

# Commodifying Bodies: An Overview of the Bioethical Implications of Transnational Commercial Surrogacy

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## **Abstract**

Commercial surrogacy is a challenging contemporary issue that raises various concerns because it commodifies the female body in a new way. It is now becoming increasingly common for couples from the Global North to seek out gestational surrogates in the Global South. These transnational commercial surrogacy arrangements raise questions about the surrogates' rights to bodily integrity, as well as patient rights and health policy, immigration and citizenship, race, power, gender, consent, and agency (Pande 2010, Bailey 2011). I explore these questions in greater detail by reviewing the literature on the rights and bioethics discourse of transnational surrogacy in the Indian context. I also examine contemporary issues concerning the intersectionality of transnational commercial surrogacy from a feminist perspective, especially the commodification of the "othered" reproductive female body.

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## **Introduction**

Commercial surrogacy is a challenging contemporary issue that raises various concerns. It traverses both biological and social domains, because it involves the commodification of the traditionally natural process of reproduction which challenges traditional ideas about gender (Markens 2007). It also commodifies the female body in a new way. It is now becoming increasingly common for couples from the Global North to seek out gestational surrogates in the Global South, especially in places like India where the process is relatively inexpensive (Pande,

2010). These transnational commercial surrogacy arrangements raise questions about the surrogates' rights to bodily integrity, as well as patient rights and health policy, immigration and citizenship, race, power, gender, consent, and agency (Pande 2010, Bailey 2011). I propose to explore these questions in greater detail, by reviewing the literature on the rights and bioethics discourse of transnational surrogacy in the Indian context. I will also examine more contemporary issues concerning the intersectionality of transnational commercial surrogacy, from a feminist perspective, especially the

commodification of the “othered” reproductive female body.

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## Background

Surrogacy involves an arrangement between the intended parents and a surrogate who agrees to carry and deliver their child (Inhorn 2008). Individuals who contribute their egg and sperm to reproduce the resulting child are the biological (genetic) mother and father of the child, respectively (Armour 2012). The intended or commissioning parents are the individuals who intend to raise the child. In a *traditional surrogacy* arrangement, the surrogate agrees to contribute her ovum and the intended father or a sperm donor contributes the sperm (Brinsden 2003, Armour 2012). The process of artificial insemination is used in these cases and it is a cheaper alternative to in vitro fertilization (IVF) (Brinsden 2003). Upon the birth of the child, the traditional surrogate relinquishes her parental rights as per the surrogacy agreement (Brinsden 2003, Armour 2012).

In *gestational surrogacy* arrangements, the surrogate provides the intrauterine environment, sometimes referred to in the media as a “womb to rent,” and carries the fetus for the duration of the pregnancy (Brinsden 2003, Armour 2012:233). Upon the child’s birth, she relinquishes the child and her parental rights. *Commercial surrogacy*, in turn, is a process where the surrogate is compensated for her reproductive services, which is contrasted with *altruistic surrogacy*, where only pregnancy-related costs may be compensated by the intended parents (Brinsden 2003).

The recorded history of surrogacy can be traced to the Old Testament (Ciccarelli and Beckman 2005, Palattayil et al. 2010, Brinsden 2003). Surrogacy through artificial insemination is also not a new technique, having been used without medical assistance for over 100 years (Ciccarelli and Beckman, 2005). IVF, though, is a relatively recent invention. In 1989, scientists Patrick Steptoe and Robert Edwards, pioneers of IVF, successfully delivered the first IVF surrogate child, in the United Kingdom, at Bourn Hall Clinic (Gillon 1987, Brinsden et al. 2000). The UK has played a central role in the ethical and rights debates regarding commercial surrogacy and currently only allows altruistic surrogacy.

Other countries such as Italy, Japan, Mexico, Spain, Switzerland, Turkey, Germany, and some US states, have banned any and all types of surrogacy (Armour 2012). On the opposite end of the spectrum, countries such as India, Belgium, Finland, and Greece permit commercial surrogacy, and have few restrictions regarding the process (Nakash and Herdiman 2007, Armour 2012, Pande 2010). Israel also allows commercial surrogacy, but it is tightly controlled by the state (Pande 2010).

Religious governing bodies of the Catholic Church and Sunni Islam also prohibit surrogacy (Brinsden 2003, Nakash and Herdiman 2007). However, the Anglican Church, Hinduism, Buddhism, some regions observing Shiite Islam, and the Jewish religion, consider surrogacy acceptable (Ramskold and Posner 2013, Nakash and Herdiman 2007). In most cases, there is a clear relation between a state’s majority religion and its legal stance on surrogacy, like in Israel where the

Jewish tradition urges followers to "be fruitful and multiply" (Teman 2008:80). Today, Israel, India, Guatemala, and the state of California are the most prominent sites for commercial surrogacy (Pande 2010, Rotabi and Bromfield 2012).

Commercial surrogacy is banned in Canada, though altruistic surrogacy is permitted (Armour 2012). According to the Canadian Fertility and Andrology Society and the Society of Obstetricians and Gynaecologists of Canada, commercial surrogacy arrangements are "morally unacceptable" (Nakash and Herdman 2007:247). Coercion, exploitation, and psychological and physical harm to the women are all indicated as possible negative factors by these medical societies. These factors are also commonly cited in the major ethical arguments regarding the moral permissibility of commercial surrogacy (Shanley 2002).

### ***The Case of Baby M***

In the 1980s, the case of "Baby M" became a subject of debate for legislators, popular media, and the general public (Palca 1987, Shanley 2002, Scott 2009). William and Elizabeth Stern of New Jersey attempted to have a child through traditional surrogacy. The surrogate, Mary Beth Whitehead was artificially inseminated with William Stern's sperm and delivered a baby girl to the couple for a fee of USD 10,000 as per the pre-arranged contract (Palca 1987). However, Whitehead later decided that she wanted to keep the baby which resulted in a fierce custody battle. Hence, the issue of rightful parenthood arose from disagreements about the legitimacy of the genetic contributions and contractual obligations (Palca 1987).

Whitehead had contributed the ovum and gestational resources while Stern had contributed the sperm (Palca 1987). Whitehead was also compensated for her role. For three months, Whitehead, with the help of her husband, kept Baby M from the Sterns by moving to Florida (Shanley 2002). The police eventually found and delivered Baby M to the Sterns. In 1987, a judge ruled that William Stern was the rightful parent of Baby M, as per the surrogacy contract, and Elizabeth Stern was made the legal mother through adoption (Shanley 2002). However, the New Jersey Supreme Court overturned this decision, rendering the commercial surrogacy contract invalid. Therefore, William Stern was deemed the legal father, and granted custody of Baby M, and Whitehead was named the legal mother and granted visitation rights (Shanley 2002). This case alerted the United States and the world to the possible ethical issues that may arise if proper laws are not in place to ensure that surrogacy arrangements are carried out to the satisfaction of all parties involved.

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### **Ethical Debates**

Commercial gestational surrogacy is a divisive issue because some consider it akin to prostitution, or womb-renting, as it is seen as commodifying both women's bodies and the children born through this process (Palattiyil et al. 2010). Others believe that the practice benefits both the commissioning party and the surrogate (Palattiyil et al. 2010). Similarly, some feminist critics have said that commercial surrogacy can be equated to "baby-selling" and has the potential to exploit women (Anleu 1992:30). As mentioned, the earliest

case of surrogacy appears in the Old Testament, when Abraham and Sarah's servant Hagar bears a child for Sarah (Ciccarelli 2005, Palattayil et al. 2010, Brinsden 2003). This early example reflects one of the reservations associated with commercial surrogacy—that women who are socially and economically subordinate will be exploited for the interests of the ruling classes (Anleu 1992).

Advocates of commercial surrogacy argue against the idea of “baby-selling” and emphasize that a woman receives payment for the service she provides (Shanley 2002). They argue that contracts should be made before conception and the surrogate should be a woman who has delivered a baby previously. Also, to avoid the exploitation of poor women, the surrogate should also possess a certain income-level and undergo counselling throughout the process, not only for emotional support but for psychological assessment, as well (Shanley 2002). Some proponents of commercial surrogacy claim that a woman's ability to relinquish a child upon birth shows that women are not slaves to their biology, because a refusal to abide a contractual agreement would imply a specifically female irrationality motivated by emotion and maternal instincts (Shanley 2002).

But, Shanley (2002) argues that it should not be assumed that a woman would only renege on a contract due to irrational emotionality. Instead, the surrogate's developing relationship with the fetus should be taken into account (Shanley 2002). Legally discounting the surrogate's biological connection and relationship to the child is considered unjust because the law is, then, disregarding this relationship while many

other personal relationships are legally protected (Shanley 2002). It also ignores the biological value of gestation in pregnancy as this connection is not considered as important as the genetic link (Anleu 1992, Shanley 2002). Shanley's (2002:104) argument is grounded in the surrogate's experience because these women often tend to be “economically vulnerable and socially stigmatized.” She asserts that non-commercial surrogacy or “gift pregnancy” agreements are acceptable but commercial surrogacy agreements should be prohibited because payment for reproductive services replicates “current hierarchies of race and class in the United States” (2002:104,123).

However, Anleu (1992) problematizes both non-commercial/altruistic and commercial surrogacy arrangements. This author contends that gender norms have much to do with the way commercial and altruistic surrogacies are perceived. Women as mothers are expected to be loving, maternal, and selfless. Therefore, a woman who accepts a commercial surrogacy arrangement is giving up any maternal rights and she is deviating from these gender normative assumptions (Anleu 1992). Being motivated by self-interest and accepting payment for surrogacy places women in the market sphere, as opposed to the domestic sphere, and she is deemed to be transgressing against gender expectations and threatening social order (Anleu 1992). Therefore, Anleu (1992:33) argues that commercial surrogacy contradicts traditional gender norms and “deep-seated assumptions about men and women.” An altruistic surrogacy, in contrast, is gender normative because the surrogate is being selfless and the act becomes sacrificial

(Anleu 1992). Furthermore, Anleu (1992) points out that altruistic surrogacies can also be exploitative as family pressures, evoking feelings of guilt and emotional manipulation, can lead to exploitation of the family member who “chooses” to become the surrogate.

The central argument in support of commercial surrogacy states that prohibiting payment for reproductive services infringes on women’s autonomy and freedom of choice (Shanley 2002). They often draw attention to the parallels with the oppressive stance of anti-abortion advocates regarding women’s rights and bodies. However, those arguing against commercial surrogacy often draw parallels with prostitution, human trafficking, slavery, and the black market organ trade, which are almost universally illegal, while proponents of commercial surrogacy point to the legality of selling sperm, ova, and blood (Ramskold and Posner 2013). They also argue that paid surrogacy is not like prostitution due to the differences in purpose and motivation (Damelio and Sorensen 2008).

As well, it is argued that many jobs in the US are known to pose health risks, such as coal-mining, and yet workers are entitled to choose such jobs even though it may considerably shorten their lives and endanger their health (Damelio and Sorensen 2008). However, according to Shanley (2000), when gestation is characterized as any other form of commercial production, it does not account for the liminal and indistinct boundary between gestational mother and child. The emotional, psychological, sexual and bodily experiences of women are ignored and pregnancy is objectified (Shanley 2002). As well, traditional work is

not supposed to entail psychological hardship or physical pain, and work contracts can be broken; therefore, surrogacy would not fit into this category of work (Shanley 2002).

In reviewing the scholarly literature on surrogacy for biases, Teman (2008) found that social science investigators tend to assume that women choose to become surrogates due to economic desperation, abnormal personality, or emotional instability, and that they are unable to make rational decisions and tend to act on “maternal instinct.” However, surrogates are “normal,” and they choose surrogacy for a variety of reasons, including: “an enjoyment of being pregnant, a feeling of sympathy for childless couples, a desire to earn money as stay-at-home moms, and a desire to do something ‘special’” (Teman 2008:1110).

In addition, rather than a preoccupation with the surrogates’ attachment to the babies, Teman (2008) suggests that policy makers should understand that surrogates’ satisfaction is largely linked to her relationship with the commissioning party. If the surrogates’ actual motivations were taken into consideration perhaps policy changes would reflect that an extended relationship with the commissioning family, after the birth of the child, would not likely be detrimental to either party (Teman 2008). This is especially true when intended mothers and surrogates develop strong bonds and mourn the loss of this close relationship at the end of the arrangement, which is often the case. Furthermore, research shows that surrogacy is a processual experience and surrogates are often engaged in ensuring that they are distinguishing between their identity as

“surrogate” and their role of “mother” to their own biological children (Teman 2008). Therefore, policies like those in the UK, which legally define the surrogate and her partner as the legal parents of the child until adoption by the commissioning couple, problematize the identity construction of the surrogate (Teman 2008). These are the issues that should be addressed by policy makers, and this can only be done when biases, assumptions and essentialist paradigms are cast aside (Teman,2008).

So, on the one hand, legalizing commercial surrogacy gives some women in need the chance to improve their socioeconomic circumstances, and also allows women to be compensated for their contribution rather than it being categorized as “woman’s work” or unpaid domestic labour (Shanley 2002). On the other hand, that economically vulnerable women are more likely to enter these arrangements only serves to reinforce the culturally constructed race, class and gender hierarchies in North America (Shanley 2002). Additionally, through transnational commercial surrogacy arrangements, these race, class, and gender inequities are now played out on a global scale (Shanley 2002).

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### **Transnational Surrogacy**

In the practice of transnational surrogacy, wealthier couples travel from North America, Europe, Middle Eastern countries and Australia, to countries such as India, Malaysia, Thailand, Russia, Ukraine, Guatemala and South Africa, due to the lower cost and fewer regulations of reproductive services in these countries (Bailey 2011). India is described as the

“surrogacy capital of the world” largely due to the abundance of cheap labor and lax laws, and the positive reputation and sophisticated infrastructure of the fertility clinics (Jaiswal 2012:2). Medical tourism is heavily promoted by the Indian government as well, and reproductive or fertility tourism is a rapidly growing subset (Jaiswal 2012, Sarojini et al. 2011). In India, the whole process can cost USD 5,000 to 25,000, which is significantly lower than the USD 50,000 to 250,000 it costs in the U.S. (Bailey 2011, Shetty 2012). Therefore, in the Indian context, modernized, world-class medical care is juxtaposed with the comparably cheap cost of services and the abundance of poverty-stricken women willing to become surrogates (Palattiyil et al. 2010). The process also takes less time in India, due to the lack of bureaucratic procedures and specialist consultations, which may take years in some Western countries (Palattiyil et al. 2010).

As of 2012, it is estimated that there are 200,000 artificial reproductive technology (ART) clinics operating in India, generating USD 2.3 billion per year (Jaiswal 2012, Shetty 2012). These clinics are unregulated (Bailey 2011). The governing bodies of medical research in India, the Indian Council of Medical Research and the National Academy of Medical Sciences, have only proposed voluntary guidelines for ART clinics which state that the surrogate mother shall not be considered the legal mother, and the genetic parents are to be named as legal parents on birth certificates (Jaiswal 2012). This is in contrast to the legal policies of England and Australia which state that the surrogate is always designated as the legal mother of the child, even if her egg was not used to conceive the child (Jaiswal 2012).

Despite the proposed guidelines in India, complications do arise, especially if the egg has been donated by a third woman (an anonymous donor) other than the intended mother or gestational surrogate (Jaiswal 2012). Legal complexities also arise if the commissioning parents separate or when the commissioning couple's home country does not recognize children of surrogacy (Jaiswal 2012). As a result, the children may be left parentless or stateless, and the commissioning parent(s) may endure much legal strife and delay until they can return to their home countries with their children (Jaiswal 2012). A bill which accounts for these issues is currently awaiting approval (ART Bill) (Saravanan 2013). It states that the intended parents will be designated the legal parents on the child's birth certificate, and the commissioning party will require a letter from their country's embassy or ministry which states that their home country permits surrogacy and will grant the child citizenship (Jaiswal 2012).

Many Indian fertility clinics offer packages aimed specifically at international clients which combine accommodations and tourist attractions with treatment schedules (Sarojini et al. 2011). The intended parents come to rely heavily on the Indian clinics (Saravanan 2013). According to Saravanan's (2013) study of one clinic in Western India, all payments, accommodations, and post-natal care were arranged through the clinic. One intended parent in this study stated that the lax regulations in the country were an attractive factor, and the constant surveillance of the surrogates was a popular reason for choosing the clinic in question (Saravanan 2013). The clinics also advertise their services using popular

mediums, such as the internet, and tend to inflate success rates to entice consumers (Sarojini et al. 2011). Multiple births are used in testimonials and advertisements as a declaration of success by the clinics, while ectopic pregnancies and other side effects are under-represented (Sarojini et al. 2011). In this way, economic interest determines the presentation of these clinics which further equates them with commercial businesses.

Along with the clinics, the Indian surrogates stand to profit too, as they may earn an amount equivalent to more than a decade's worth of wages, especially in rural communities (Bailey 2011). Bailey (2011) reports that middle-class women in India are becoming surrogates too, to support their husbands after job-loss, or their children after divorce, or to pay for their family's medical bills and surgical procedures (Bailey 2011). Many of the surrogates feel that surrogacy helps them survive and they see the process as a "win-win situation," because both surrogate and commissioning couple are contractually fulfilled (Bailey 2011). This notion of "mutual benefit" is especially reinforced by the physicians and brokers who operate and recruit for the clinics (Pande 2009).

It seems that the public attitudes regarding transnational commercial surrogacy mirror this "win-win" outlook. In her study, Markens (2012) sought to discover what dominant media discourses say about cultural attitudes towards transnational surrogacy. She studied three American media accounts from 2008 of: the surrogacy industry in India, a personal account of surrogacy, and a cover story in Newsweek entitled "Wombs for Rent." She also analyzed associated online news stories, responses and blog comments, and

found that supporters of surrogacy in America focused on altruistic and family-building motives while avoiding any accusations of body-commodification, which are frowned upon in the American context. Interestingly, she found that when the surrogate in the news story was located in India, commercial surrogacy was looked upon favorably because the discourse shifted from greed in American contexts to one of empowerment in the context of Indian poverty (Markens 2012).

Marken's (2012) study brings up many important issues of media representation, and indicates a "saviour complex" (as transnational surrogates are said to be rescued from poverty by virtuous others), and the media construction of narrative framing that subverts any questions of exploitation (Markens 2012:1751). Issues of ethnicity are also relevant as the study points out that certain bodies ("brown bodies") are judged as being acceptable as commodities in certain contexts, while others are not (Marken 2012, Harrison 2010). Furthermore, Bailey (2011) argues that Western accounts of Indian surrogates' experiences, especially in popular media, may distort the truth of their lived experience and fail to translate their reality for a Western audience. Therefore, it is important to understand how the surrogates perceive the experience of surrogacy. Ethnographic studies carried out in India and other commercial surrogacy markets aid in illustrating these various perspectives.

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## **Ethnographic Insights on the Surrogate Experience**

India has a low female literacy rate which limits opportunities for women (Jaiswal

2012). This inequality extends to their treatment in the workplace and the wages they earn, which are significantly lower than those earned by their male counterparts (Jaiswal 2012). Jaiswal (2012) reasons that because of the earning potential of surrogacy women may be pushed into this work by their husband or their family. Surrogacy brokers and agents also recruit desperate women by taking advantage of their anxieties about finances and questioning their capabilities as a mother and provider for their children (Pande 2010). As the surrogates are required to have birthed one child previously, their maternity is exploited as a recruitment strategy (Pande, 2010). Rotabi and Bromfield (2012) suggest that these predatory recruitment strategies are similar to those used by human traffickers who coerce women into sex work.

The city of Anand, in the state of Gujarat, is the epicentre of the Indian surrogacy industry (Jaiswal 2012). This is where Amrita Pande undertook her ethnographic research at the New Hope Fertility Clinic (Pande 2009, 2010). The surrogates at this clinic live on-site in dormitories where they are continuously observed by caretakers, staff and the commissioning parents. The surrogates' bodies and activities are highly controlled and their diets and nutritional intake are also constantly monitored (Khader 2013). This way, the commissioning parents can feel secure in knowing that the surrogate, and their child, is being well taken care of.

Pande's (2009) study sheds light on this marked discrepancy between the poor reproductive care given to the average Indian woman and the comparatively stellar care provided to her if she becomes a surrogate (Jaiswal 2012). India has one of



the highest maternal mortality rates, especially in rural areas, due to lack of accessibility, hygiene and basic health provisions (Jaiswal 2012). In stark contrast to this, surrogates in Pande's (2009, 2010) ethnography find themselves in a spacious residence where they are cared for around the clock by multiple doctors, nurses, housekeepers, and cooks (Jaiswal 2012, Pande 2009). Many of the women in Anand did not even have access to professional medical care for their own pregnancies (Jaiswal 2012). Therefore, the value of Indian women's pregnancies is "tied to the social or market value of the fetus they are carrying" (Bailey 2011:22).

However, most of the surrogates preferred the hostel setting (Pande 2010:982). Since the Indian cultural paradigm relates surrogacy to prostitution, the practice carries much social stigma; therefore, some surrogates prefer to live at the hostel and away from public view (Pande 2010). Some surrogates found the hostel to be a respite from daily chores and domestic issues at home, while others were sad to be away from their own children and babies of breastfeeding age who were only allowed to visit on weekends (Saravanan 2013, Pande 2010). This separation from their family and children can have detrimental effects on their psychological well-being (Palattiyil et al. 2010). Furthermore, in some cases, due to staying away from home for nine months during their pregnancy, some Indian surrogates have also been rejected by their families upon returning home (Chaudhari 2013).

Pande (2010) argues that the Indian surrogate is akin to the underpaid factory or "sweatshop" workers of the Global South. They are made to be "cheap, docile, selfless, and nurturing" through the

fertility clinics and hostels (Pande 2010:970). Thus, she terms them "perfect mother-workers" (Pande 2010). For example, women at the Gujarati hostel in Pande's (2010) study were given lessons in English and computer usage. Pande (2010) argues that these lessons only seek to improve the surrogates' communication skills so that they may be able to converse more effectively with the affluent commissioning parents, especially if this communication is carried out on the computer.

Many of the commissioning parents who seek out the services of this surrogacy clinic hail from foreign countries and/or from higher socioeconomic statuses and castes within India (Pande 2009:388). While the surrogates are aware of these class, race and caste differences, the process of surrogacy seems, for them, to transcend these social boundaries. For them, the connection created between gestational and biological mother is given more importance than prescriptive societal constructs such as religion (Pande 2009:388). Some of the surrogate and intended mothers even maintain contact long after delivery and form strong bonds with each other (Pande 2010). And, some even come to describe each other as "sisters" (Pande 2009:388).

Interestingly, the lack of genetic linkage allows commissioning parents and surrogates of disparate ethnic and racial backgrounds to shift away from any problematic aspects of race and ethnicity. In fact, perceived racial and ethnic difference by both parties can further help the surrogate distance herself from the child due to lack of racial resemblance. Furthermore, according to Vora's (2009) study of the Akanksha Clinic, if the

intended mother does not have viable eggs then an outside donor is used. The surrogate's eggs are not used in order to discourage the establishment of an emotional and genetic connection with the baby (Vora 2009). The surrogates in Vora's (2009:9) study use the analogy of a "spare room in a home, where someone else's baby will stay and grow," separating her uterus from her body and justifying its commodification. In this way, these surrogates disconnect themselves from the child they are carrying.

Similar, in Teman's (2003) study of Israeli surrogacy clinics, the surrogates interpret their bodies differently in this context in order to adapt to the pregnancy. Teman (2003:85) conducted open-format interviews with commissioning mothers and surrogates and found that the surrogates redefined their bodies as "artificial" during the course of the surrogacy, when their bodies were being "medically managed." The surrogates in this case were also economically marginalized, and, as per Israeli law, met the requirement of being "unmarried women with children" (Teman 2008:92). Surrogacy was an appealing alternative to other ways of earning money because of the large financial gain in a relatively short period of time, similar to the motivations of Indian surrogates (Teman 2008). Based on this economic desperation, Bailey (2011) warns that applying the discourse of good, logical or feminist "choice" obscures the truth about the Indian surrogates' motivations as they are often "choosing" surrogacy due to extreme poverty, rendering moot this Western notion of "choice" (Bailey 2011:721-722). According to Bailey (2011:716), this is an example of "discursive colonialism."

Furthermore, Bailey (2011) also states that Western feminist' notions of commodification, "baby-selling," reproductive autonomy and contract issues in commercial surrogacy may not be present or expressed in Indian surrogacy arrangements due to differences in cultural understandings of surrogacy and pregnancy (Bailey 2011:721). For example, the "wombs-for-rent" notion is subverted by one surrogate at the New Hope Clinic in India who argues that she is unique and has been chosen repeatedly for special reasons such as her fairer skin and is paid a greater amount than any of the other surrogates at the clinic (Pande 2010). Some also resist the notion that they are only bodies bound by contracts, waiting to be commodified, by establishing a personal and enduring connection with the parents (Pande 2010). Their ties with the child they carry are also an important aspect of their experience.

Thus, Bailey (2011:724, 736) concludes that, rather than seeing commercial surrogacy according to a moral binary of "a free choice" or "an exploitive practice from which Indian women must be rescued," the moral abstractions that these women face must be considered from a social justice perspective, along with their long-term reproductive health and the social inequalities that produce their need to undertake contract pregnancy.

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## Health Risks

The long-term mental and physical health outcomes from surrogate pregnancies have yet to be examined, though the mental and physical health risks are well-known (Palattiyil et al. 2010). Surrogacy may entail various medical risks (Kumar et al., 2013).

All the surrogates are required by most clinics to undergo medical tests to determine their reproductive health status (Saravanan 2013). Indian surrogates, in particular, are at risk for complications as they may be implanted with up to five embryos, compared to two in the US, which may endanger the surrogate's health (Kumar et al. 2013). In Saravanan's (2013) study of an Indian fertility clinic, due to the conception of multiple embryos, one surrogate had to undergo selective abortion (Saravanan 2013). Unfortunately, this surrogate suffered a miscarriage and all the embryos were lost (Saravanan 2013). At this clinic, all the surrogate mothers deliver by caesarian section which also carries the common risks associated with surgery (Saravanan 2013). Some economically disadvantaged Indian women also choose to become surrogates more than once, further endangering their health and well-being (Jaiswal 2012).

The surrogates are also at an increased risk for pre-eclampsia, and gestational diabetes due to possible "immune mismatch" (Shetty 2012:1634, Kumar et al. 2013). Other pregnancy-related issues may include post-partum depression, urinary tract infections, stress incontinence, and hemorrhoids (Kumar et al. 2013). And, pulmonary embolism, hypertension, stroke, placental abruption or a hemorrhage may prove fatal (Kumar et al. 2013). The numerous fertility hormones and drug cocktails required for surrogates may also cause adverse reactions, as well (Kumar et al. 2013).

Usually, surrogates have children of their own and are supported by their partner and families, though they receive less support from extended family and friends, which has been shown to result in

interpersonal conflict and loss of relationships (Ciccarelli and Beckman 2005). Some women do end up regretting their decision to become a surrogate, especially if their relationship with the commissioning couple is strained (Ciccarelli and Beckman 2005). Professional psychological support for the surrogate and the commissioning couple, before, during and after the pregnancy, is a common recommendation (Ciccarelli and Beckman 2005, Jaiswal 2012). Many surrogates also lack follow-up physical and mental health care (Khader 2013).

As mentioned, a strong indicator of psychological satisfaction for the surrogates is the quality of her relationship with the commissioning party. Therefore, a weak relationship and lack of support may negatively affect the surrogate's psychological well-being. According to Saravanan's (2013) study, the intended parents of one surrogate baby did not meet the surrogate and little social or psychological support was given to the surrogates at this clinic. As well, some of the surrogates were depressed following the relinquishment of the baby and were disappointed when the intended parents did not maintain contact with them after returning to their home country (Saravanan 2013). Two of the intended parents in this study did keep contact with the surrogates, but most did not and they were informed by the clinic staff that they did not need to "feel indebted or contact her further" because the surrogate was being remunerated for her services (Saravanan 2013:10). This shows that the surrogate's psychological health and emotions are of little concern to clinic staff.

Psychological harm is also increased due to the lack of regulatory laws which

provide no rights to surrogates in places like India (Khader 2013). Consent and medical rights are an important and often overlooked aspect of the surrogate's experience. Indian surrogates lack more autonomy than their American counterparts, especially regarding decision-making during the pregnancy (Khader 2013). Less than 3 percent of surrogates were asked for consent before undergoing abortion procedures (Khader 2013). For many women, especially those who are illiterate and live in rural areas, surrogacy and ARTs are foreign concepts and they lack the appropriate medical understanding of the process to provide consent (Khader 2013). Therefore, these issues should also be taken into consideration when formulating fair policies for surrogates.

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## Recommendations and Future Directions

Due to the ethical implications of gestational surrogacy, and the health risks posed to the surrogate and embryo, most scholars stress the development of new policies or changes to existing policies which may aid in securing rights for all parties involved to ensure fairness in surrogacy arrangements, which continue to be the only option for many couples who desire biological children. Humbyrd (2009), for example, takes on the issue of international underpaid surrogates and proposes "fair trade surrogacy." This intercountry agreement would account for standardized payment, nationally accredited surrogacy brokers and agents, safe environments, transparency and accountability, and occupational health guidelines, based on regulatory standards.

Ramskold and Posner (2013) recommend that a Hague Convention or Intercountry Surrogacy Agreements would be able to increase security and standards, and create a regulatory framework that would allow for commercial surrogacy while protecting the rights of all parties involved. Indeed, dilemmas surrounding transnational commercial surrogacy were examined by the Hague Conference on Private International Law, however little has been done to move forward with the findings from preliminary reports produced from the convention (Tobin 2014). While Tobin (2014) argues that commercial transnational surrogacy should be prohibited by international law because it is deemed synonymous with selling a child and maintains gender inequality in developing countries, Damelio and Sorensen (2008) suggest an "opt-out clause" in contracts so that a surrogate who wishes to keep the baby may do so, so that the rights of the surrogate mother are protected.

Jaiswal (2012) concludes that changes at the institutional level should be made to ensure that commercial surrogacy in India is as fair as possible for the surrogate, before and after her pregnancy. In most cases, surrogates and their families are not paid if they or the fetus die as a result of the pregnancy. So, Jaiswal (2012) recommends mandatory life-insurance coverage for the surrogates, along with counselling to ensure that they are aware of the medical risks and complications that may arise (Jaiswal 2012). Brinsden (2003) also recommends, based on the current requirements at Bourn Hall Clinic, that a team of competent doctors, lawyers, counsellors, and an ethics committee

should be provided for parties involved in surrogacy arrangements.

Ethnographic fieldwork has aided in correcting for the biases present in popular discourses regarding surrogacy, but they may not be doing enough (Bailey 2011). More work is needed, especially in emerging sites of commercial surrogacy. Rotabi and Bromfield (2012) express concern that Guatemala is primed to become an even more popular centre for surrogacy than India due to the lower cost of travel, especially for U.S. citizens. The Guatemalan context, similar to India, involves the exploitation of poor, desperate, women of color. Due to its poor reputation regarding human rights abuses, gendered violence, and a large indigenous population, poor Guatemalan women are at risk of being exploited through this emerging surrogacy industry (Rotabi and Bromfield 2012).

While little is known about Guatemalan clinics, they seem similar to the Indian clinics in terms of their presentation; they claim to be highly professional and aim to cater to the commissioning party's every whim, while failing to comment on the oppressive conditions that produce the surrogates (Rotabi and Bromfield 2012). Thus, research in this area can aid in creating fair policies for the surrogates based on their experiences. As Sobo (2009) argues: anthropological work on medical travel can assist in creating fair policies for patients, consumers and host populations by examining the complexities and contexts at ground level.

As well, there are no studies on the experiences of children born of surrogacy (Ciccarelli and Beckman 2005, Nakash and Herdman 2007). Therefore, this is a

promising area for future research as it would have the potential to provide important insight about the child's perspective on surrogacy and human rights. In the case of the Sterns from the Baby M case, their daughter, whom they named Melissa, bonded with her parents and terminated Whitehead's rights as an adult so that her intended mother could adopt her, and she also praised her parents in media reports (Scott 2009).

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## Conclusion

From the present review, it is clear that it is not only the Western consumer base that is complicit in the exploitation of women in India and other countries, but also the mediators and clinicians within these countries that strengthen the social inequalities therein because they stand to profit from them. Therefore, the technology and prevalence of transnational surrogacy allows privileged populations to reinforce the subjugation of poor women of color by reconstructing the discourse to their advantage. While ethical debates aid in dismantling popular attitudes regarding commercial surrogacy, the discourse is still embedded in Western media's interpretation of poor Indian women's experiences. Euro-American and privileged Indian consumers, along with some doctors and agents, emphasize the "win-win" aspect of surrogacy which reinforces social, economic and gendered inequalities. Popular media dispenses an incorrect, and sometimes overly positive, representation of transnational surrogacy which influences public opinion. This, in turn, perpetuates the exploitative aspects of the transnational surrogacy industry.

However, in comparison to popular media opinions, ethnographic accounts, like those discussed, seek to correct this concern, as moral complexities in the surrogate's decision-making and experience are taken into account, along with other cultural factors and social realities. Ethnographic fieldwork presents the surrogates' interpretations of their own experience and should be used by policy-makers and legislators to construct fair policies and regulations, taking the rights of all parties into account, to limit harm to surrogates and prevent further exploitation.

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