3.1.1 How surrogacy is framed and problematized in the USA**

Susan Markens, sociologist, have done a comparative study investigating how surrogacy emerged as a social problem in the US states of California and New York and what policy response high profile surrogacy cases created. Markens describes the social climate at the end of the 21st century and how the discussions about reproductive rights was increasingly focused on foetus rights while abortion and women's rights eroded (Markens 2007:52). The study finds surrogacy discursively framed as a social problem in two ways resulting in two policy responses that Markens calls, "baby selling"- the disapproval of marketplace values into the private family and "the plight of infertile couples"- that is the sympathy for people's "natural" desire to have a family without state interference (2007:80). In Markens analysis the "baby selling" framing of surrogacy recognises the problem to be intrusion in a sphere where non-economic values should apply and where the policy response and viewed solution

is a ban on surrogacy (Markens 2007:81). “The plight of the infertile couple”-framing represents the problem with surrogacy as state intrusion that can be solved by regulation (ibid.). Important to point out in Markens analysis is that those advocating both for and against surrogacy shared many assumptions about family and along with non-recognition of the significant disparities between racial/ethnic groups access to reproductive rights (ibid.). Markens argues that the “baby selling” frame is no less traditional in view of the family as the court cases that lead the way for the ban of surrogacy in New York recognising genes rather than gestation as the marker of relatedness, reinforcing a notion of kinship as built on genetics and blood (Markens 2007:174). Therefore Markens argue that both framings support normative constructions of family and kinship (ibid.).

### **3.1.2 Surrogate mothers, the body and the practice**

In commercial surrogacy the labour of carrying a child is moved from the private sphere, the institution of the family, where it is granted legitimacy and recognition, to the sphere of the market. As the norms of childbirth also transgress and apply to commercial surrogacy without change it results in categorising commercial surrogacy as indecent (SAMA 2012:133). The norms of reproduction make commercial surrogacy illegitimate work that is stigmatised and undignified (ibid.). However the medical practice is motivated by the success rates of the clinics and the demand of the commissioning parents which leads to invasive procedures that affects the surrogates’ body both under and post-pregnancy (SAMA 2012:137). The treatment of one party, the infertile couple, is risking the health of another party, the surrogate, and this poses great medical ethical challenge where the treatment of the financially privileged are directly damaging for the health of the unprivileged (ibid.).

Pande also studies how the popularly used rhetoric of commercial surrogacy in the global North of *gift*, *sisterhood* and *mission* is used in India (Pande 2011:624). She concludes that the narratives of these concepts materialise inequalities between the surrogate mother and the commissioning parents that are based on class, nationality and race instead lessen the monetary character of commercial surrogacy (ibid.). The narratives surrounding commercial surrogacy reinforce the primary identity of the surrogate mothers as dependent mothers and not as independent workers (Pande 2009:141). Surrogates, intended surrogates, medical practitioners, government officials, commissioning parents and representatives of the civil society in India communicate surrogacy within three main definitions, as a medical intervention, with the technique and the infertile parents to be in focus, as a commercial enterprise, with the economic benefits of the parties and society in focus, and as altruistic exchange, where the process is communicated as charitable and as an act of solidarity.

## **3.2 Theoretical framework – social problems and feminist economics**

In this section two theoretical frameworks are presented, theory on social problems and on gendered political economy. Both frameworks should be seen as complementing each other in order to do a more thorough analysis. I have chosen five concepts, central to gendered political economy as viewpoints and it is through them that I apply the second theoretical framework on the results from the application of the first framework, '*What's the problem represented to be*'-analysis. However both theoretical frames blend and overlap regardless of the different stages in the analysis they are introduced.

### **2.2.1 Bacchi and different approaches to social problems**

Social problems as phenomena and concepts are exceptional to modern society (Gusfield in Bacchi 1999:6). Categorising an issue as social implies a public responsibility to address the issue while categorising an issue as a problem implies it is unwanted or morally disapproved of (Bacchi 1999:6). Bacchi lifts Gusfield's thought on social problems as a way of pinpointing particular conditions and claiming change through public action (ibid.). In this study a social problem is seen as a label that a group can put on a phenomenon that is disapproved of and thereby call for public action.

The '*What's the problem represented to be*'-method investigate the discursive construction on which problems are built. One could say that rather than traditional policy research investigating the problem itself or the difference between policy and implementation, Bacchi's approach examines the problematization, the process in which an issue is labelled a problem. The method does not see policy as a response to an existing problem but as a discourse where both the problem and the solution are created (Bacchi 1999:2). The approach is grounded in post-structuralism theory and builds on Foucault's discourse theory. The evaluation part of the policy analysis separates Bacchi from other social problem theorist (Bacchi 1999:10).

Bacchi developed the method to shift the focus of policy research from policy as 'a solution to a problem' to policy as 'an interpretation of a political issue' (Bacchi 1999:2). Further Bacchi wants to incorporate in the analysis of policy what the government leave untouched and unarticulated both deliberately and unintended (Bacchi 1999:3). The method is constructed on the assumption that the definition of a social problem is not fixed nor is the fact that there are problems at all (Bacchi 1999:4). Bacchi uses pornography as an example and states that while some see the concern with pornography as moral degradation seeing the cause as moral degradation while some think of it as



an abuse of women and perhaps see the cause as men's desire to control women while some do not regard pornography as a problem at all (ibid.). Not all phenomena that cause damage or hurt people are necessarily framed as problems (Bacchi 1999:6). Policy studies are unavoidably political according to Bacchi whether or not they claim to be (Bacchi 1999:5f).

### **3.2.2 Gendered international political economy**

Gendered international political economy is the study of how gendered social relations, that is how men and women are situated historically, structurally and discursively, are played out in the context of political economy and with what outcome (Rai 2013:1). These outcomes are different depending on the situation but have generally been more negative for women than for men (ibid.). Gendered international economy recognises that the spheres of the market, the economy and gendered social relations overlap and are co-constructive rather than separated (ibid.). It also highlights the relationship between institutional decisions and the structures within which gendered social relations reside (Rai 2013:2). Along with feminist political economy, gendered international political economy is a critique of mainstream economic theory. This critique is based in recognising and questioning the binaries between the private and the public, productive and reproductive along with the gendered structures in the state and the market (Rai 2013:1f). Bacchi aims at highlighting and changing policy that is harmful to certain groups of people is in this study interlaced with the feminist political economics' commitment to challenge gendered structures in order to promote gender equality and forms a theoretical starting point (Rai 2013:3).

The concept of *sexual or gendered division of labour*, derives from socialist feminists in the 1970s and 1980s and is used to illustrate how capitalism has taken advantage of inequalities created by patriarchal social relations and created hierarchal working practices (Kuhn, Wolpe and Hartmann in Ferguson 2013:1f). At the same time Elson and Pearson analysed the gendered impact of the shift of production from the global North to the global South (Rai 2013:6). They show how export oriented production built on cheap labour of the global South, foremost female labour, was seen as disciplined and pliable and with that reinforced gender hierarchies (ibid.). They, in line with gendered international political economy, discussed how women's skills are seen as natural and valued less than the skills of men that are seen as acquired (Rai 2013:6). Some feminist analysis of economics engaged in showing how the state regulated and stabilised gendered divisions of labour and how activists challenged exploitation and developed alternative measurements and categorisations of work (Rai 2013:7). To recognise a gendered division of labour does not necessarily mean that women are always in a worse position than men but that labour markets are always gendered (Ferguson 2013:2).

*Social reproduction* is a central concept for investigating the consequences for women of the public/private divide (Rai 2013:3). Social reproduction can be defined as biological reproduction, unpaid production of services and goods and as reproduction of ideology and culture that stabilises the dominating social relations (Hoskyns and Rai in Rai 2013:3). Leaving out social reproductive work from national calculations of production and exchange leaves most of the reproductive labour outside of what is seen as production (Rai 2013:3). Not recognising social reproductive labour makes the work hard to value and to compensate for its effects (Rai 2013:4). Most of the social reproduction is done by women and is not acknowledged as work (Rai 2013:3). Different views on how social reproduction should be viewed, as commodity production or if the concept is too complex to view as production at all have been discussed by feminist scholars (ibid.). From a gendered international political economy-approach the concept of social reproduction can be used in order to point at the physical and mental drain of resources of the people involved in this type of work, to limit harm and compensate market subsidies that result in cheaper goods and services, leading to increasing consumption (ibid.).

The concept of *feminization of employment* stands for an increase of women's integration in the paid workforce along with an increase of unstable working conditions that are viewed as connected to female work, for both men and women (Ferguson 2013:2). Some of these conditions, like low-pay, informal and dependent on embodied attributes of the worker, like emotional labour, are found in the part of the service sector that is made up by women, that is catering, care and cleaning work (Ferguson 2013:4). Arguments that support these conditions concern the qualities one need to perform a certain kind of job. When it comes to emotional labour and work seen as female the qualities that are needed is seen as natural, less valued than formal, trained skills and therefore do not require proper payment (Perrons in Ferguson 2013:4).

In the 1970s a new *international division of labour* emerged, by some called the beginning of globalisation, this meant decentralisation of manufacturing production from industrialised countries to less developed countries for reasons of lower labour costs and few regulations (Ferguson 2013:2). The work of Elson and Pearson's on this shift and its gendered impact on women of the global South is mentioned above. Now the process of globalisation, which is restructuring the international division of labour, has come to include the service and agricultural sectors (ibid.). Export oriented production, foremost in the global South, reproduces capitalist social relations and with that, hierarchies of gender, class and cast, this production regime also globalise the gendered division of labour (Elson and Pearson in Rai 2013:6).

*Feminist critique of the state* has multiple focus points. One fundamental argument is that the state, by policy, law and discursive practices supports continued dominance of patriarchal structures of production and social reproduction (Rai 2013:7). Also parts of this critique concerns how globalisation and neo-liberalisation is reshaping entitlements to rights for citizens along with inclusion and exclusion through how social policy is framed (ibid.). That is, state policy is undermining social protection as the neo-liberal social order is reflected in new regulatory systems and institutions (Rai 2013:8). Feminist economists claim that markets are socially embedded which means that non-market criteria matter in the market arena (Harriss-White in Rai 2013:7). They have shown that non-market criteria are built into features of the state, which result in unequal capabilities, and bargaining power of actors in the market (Rai 2013:7). This critique aim to demonstrate how trade liberalisation has reshaped and stabilised gender inequalities (ibid.).

### ***3.3 The framing, dealing and problematization of surrogacy in policy***

This section presents the result of the ‘*What’s the problem represented to be*’- analysis of the draft bill and the circular along with insights from the informants of the study. It aims to answer the first sub question of how commercial surrogacy is categorised, labelled and framed by the government.

#### **3.3.1 Voices from the civil society**

*“I see it as one more labour option.” I1:6*

My informants view surrogacy and how it should be labelled in different manners but they all regard surrogacy in India problematic in some aspect. I1 describe the problem with surrogacy as exploitation, a feudal set up where the surrogate mothers are depending on the goodness of the commissioning parents. I1 suggest regulation rather than a ban but highlight the importance of imposing obligations of the clinics towards other stakeholders. She sees the clinics bad behaviour as a problem in the surrogacy business. I3 know from her own research that surrogates are treated badly. The informant’s opinion is that monitoring the business is one part in having better conditions while another is to have researchers from several disciplines come together to make policy recommendations. Also she believes that exploitation can be partially minimised by informing potential surrogates of their rights and give them information on surrogacy in order to create awareness about the surrogacy industry and how it works. With I3 the problem is represented to be the unethical behaviour of clinics along with uninformed surrogates. I4 thinks that the remedy to problems and exploitation in the surrogacy industry is solid and extended contracts that include more obligations towards the surrogate’s health. In I4’s way of framing surrogacy the problem is represented to be inadequate contracts that do not cover the rights of the surrogate mother

concerning health nor clear agreements on the surrender of the child by the surrogate. IS claims the need for research on the long term health effects surrogacy and pre-surrogacy treatment has on the surrogate mothers, on the decision making process within the clinics and how the support and subsidies for medical tourism is affecting the public health system in India.

### **3.3.2 Draft the assisted reproductive technologies (regulation) bill – 2010, Ministry of health and family welfare, Government of India**

#### Key interventions/initiatives of the draft bill

The draft bill confirms commercial surrogacy arrangements as legal since it allows both commissioning parents and ART banks to pay surrogates (MHFW 2010:20 and 26). However it prohibits surrogacy for people that can normally carry a child (MHFW 2010:16 and 18). The first key initiative of the draft bill is to create a register and a supervision body for the ART banks and clinics (MHFW 2010:1f). The second initiative, is to only allow ART banks to advertise for surrogates and without mentioning details of cast, ethnical identity or decent (MHFW 2010:17, 20, 26, 31 and 34). The draft bill also regulates a few health issues of the people involved, such as screening gametes and surrogates for diseases, the age and prior births of the surrogate along with demanding the commissioning parents to pay health insurance for the surrogate (MHFW 2010:20, 27f). The draft bill secures the confidentiality of the surrogate's identities (MHFW 2010:15, 16, 26, 27 and 29). It also includes particular regulation for foreign commissioning parents concerning who has the custodial right the child conceived through surrogacy along with a demand of the foreigners home country to recognise surrogacy arrangements (MHFW 2010:28). Further the draft bill demands that surrogate is an Indian citizen along with the consent of her husband, if she is married (MHFW 2010:28).

#### Presuppositions and assumptions

The introduction of the draft bill states every couple's right to a child (MHFW 2010:1). This provides couples an opportunity to claim surrogacy and strengthens their rights as consumers. Every couple has a right to a child but as everybody does not have the right to adopt in India nor can afford a fertility treatment the argument only strengthens the right of the wealthy to consume.

In the draft bill surrogacy is a treatment for people that cannot have a child on their own. Not having children is presented in the draft bill as a social stigma and an economic problem in India (ibid.). This view of the commissioning parents, as patients, enhances the idea and representation of being childless as socially unacceptable and contributes to the pathologization of it. However the draft bill

uses several different concepts when referring to the commissioning parents. The draft bill, without consistency, use 'person seeking surrogacy', 'couple/individual', 'patient', 'infertile couple' and 'parents'. To name the same group in several ways implies the commissioning parents different roles in the surrogacy arrangement, but it also makes their position unclear.

The term *donation* is used to describe both selling and donating gametes but this hides the financial transaction of the arrangement whereby many people do get paid to provide gametes. The providers of gametes are referred to as donors whether or not they have been paid or have donated without any compensation (MHFW 2010:3). However if the commissioning parents also are the providers of gametes they are not called donors, even if they are probably the largest group of non-paid gamete providers. Using donor hides the economical nature of the acquisition of gametes.

The bill states that the surrogate mother does not have a biological relationship with the child that she is carrying. Traditional surrogacy is represented to be a problem because it means a biological tie through genetic heritage and is therefore prohibited in the draft bill. As mentioned earlier traditional surrogacy is where the surrogate and the child are *genetically* related and in gestational surrogacy they are not. To claim that *gestational* is not *biological* carries assumption of heritage through genes rather than gestational environment and downgrades the bond between the carrying mother and the child in benefit for the genetic bond.

#### Origin of the problem representation

*"...this bill is now tossing for the last seven years between Ministry of Legal Affairs and ICMR, Indian Council of Medical Research. In many ways we are not so friendly with them. They have claimed to do national level debate on this issue among various stakeholders and then they have come to this conclusion (the guidelines). When we asked them in our talks and via phone to revile what stakeholders have you been consulting so that the doubts that we have can get clarified why certain issues have been incorporated in the bill. Till today they have not given us those lists."* 13:2

*"Unfortunately this issue (surrogacy and ART) is not a priority for the people who are passing the bills."* 14:3

These two quotes from my informants illustrate how little is known in the work leading up to the draft bill. We know that it is based in the guidelines developed by the ICMR, that treats medical ethical issues by appointment of the government. Surrogacy is bundled up with treatments of infertility as it is in the same draft bill as assisted reproductive technology. The drafting committee of

the draft bill constitutes of four representatives from the Ministry of Family Health and Welfare, three representative, one of them also being a supreme court advocate, from a centre for non-profit legal back-up in human rights, civil liberties and social justice, four infertility specialist running or working at infertility clinics that provide surrogacy, one representative is a researcher with biotechnology as main field with long experience in bioethics and legislation. This tells us that no surrogates or any representative from the medical fraternity that opposes surrogacy was a part of the drafting committee.

### Silences and alternative representations of the problem

*“What is centrally missing in this proposed bill (draft bill 2010) is the presence of women (surrogate mothers)” 11:6*

This quote, in the background of the composition of the drafting committee, points towards the lack of opinion from surrogates in the legislative process. The draft bill states that the surrogates should be allowed payment however there is no mentioning of a minimum wage or how the payment can be done (MHFW 2010:26). The draft bill does only partially problematize the different roles and positions of power in the surrogacy arrangement. The surrogates are hired through a contract with the commissioning parents while the hiring party is not allowed to advertise for a surrogate, that being the role of the sperm/egg bank, that is to say, the sperm/egg bank is the supplier of the material. This distribution of responsibility categorises sperm, egg and surrogate together. This is not problematized nor is the fact that the fertility clinic is not a part of the legal agreement. Also the draft bill fails to reflect over the limits the proposed policy poses to the demands that can be included in the contract and how the policy holds the commissioning parents responsible for procedures that they have little control over. The draft bill does not demand a contract between the commissioning parents and the clinic. It is twofold, on one hand the draft bill puts the commissioning parents in charge of the business arrangement as they contract the surrogate, on the other hand the same draft bill diminishes or obscures their role as an employer/contractor since they are sometimes referred to as commissioning parents and sometimes referred to as patients. To be a patient seems like an exposed position, which they might have however the terms employer or contractor are not used at all. This makes it difficult to understand who is responsible for the arrangement as a whole.

The surrogate's health and their situation under the contract are only briefly noted (ibid.). It is not raised as a problem that it is often the clinics that engage with the surrogates, giving them the main responsibility towards the surrogates and their health.

The draft bill does not challenge the system in which surrogacy arrangements take place. The draft bill accepts and permits the surrogacy industry to continue apart from a few changes such as making a clear divide between ART clinics and ART bank. The problem is represented to be lack of order in the business and the uncertainty of a completely unregulated business. The draft bill gives the surrogacy business stronger legitimacy and provides a legal frame in which the business can grow further. This could be a step towards making India a global health care destination, as the aim of the regulation is to create a frame in which the surrogacy business can function and become more predictable. The regulations are mostly focused on creating a healthy child and only very basic protection for the surrogate. An alternative way of problem representation could be that this system in which surrogacy arrangements are made is, in itself, harmful for the Indian society and restrains the surrogate's power over the arrangement.

#### Effects of the problem representation

That the protection of the surrogates identity is mentioned on several occasions (MHFW 2010:16, 25, 27 and 29) while the protection of their health is focusing on making sure she is insured and that the embryo does not carry disease. A discursive effect of this focus on the protection of the surrogate's identity enforces a stigma connected to being a surrogate. The surrogates are presented as a way to a means. They are subjectified as a treatment for childlessness. This is enhanced by the strong identity protection that the draft bill offers as it also positions being a surrogate as something shameful. This emphasis on the protection of the surrogate's identity may make it difficult for the surrogates to organise and to share experiences outside of the clinics, which in turn weakens their bargaining position when entering the arrangement.

*“So many of these women talk about being in touch with these couples years later and the doctors will tell you very proudly that some of the couples are very good and kind hearted, they have sponsored the education of the surrogates children till the tenth grade. That is very nice and touching but you can't have a contract based on the good will of one party.” l1:7*

*“Off course they are most likely to be very good people who are grateful and not some evil people but this is a feudal set up. If she depends on their goodness.” l1:8*

The draft bill supporting surrogacy as a contractual agreement between the surrogate and the commissioning parents have the lived effect of keeping the clinics out of the contract and with that responsibility for the surrogate. This means that it is a private arrangement and the contract can be

formulated in any way, except for some responsibilities by both parties demanded in the draft bill. The surrogate being contracted only by the commissioning parents and not the clinic also puts her in an exposed situation, as it is the commissioning parents that have the contract with the clinic. This makes it possible for the clinics to favour the wishes of the commissioning parents over the health of the surrogate mother, for example by always doing caesarean sections to fit the commissioning parents time schedule at the benefit of the surrogates health. The surrogates are not talked of as work force having the rights of other employees, which limits their possibilities to reduce health risks to depend on the contract.

### Questioning the representation of the problem

*“In the Indian scenario commercial surrogacy is very much accepted.” I5:5*

*“...if you look at when and how this thing started because in the 1970s and 1980s surrogacy was a big debate and if you have read baby M’s case it was more of traditional surrogacy. The bonding was there, but now it has been purely commercialised it is more of gestational surrogacy. So the surrogate does not have any right over the baby, as it does not share any genetic material. So then it can be more easily commercialised.” I5:5f*

Researchers have asked why the draft bill prohibits traditional surrogacy, as it is simpler, safer and cheaper and claimed that this is also a way of reducing the influence of the surrogate by refusing the less invasive version of the procedure (Qadeer and John 2009:11, CSR 2013:19f). To make the opposite decision and allow traditional surrogacy and prohibit gestational surrogacy would restrict the commissioning parents’ choice of genetic heritage of their child while promoting the value of the surrogates’ health.

### **3.3.3 foreign nationals intending to visit India for commissioning surrogacy – circular from the Ministry of Home Affairs, Government of India**

#### Key initiatives of the circular

- 1) Foreigners that are visiting India for commissioning surrogacy should be issued medical visa only (MHA 2012).
  
- 2) The medical visa shall only be granted to couples that  
-have been married at least two years



- can provide a letter from their embassy or foreign ministry stating that their home country accepts surrogacy and regards children born of surrogacy arrangements as the biological children of the commissioning parents
- assures the treatment is done at a registered ART clinic
- provide the contract between the surrogate and the commissioning parents
- the commissioning parents supply an undertaking stating that they will take care of the child (MHA 2012).

The second set of interventions implies that unserious persons come to India to commission surrogacy and that this is a problem, harmful for India and/or Indian citizens i.e. that Indian surrogates are cheated by foreigners who come to India for surrogacy. By defining four areas where foreign commissioning parents need to provide documentation on their appropriateness the circular assumes that foreign commissioning parents are cheating Indian surrogate mothers. The information we get from the circular is that foreign commissioning parents do not write contracts as part of the agreement, that the commissioning parents are from a country where the state does not allow surrogacy or allow the parents to bring the child back, leaving the surrogate mother with the responsibility of the child, that the procedures are done in an unserious clinic and that the parents are not married, are single or gay or have only been married a short time.

As we know from past famous cases of surrogacy, there have been foreign commissioning parents that have not been allowed to bring their child/children back to their native country, as surrogacy is not legal there, creating a problem for Indian authority as of how to handle the situation. The problem is represented to be that the administrative authorities in India are left with children born through surrogacy that are not permitted to leave the country. The circular addresses this represented problem.

Why all foreign nationals that have been married less than two years or not at all represents a problem to the Ministry of Home Affairs can have several explanations. The idea that single commissioning parents should not be suitable or more inclined to cheat the surrogates can be viewed in the light of the famous Baby Manji-case. In the Baby Manji-case the commissioning couple separated and the man was not able to bring the child home to Japan. This case got a lot of attention and the exposed position of the child was discussed in media. However having been married more than two years does not prevent divorce. Therefore one might think that a long-term married couple is what the Ministry of Home Affairs sees as suitable and serious commissioning parents. What is

clear is that single, gay or unmarried foreigners are seen as unsuitable for engaging in surrogacy in India.

### Presuppositions, assumptions and effects

Underlying the representation of the problem is an assumption that only heterosexual married couples are suitable parents<sup>5</sup>. The assumption about who is a good parent is entwined in the issue of surrogacy. Pande's study on how ideas about *good* and *bad* motherhood are used in the creation of a surrogate identity is an example of this (Pande 2010). Further the reason stated for the criteria in the circular are to ensure responsible and honest commissioning parents that do not cheat. There is an underlying assumption that married couples are responsible and honest while unmarried couples are irresponsible, dishonest and unrespectable. This circular marks one group, married heterosexual couples, as trustworthy business partners and all other groups as more likely to cheat or strike an unserious deal. These assumptions are reinforcing a patriarchal stereotype of a nuclear family along with categorizing non-normative commissioning parents as cheaters and problematic individuals that need to be restricted. The subjects that are produced are the accepted/respectable foreign commissioning parents and the unacceptable/unrespectable foreign commissioning parents.

Creating a policy that categorises the reasons for foreign commissioning parents who come to India for surrogacy as medical treatment, not tourism or business is portraying surrogacy as a medical treatment first and foremost, business as second. This follows a line of talking about surrogacy as a fix for infertility in first hand, disregarding and diminishing, the economic and business aspects of surrogacy. In surrogacy the commissioning parents only sometimes go through a medical procedure themselves. Writing about the surrogates as victims of unserious foreign commissioning parents pictures the surrogates without agency and control while framing the foreign commissioning parents as the villain. Categorization commissioning parents reasons for entering India as medical purposes also makes it clear that the commissioning parents are seen as patients, coming to India for a treatment. Infertility or childlessness is seen as the disease even though the circular do not rule out commissioning parents that are physically able to carry a child to term.

The lived experience of this policy is a restrain in access to the Indian surrogacy market and might mean that foreigners seeking surrogacy will not be able to have it. Also to mark these groups as unacceptable/unsuitable/dishonest parents contributes to further marginalisation and possible stigmatisation of these groups as parents and as people in India and abroad. Another lived effect of

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<sup>5</sup> Gay marriage is not recognised in India

this circular is that the surrogates are treated as victims rather than, let's say workers in the eyes of the government. This can have all sorts of lived effects where the stigma and exclusion that surrogates face is reinforced.

#### Silences and alternative representations of the problem

*"There is absolutely no attempt of the fertility industry, which is making millions of rupees, to track the impact of what they are doing in all of these processes." I1:6*

*"There are lots of different kinds of problems. I feel that a lot of foreigners get exploited when they come here because they are so desperate to have a child that they are willing to pay anything for it."*

I:1

The circular produces the problem as a *demand* problem as the commissioning parents are situating the problem since they are portrayed as likely to cheat the surrogate mother. That leaves the *supply side*, which are the ART clinics, underplayed and under-examined. The possibility that foreigners along with the surrogates are in an exposed situation and could be cheated and misled by Indian clinics is not explored further than demanding that the clinic must be registered. Bacchi's '*What's the problem represented to be*' –analysis encourages us to link the shape of social policy to government finance and economic policy (Bacchi 2009:54f). Earlier I have discussed how medical tourism is supported and encouraged by the Indian government and how it is believed to add to the countries foreign exchange revenue. Ensuring that the foreign commissioning parents are able to follow through the surrogacy arrangement smoothly favours the government in their work to establish India as a medical tourism destination. Cases where the parents have had problems to collect their children makes bad press for India as an uncomplicated and preferable health care destination. Stricter regulation concerning who is allowed to commission surrogacy in the first place can work partially preventive of the troubled cases. If the intent is safeguarding the surrogates from the commissioning parents, the government could choose to categorise the commissioning parents visit to India a business trip and only granting them a business visa. However they do not, but choose to see surrogacy as a part of the medical tourism sector.

### **3.3.4 Conclusion of results**

First, the draft bill supports every couple's right to a child and therefore the right of the consumer in the surrogate arrangement. Second, as the draft bill does not reflect on the distribution of responsibility in the surrogacy arrangement when it comes to the ART clinics. It fails to problematize that clinics are not a part of the legal agreement with the surrogate, only with the commissioning

couple. This makes the commissioning parents responsible of procedures that they have little control over and fails to hold the clinic responsible towards the surrogate. Thirdly, the bill accepts surrogacy arrangements and at large, the form and distribution of responsibility within them. This, along with creating a legal framework, makes the surrogacy business more predictability and strengthens the legitimacy of the business as it is supported and affirmed by the state. Forth, the draft bill supports surrogacy as a contractual agreement between the commissioning parents and the surrogate, leaving out the clinics giving them only limited responsibility for the surrogate. However as the commissioning parents have a contract with the clinic, the clinic becomes more inclined to favour the wishes of the commissioning parents over the health of the surrogate. A final argument that points towards that the result of the draft bill is creating a predicable surrogacy business with the wishes of the commissioning parents in focus on behalf of the surrogates rights, health and wishes is the prohibition of traditional surrogacy and approval of gestational surrogacy. That being for no apparent reason other than distancing the surrogate from the child.

The circular is claiming to deal with unserious persons coming to India setting up surrogacy arrangements with unserious clinics. It frames what groups are reliable and trustworthy and what groups are not, supporting a patriarchal hetero-normative stereotype of family and respectability. The circular leaves the supply-side, the clinics, underexplored and unattended to. The circular does what it can to ensure a smooth arrangement involving foreign commissioning parents in order to promote India as a medical tourism destination as it presents surrogacy as a medical treatment for infertility first hand and business as second.

The contradictions between the two documents lie in whom they accept as a commissioning parent. While the draft bill allows only persons who cannot naturally carry a child to be commissioning parents the circular do not have that requirement. The circular demands a married couple while the daft bill does not.

### ***3.4 Discursive complications and dilemmas from a feminist perspective***

This section brings back the concepts presented in the section on gendered political economy. It discuss the findings from the '*What's the problem represented to be*'- analysis along with material from the informants against the backdrop of gendered international political economy. For example the circular categorises respectability/reliability in business agreements by sexuality and how well

persons fit the patriarchal family norm. This illustrates how non-market skills or nonmarket information matter on the surrogacy market.

### Social reproductive labour

*“The Indian debate is between banning and regulation, it mirrors in many ways the debate over sex work.” I2:1*

This quote by I2 can be connected to the binary of production/reproduction and to a debate on whether surrogacy and sex work can be seen as work or not. Surrogacy can be described as care work and categorised as social reproductive labour as it is biological reproduction. How surrogacy is categorised by the government shows how it is treated as social reproductive labour since it is presented as a fertility treatment first and as business second. Typically for social reproductive labour the work aspect comes second if regarded at all. The government’s problem representation of commercial surrogacy reproduces dominant social relations as it strengthens ideas about reproductive labour not being regarded as remunerative labour. This can be seen in how payment to the surrogate is not regulated at all, not by minimum wage or prohibiting lower pay rates for darker skinned surrogates. This is connected to Pande’s research on surrogacy in India and the three categories through which surrogacy is communicated; as a medical intervention; as a commercial enterprise focusing on the economic benefit of all involved and as altruistic exchange. We can see all of these categorise in the policies with medical intervention being the main category, while the business agreement takes a minor role but still gives room for altruistic exchange as pay for surrogacy is not a given.

### Feminisation of employment

In the draft bill only physical qualifications are required of the surrogate. Viewed in light of the feminisation of employment, surrogacy is a typical kind of work that is underpaid because of the low value of these physical qualification or *natural* skills. The problem representation reinforces the view that natural skills should be less valued than trained skills due to the fact that is inly allows payment but not make it compulsory.

The draft bill supports surrogacy as contractual labour, which means less stable and conformed employment along with not being covered by labour laws. To describe contractual labour as informal is misleading but as labour laws do not cover employees, it has informal characteristics (Standing in Ferguson 2013:5). That the Indian government is not problematizing the informal traits of surrogacy labour and that its own policies are strengthening the feminisation of employment should be seen as

complications as the government represents all citizens, women and workers included. A part from demanding registered ART clinics the circular leaves the responsibility of the clinics underexplored and the informal characteristics of the surrogacy employment unattended. This is an example of how silences can be lifted and how this underexploration of responsibility leads to complications for both the surrogate and the commissioning parents and leaves room for companies, in our case, ART clinics to take advantage of unstable working conditions.

### International division of labour

*"...we realised that IVF and surrogacy is some of the main feeders into medical tourism. There has been lots of development in terms of promoting surrogacy in India and there are reasons for that, the cost of it and the medical expertise, in many countries it is not legal to have surrogacy."* 15:1

The informant describes India's advantages in surrogacy and medical tourism compared to the global North, as a part of the international division of labour and shift of service production and outsourcing to the global South. This export production of services reproduces hierarchies of gender, cast and class as can be seen in how the consumer is the focus of the government.

*"Off course in India one of the things we had to regulate was blood donation. Which was one of the worst forms of exploitation we had in our markets. People were suffering enormous health damages.*

*I think that is was thanks to the scare for HIV and AIDS that this whole thing got a bit more regulated."* 12:7

The informant claims that the liberalisation of blood trade was stopped because of the fear of HIV/AIDS and not because of the conditions in the business. The trade with blood was permitted in India for a time period and was later banned. I bring this up, as the framing of surrogacy is not foremost concerned with the conditions of the surrogate but of the commissioning parents. Both cases have the consumers in focus - consumers found both in the global North and domestic brought to the Indian market for cheap goods. The circular categorises respectable/reliable judged on sexuality and fulfilment of patriarchal family norms highlights how not only gendered structures play a part on the surrogacy market but also how different hierarchies are active in the governments policies and view of surrogacy.

### Feminist critique of the state

The 'What's the problem represented to be' -analysis shows that the policy documents is a step in creating a predicable and stable surrogacy industry with the consumers/commissioning parents wishes in focus at the benefit of the surrogates/workers. This can be connected to the feminist

critique of the state, how the state act in disfavour of women as well as it shows the gendered outcomes of its decision making process.

*“However my personal view is that the government does not value women, they do not value the life of the women whom go through all these problems. I do not think that the government has applied its mind to it.” 14:3*

I4 argues that female foeticide is on the rise despite of legislation and being an issue people feel strongly about. She claims that this is because the government is not monitoring that the laws are followed. This is an example of how gendered practices and discrimination of women is a built in feature of the state and how these values have consequences for the legitimacy of the government.

*“In India we have this open policy in terms of opening up the markets. So much innovation in biomedicine and biotechnology especially in the reproductive and conceptive technologies, the new reproductive technologies. All of these are very well established in India. On one hand there have been a lot of movements against this, Indian activism, but at the same time you have the state promoting all this, directly or indirectly.” 15:4*

*“One of the reasons it (commercial surrogacy) has come up in India is because of the ART bill which has a whole section on surrogacy and therefore we are one of the few countries that says yes to commercial surrogacy for seemingly very straight forward (reasons of) economic benefit. This makes India a big destination given that other countries have more complex laws and indeed do not allow commercial surrogacy.” 12:1*

This quote by I5 indicates how there are several forces within India and that there is a criticism of the government. She points out that there are alternative problem representations of the reproductive technologies in India. Also I2 claim that surrogacy is allowed for reasons of economic benefit.

## **4. Conclusion**

The objective of this study has been to investigate how commercial surrogacy has been received and institutionalised in the Indian society. The main question has been *How is commercial surrogacy produced and approached as a social problem by the Indian government?* Followed by two sub-questions; *How is commercial surrogacy categorised, labelled and framed by the government?* And *From a feminist perspective, what are the discursive complications and dilemmas produced by this problem representation?* This study present India as an exemplifying case of how nation states problematize and deal with commercial surrogacy. It follows a neoliberal way of thinking and dealing

with a new business where the choice and rights of workers, in this case, women of the global South, are disregarded in favour of the consumer, who is also the employer.

The circular categorise what groups are reliable and trustworthy and what groups are not, supporting a patriarchal heteronormative stereotype of family and of reliability and respectability. As it does this, the problem with commercial surrogacy is represented and framed as a demand problem; the problem is the commissioning parents. The draft bill frames commercial surrogacy as contractual labour and frame it as activity that need a regulatory framework in order to function in an acceptable way. Despite some contradictions between the documents the Indian government consistently label and framed commercial surrogacy as a medical issue in first hand. The labelling is a consequence of the government's categorisation of the commercial surrogacy as a source for foreign exchange revenue.

A discursive complication that arises from the government's problem representation of commercial surrogacy is that payment for acting as a surrogate is allowed but not demanded nor is it regulating amount or payment manner. This strengthens the view of social reproduction as being not proper work worth paying for. A complication of this is a weakening of the surrogates bargaining position created by the government. That the policies only require physical qualities from the surrogate also produces complications for the surrogates since it undermines the role of the surrogate. Secondly, categorising surrogacy as contractual labour supports the feminisation of employment and works in disfavour of the surrogate. The problem representation of the Indian government creates complications for the surrogates. This poses a dilemma of how the government can act to keep the surrogates bargaining position weak when they are set to represent them The same dilemma, the government not representing the interest of the women, is exposed in the labelling of surrogacy as a medical issue, focusing policy on the wellbeing of the commissioning parents, the consumers.

Finally, commercial surrogacy is approached as a medical phenomenon, which task, it is to provide children to respectable parents who can afford. Commercial surrogacy is only viewed as a social problem when the process is not smooth; that is when the commissioning parents are not pleased. This view is produced in both documents used as material in this study. An ambition when applying Bacchi's method was to evaluate and make visible problem formulations that can be harmful for certain groups. The second sub question incorporates this ambition into this study. When the polices do not problematize what implications the informal features of the surrogate arrangement has on the surrogates and as the policies have a consumers focus the concluding remark of this study is that these reasons make the governments problem formulation harmful for the surrogates. The Indian



governments policy, proposed and implemented, regarding commercial surrogacy forms discursive complications that can be harmful for surrogates.

Continuing the analysis of the policy could include an intersectional approach. One could see surrogacy as a medical fix for fulfilling societies demand on women, which is to become mothers. Commercial surrogacy has increased parallel to the pathologization of infertility (SAMA 2012:138). This along with the high value of biological lineage is what new reproductive technologies capitalise on (Lingam 1998:232). The new reproductive technologies also reinforce biological motherhood (ibid.). There is a strong focus on the 'biological child' and the return of a strong interest in genetics and biological heritage (Markens 2007:15). These are interesting reflections and the starting points to further research and discussions about how problem representation, regarding new reproductive technologies, like surrogacy, is used in public policy. This study has focused on the government and on feminist political economy. I would very much like to see a further discussion concerning the how the neoliberal hegemony shapes problem representation concerning new reproductive technologies but also what effects the genetic/biological hegemony have on the same representations.

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## Appendix 1

Foreign nationals intending to visit India for commissioning surrogacy, 9th June 2012, Ministry of Home Affairs, Government of India

S/NO-5(7) (12)

F.No.25022/74/2011-F.I  
Government of India  
Ministry of Home Affairs

NDCC-II Building, Jai Singh Road,  
Near NDMC Pakika Kendra, New Delhi-110001.  
Dated 9<sup>th</sup> July, 2012.

To

**Shri Amarendra Khatua**  
Additional Secretary (PV),  
Ministry of External Affairs,  
Government of India,  
Patiala House, New Delhi.

Subject : Foreign nationals intending to visit India for commissioning surrogacy.

Sir,

With reference to the above, I am directed to state that it has come to the notice of this Ministry that some foreign nationals are visiting India on Tourist visa for commissioning surrogacy. This is not the appropriate visa category and such foreigners will be liable for action for violation of visa conditions. The appropriate visa category will be a medical visa. It will also be necessary in such cases to ensure that the surrogate mother is not cheated. Therefore, such a visa may only be granted if the following conditions are fulfilled :-

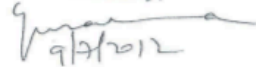
- (i) The foreign man and woman are duly married and the marriage should have sustained atleast for two years.
- (ii) A letter from the Embassy of the foreign country in India or the Foreign Ministry of the country should be enclosed with the Visa application stating clearly that (a) the country recognises surrogacy and (b) the child/children to be born to the commissioning couple through the Indian surrogate mother will be permitted entry into their country as a biological child/children of the couple commissioning surrogacy.

...2/-

11

- (iii) The couple will furnish an undertaking that they would take care of the child/children born through surrogacy.
  - (iv) The treatment should be done only at one of the registered ART clinics recognised by ICMR. (The list of such clinics will be shared with MEA from time to time).
  - (v) The couple should produce a duly notarised agreement between the applicant couple and the prospective Indian surrogate mother.
3. If any of the above conditions are not fulfilled, the visa application shall be rejected.
  4. Before the grant of visa, the foreign couple need to be told that before leaving India for their return journey, 'exit' permission from FRRO/FRO would be required. Before granting 'exit', the FRRO/FRO will see whether the foreign couple is carrying a certificate from the ART clinic concerned regarding the fact that the child/children have been duly taken custody of by the foreigner and that the liabilities towards the Indian surrogate mother have been fully discharged as per the agreement. A copy of the birth certificate(s) of the surrogate child/children will be retained by the FRRO/FRO alongwith photocopies of the passport and visa of the foreign parents.
  5. It may be noted that for drawing up and executing the agreement cited at para 2 (v) above, the foreign couple can be permitted to visit India on a reconnaissance trip on Tourist visa, but no samples may be given to any clinic during such preliminary visit.
  6. These guidelines may kindly be circulated to all the Missions for strict compliance.

Yours faithfully,



(G.V.V. Sarma)  
Joint Secretary (Foreigners)  
Ph: 23438034

## Appendix 2

Chapter 7, Draft Assisted Reproductive Technologies (Regulation) Bill 2010 Ministry of Health and Family Welfare, Government of India

### CHAPTER - VII

#### RIGHTS AND DUTIES OF PATIENTS, DONORS, SURROGATES AND CHILDREN

##### 32. Rights and duties of patients –

- (1) Subject to the provisions of this Act and the rules and regulations made thereunder, assisted reproductive technology shall be available to all persons including single persons, married couples and unmarried couples.
- (2) In case assisted reproductive technology is used by a married or unmarried couple, there must be informed consent from both the parties.
- (3) The parents of a minor child have the right to access information about the donor, other than the name, identity or address of the donor, or the surrogate mother, when and to the extent necessary for the welfare of the child.
- (4) All information about the patients shall be kept confidential and information about assisted reproductive technology procedures done on them shall not be disclosed to anyone other than the central depository of the Department of Health Research, except with the consent of the person or persons to whom the information relates, or by a court order.

##### 33. Rights and duties of donors –

- (1) Subject to the other provisions of this Act, all information about the donors shall be kept confidential and information about gamete donation shall not be disclosed to anyone other than the central database of the Department of Health Research, except with the consent of the person or persons to whom the information relates, or by an order of a court of competent jurisdiction.
- (2) Subject to the other provisions of this Act, the donor shall have the right to decide what information may be passed on and to whom, except in the case of an order of a court of competent jurisdiction.
- (3) A donor shall relinquish all parental rights over the child which may be conceived from his or her gamete.
- (4) No assisted reproductive technology procedure shall be conducted on or in relation to any gamete of a donor under this Act unless such donor has obtained the consent in writing of his or her spouse, if there, to such procedure.
- (5) The identity of the recipient shall not be made known to the donor.

**34. Rights and duties in relation to surrogacy –**

- (1) Both the couple or individual seeking surrogacy through the use of assisted reproductive technology, and the surrogate mother, shall enter into a surrogacy agreement which shall be legally enforceable.
- (2) All expenses, including those related to insurance if available, of the surrogate related to a pregnancy achieved in furtherance of assisted reproductive technology shall, during the period of pregnancy and after delivery as per medical advice, and till the child is ready to be delivered as per medical advice, to the biological parent or parents, shall be borne by the couple or individual seeking surrogacy.
- (3) Notwithstanding anything contained in sub-section (2) of this section and subject to the surrogacy agreement, the surrogate mother may also receive monetary compensation from the couple or individual, as the case may be, for agreeing to act as such surrogate.
- (4) A surrogate mother shall relinquish all parental rights over the child.
- (5) No woman less than twenty one years of age and over thirty five years of age shall be eligible to act as a surrogate mother under this Act.

Provided that no woman shall act as a surrogate for more than five successful live births in her life, including her own children.

- (6) Any woman seeking or agreeing to act as a surrogate mother shall be medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the child, and must declare in writing that she has not received a blood transfusion or a blood product in the last six months.
- (7) Individuals or couples may obtain the service of a surrogate through an ART bank, which may advertise to seek surrogacy provided that no such advertisement shall contain any details relating to the caste, ethnic identity or descent of any of the parties involved in such surrogacy. No assisted reproductive technology clinic shall advertise to seek surrogacy for its clients.
- (8) A surrogate mother shall, in respect of all medical treatments or procedures in relation to the concerned child, register at the hospital or such medical facility in her own name, clearly declare herself to be a surrogate mother, and provide the name or names and addresses of the person or persons, as the case may be, for whom she is acting as a surrogate, along with a copy of the certificate mentioned in clause 17 below.
- (9) If the first embryo transfer has failed in a surrogate mother, she may, if she wishes, decide to accept on mutually agreed financial terms, at



most two more successful embryo transfers for the same couple that had engaged her services in the first instance. No surrogate mother shall undergo embryo transfer more than three times for the same couple.

- (10) The birth certificate issued in respect of a baby born through surrogacy shall bear the name(s) of individual / individuals who commissioned the surrogacy, as parents.
- (11) The person or persons who have availed of the services of a surrogate mother shall be legally bound to accept the custody of the child / children irrespective of any abnormality that the child / children may have, and the refusal to do so shall constitute an offence under this Act.
- (12) Subject to the provisions of this Act, all information about the surrogate shall be kept confidential and information about the surrogacy shall not be disclosed to anyone other than the central database of the Department of Health Research, except by an order of a court of competent jurisdiction.
- (13) A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy.
- (14) No assisted reproductive technology clinic shall provide information on or about surrogate mothers or potential surrogate mothers to any person.
- (15) Any assisted reproductive technology clinic acting in contravention of sub-section 14 of this section shall be deemed to have committed an offence under this Act.
- (16) In the event that the woman intending to be a surrogate is married, the consent of her spouse shall be required before she may act as such surrogate.
- (17) A surrogate mother shall be given a certificate by the person or persons who have availed of her services, stating unambiguously that she has acted as a surrogate for them.
- (18) A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple/ individual. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.
- (19) A foreigner or foreign couple not resident in India, or a non-resident Indian individual or couple, seeking surrogacy in India shall appoint a local guardian who will be legally responsible for taking care of the surrogate during and after the pregnancy as per clause 34.2, till the child / children are delivered to the foreigner or foreign couple or the

local guardian. Further, the party seeking the surrogacy must ensure and establish to the assisted reproductive technology clinic through proper documentation (a letter from either the embassy of the Country in India or from the foreign ministry of the Country, clearly and unambiguously stating that (a) the country permits surrogacy, and (b) the child born through surrogacy in India, will be permitted entry in the Country as a biological child of the commissioning couple/individual) that the party would be able to take the child / children born through surrogacy, including where the embryo was a consequence of donation of an oocyte or sperm, outside of India to the country of the party's origin or residence as the case may be. If the foreign party seeking surrogacy fails to take delivery of the child born to the surrogate mother commissioned by the foreign party, the local guardian shall be legally obliged to take delivery of the child and be free to hand the child over to an adoption agency, if the commissioned party or their legal representative fails to claim the child within one month of the birth of the child. During the transition period, the local guardian shall be responsible for the well-being of the child. In case of adoption or the legal guardian having to bring up the child, the child will be given Indian citizenship.

- (20) A couple or an individual shall not have the service of more than one surrogate at any given time.
- (21) A couple shall not have simultaneous transfer of embryos in the woman and in a surrogate.
- (22) Only Indian citizens shall have a right to act as a surrogate, and no ART bank/ART clinics shall receive or send an Indian for surrogacy abroad.
- (23) Any woman agreeing to act as a surrogate shall be duty-bound not to engage in any act that would harm the foetus during pregnancy and the child after birth, until the time the child is handed over to the designated person(s).
- (24) The commissioning parent(s) shall ensure that the surrogate mother and the child she deliver are appropriately insured until the time the child is handed over to the commissioning parent(s) or any other person as per the agreement and till the surrogate mother is free of all health complications arising out of surrogacy.

**35. Determination of status of the child –**

- (1) A child born to a married couple through the use of assisted reproductive technology shall be presumed to be the legitimate child of the couple, having been born in wedlock and with the consent of both spouses, and shall have identical legal rights as a legitimate child born through sexual intercourse.

- (2) A child born to an unmarried couple through the use of assisted reproductive technology, with the consent of both the parties, shall be the legitimate child of both parties.
- (3) In the case of a single woman the child will be the legitimate child of the woman, and in the case of a single man the child will be the legitimate child of the man.
- (4) In case a married or unmarried couple separates or gets divorced, as the case may be, after both parties consented to the assisted reproductive technology treatment but before the child is born, the child shall be the legitimate child of the couple.
- (5) A child born to a woman artificially inseminated with the stored sperm of her dead husband shall be considered as the legitimate child of the couple.
- (6) If a donated ovum contains ooplasm from another donor ovum, both the donors shall be medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the child, and the donor of both the ooplasm and the ovum shall relinquish all parental rights in relation to such child.
- (7) The birth certificate of a child born through the use of assisted reproductive technology shall contain the name or names of the parent or parents, as the case may be, who sought such use.
- (8) If a foreigner or a foreign couple seeks sperm or egg donation, or surrogacy, in India, and a child is born as a consequence, the child, even though born in India, shall not be an Indian citizen.

**36. Right of the child to information about donors or surrogates –**

- (1) A child may, upon reaching the age of 18, ask for any information, excluding personal identification, relating to the donor or surrogate mother.
- (2) The legal guardian of a minor child may apply for any information, excluding personal identification, about his / her genetic parent or parents or surrogate mother when required, and to the extent necessary, for the welfare of the child.
- (3) Personal identification of the genetic parent or parents or surrogate mother may be released only in cases of life threatening medical conditions which require physical testing or samples of the genetic parent or parents or surrogate mother.

Provided that such personal identification will not be released without the prior informed consent of the genetic parent or parents or surrogate mother.

## Enclosure 1, Interview guide

A short orientation about the study and myself.

Do you mind if I record our talk?

### **“Your relation/meeting/connection with commercial surrogacy”**

How dose the ART-industry and in particular surrogacy come into your work/area of study?

You come from a medical and health background. How does that matter in the way you think of/study surrogacy?

How has the work with your studies been?

When, how come you first encountered surrogacy?

### **“Women’s work, political economy” (labour market, global and gendered division of labour, workers rights, national level)**

What are your view of the guidelines and the proposed bill?

What are your thoughts on surrogacy in general?

What are your thoughts on commercial surrogacy in India specifically?’

In an article you discuss medical tourism and map government policy as well as implications for general medical care. How was it received? Did you get any comments on it?

*When I read about the issue of infertility and surrogacy in India I have touched upon programmes and politics for population control (reproductive control) (I am thinking foremost of newspaper articles about how mostly women are paid to tie there tubes) that I have read about. An article discusses the problem supporting development of medical tourism because it makes the gap larger between classes of society. If looking particularly on reproductive tourism, like I do, population control schemes vs. reproductive tourism presents the same policy divide between groups in society.*

There are some groups that are engaged in the issue of surrogacy and some scholars. How do you think scholars have discussed and dealt with surrogacy in India in a sufficient way? Are there aspects that have not gotten enough attention?

I do not have any more questions do you have anything you would like to add before we end the interview?

Interview end and recorder is shut off.