

THE NEW GLOBAL DIVISION OF LABOR: TRANSNATIONAL SURROGACY IN INDIA

by

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A dissertation submitted to the Graduate Faculty in Anthropology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2013

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This manuscript has been read and accepted for the Graduate Faculty in Anthropology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

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This dissertation examines the transnational surrogacy industry in India, in which would-be parents travel from around the globe to India in order to obtain assisted reproductive technology (ART) procedures such as in vitro fertilization, egg donation, and gestational surrogacy. While processes of human reproduction have become increasingly commodified and disaggregated, a new spatial division of labor has surfaced as laws in different countries facilitate or impede various fertility treatments. In recent years, India has emerged as a global “hub” of transnational surrogacy arrangements, in part because of lower costs but also due to minimal regulatory frameworks for the provision of ARTs. This dissertation details how these variables—the absence of laws governing ARTs in India, the relatively low cost of services, and the transnational clientele—influenced the expansion of ART services in India aimed specifically at global consumers, and the attendant implications for understanding kinship relations within global reproductive networks.

Based on thirteen months of ethnographic fieldwork in Mumbai, India, this dissertation draws primarily on interviews and participant observation with surrogates, egg donors, commissioning parents, caretakers, and doctors. Across transnational and local socioeconomic hierarchies, how do these varied reproductive actors come together, and how do they understand and articulate their relationships with one another as they collaborate in the creation of babies? In

addressing this question, this study focuses on the ways in which previously “inalienable” entities (such as sperm, eggs, and wombs) become alienable in the global reproductive market. In particular, it argues that actors make sense of this process through concealment or, to use Bourdieu’s term, “misrecognition” of the commodification of reproduction and family making. This dissertation contends that such acts of misrecognition ultimately obscure broader patterns of stratification, while reinforcing hierarchies of ethnicity, class, gender, and nation, though in unexpected ways. The study illustrates the complexities and contradictions of stratified reproduction, as well as the constellation of relations embedded in transnational surrogacy, through several intersecting theoretical lenses: anthropology of kinship, critical race theory, feminist and urban geography, and theoretical analyses of agency and power.

ACKNOWLEDGMENTS

First and foremost, I thank the research participants who gave of their time, and the generosity of those who invited me into their homes and lives in the course of this research. This dissertation would not have been possible without them.

I am deeply grateful to my dissertation committee, Leith Mullings, Katherine Verdery, Murphy Halliburton, and my outside reader, Rayna Rapp, for their invaluable comments, advice, and support throughout graduate school, fieldwork, and the dissertation writing process. As chair of the committee, Leith has been an ideal adviser, posing critical questions and providing thoughtful comments throughout multiple drafts of this work.

In India, I owe thanks to many individuals who facilitated my fieldwork in 2008 and 2010. I am greatly indebted to my research assistants, Prachi Bari, Kaveri Dadhich, Mrinmayee Ranade, and Vasudha Mohanka, for their insights and service. Prachi, who worked with me in the majority of interviews with surrogate mothers, deserves special thanks for her enthusiasm for this project, willingness to travel long distances, and tireless energy even amid long days of interviews. I would like to thank the staff of the International Students Office at the Tata Institute of Social Sciences for welcoming me as a visiting research scholar and for easing my transition to Mumbai at the start of my research. I thank Bishakha Datta, Amar Jesani, Lakshmi Lingam, Vimla Nadkarni, Chayanika Shah, and Sandhya Srinivasan for their invaluable insights and advice on various aspects of this research. I am grateful to Abby Rabinowitz and Kainaz Amaria for their friendship in “the field.” I owe profound thanks to Abby, who had a shared interest in surrogacy in India and who introduced me to several key participants in this research. Fieldwork in Mumbai would have far less rich, interesting, and enjoyable without her.

There are many faculty and students at CUNY who deserve thanks. Gerald Creed and Ellen DeRiso make the Department of Anthropology a more pleasant place to be. Thanks to Ida Susser and Rosalind Petchesky for their guidance and support in the early stages of graduate school and this research. I am grateful for the collegiality of fellow students, among whom I would especially like to thank Sophie Bjork-James, Carwil Bjork-James, Risa Cromer, and Martha Lincoln. Thank you to fellow writing group members for getting me through the final year of writing: Ujju Aggarwal, Sophie Bjork-James, Maggie Dickinson, Harmony Goldberg, and our intrepid organizer, Karen G. Williams. Thanks to Lauren Jade Martin for comparing notes on fieldwork and reproductive tourism in the United States.

I am thankful for colleagues and professors beyond CUNY, who offered advice on research strategies, commented on conference papers and chapter drafts, and were welcome interlocutors on all topics related to surrogacy and assisted reproduction in India: Aditya Bharadwaj, Rebecca Haimowitz, Marcia Inhorn, Molly Shanley, Nayantara Sheoran, Vaishali Sinha, Elly Teman, Cecilia Van Hollen, and colleagues at the Center for Genetics and Society and the 2011 and 2012 Tarrytown Meetings.

I gratefully acknowledge the institutions that provided financial support for graduate training, field research, and writing of this dissertation. Preliminary research was funded by the City University of New York; Hindi language training was supported by a Foreign Language and Area Studies (FLAS) Fellowship from the University of Wisconsin; the National Science Foundation and the Wenner-Gren Foundation supported field research in India; and writing of the dissertation was funded by fellowships from the Ford Foundation and the City University of New York.

Finally, there are many friends and family who have supported and sustained me throughout my dissertation. Thanks to my dearest siblings and siblings-in-law who keep me grounded. To my parents, Fe and Dom, and my parents-in-law, Sheila and Isaac, I extend my deepest gratitude for their generosity, love, and consistent support. I am eternally grateful for Mirabelle, and thank you, above all, to Michael, for everything.

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INTRODUCTION

On a Sunday afternoon in the midst of monsoon season, I sat in a hotel restaurant sipping coffee with Eben,¹ a Middle Eastern entrepreneur who had landed in Mumbai several days earlier. Eben is founder and head of a company based in the Middle East that facilitates surrogacy arrangements in India for prospective parents from all over the world. Eben and his partner themselves were parents to a baby girl born via gestational surrogacy in the United States, and he explained to me the core motivation for starting his company: to make gestational surrogacy a feasible option for more infertile and gay couples. According to Eben, surrogacy in the U.S. was simply unaffordable for most of his clients, many of whom required the assistance of egg donation and preferred a white egg donor that might physically resemble them. Yet they found surrogacy and egg donation in India to be a daunting alternative. Eben thought pragmatically, “Let’s find a way to mix the two.” His first clients were a Middle Eastern gay couple; Eben shipped frozen sperm from one of the male partners to the U.S., where embryos were formed with donor eggs from a white U.S. woman. Doctors then froze and shipped the resulting embryos to India, where Indian doctors thawed and transferred the embryos into the uterus of an Indian woman.

As Eben went on to explain different aspects of his business, he noted that he does not match clients and surrogates prior to embryo transfer. Instead, doctors transfer embryos into the wombs of surrogates who happen to be prepared to undergo transfer at that time, and the

¹ All names of persons in this dissertation are pseudonyms. I have replaced participants’ names with other names of the appropriate gender and place of origin, depending on the participant’s background. I have also replaced names of places and institutions such as clinics and hospitals.

commissioning parents² and surrogates sign the contract only after pregnancy is confirmed. In fact, he explained, “Just today I came from a meeting with twelve pregnant surrogates for my clients. We met today and we did all these signatures [for the contracts].” As I imagined Eben in a room filled with a dozen pregnant Indian women, distributing and explaining the contents of the surrogacy contracts, I thought about how this piece of paper, the contract—as well as the fetus growing inside them—connected the surrogates to parents who lived half a world away and whom they would likely never meet.³

Several days later, I was sitting on the floor of Nishi’s single-room home in Nadipur,⁴ a city located less than 40 miles outside Mumbai, snacking on samosas and sipping hot chai. Nishi, a surrogate who was then five months pregnant, proceeded to tell me about her week. She excitedly told me of how several days earlier she had discovered where her client⁵ was from: “My client is Muslim! He is from Dubai, and his name is Omar Chasan.” When I asked how she knew all of this, she explained that she had not actually met her client. In fact, no one provided her with any information about him, apart from the fact that he was a foreigner. Instead, she told me, she guessed the client’s place of origin from the name she read on the contract she signed earlier that week. She went on to explain, “I didn’t meet the client, I met with somebody else

² When referring to the “infertile couples and individuals,” “intended parents,” and “commissioning parents” who pursue transnational surrogacy, I refer not only to heterosexual couples who have been medically diagnosed as infertile, but also same-sex couples and single men and women who have what infertility experts have called “social factor infertility,” which includes the absence of a heterosexual or any partner who would enable conception of a child. While much of the scholarship to date on infertility and assisted reproductive technologies has focused on the experiences of heterosexual married couples (Becker 2000; Inhorn 2003b), there is a growing literature on same-sex couples and individuals who avail themselves of ART procedures and services (Mamo 2007). I draw attention to this in order to emphasize that those traveling abroad for reproductive technologies (including participants in this study) are a diverse group including same-sex couples and single parents-to-be.

³ As I will discuss further in Chapter 1, different doctors followed different policies with respect to relationships between commissioning parents and surrogates. Some doctors actively fostered long-distance communication between surrogates and parents via Skype and telephone, and surrogates and parents often met in person at the time of contract-signing and birth of the child. On the other hand, the surrogates and clients with whom Eben worked rarely had the opportunity to meet in person, and their doctors actively discouraged any contact or communication.

⁴ “Nadipur” is a pseudonym for the city in which the majority of the surrogates I interviewed, including Nishi, lived.

⁵ Surrogates and doctors typically used “client” to refer to the commissioning parents.

who came to get the agreement signed. He was carrying twelve contracts with him and we were twelve surrogates in the room. He took my photograph, asked me my name, and went away.” The “guest” pressed a five hundred-rupee bill (approximately US\$11)⁶ into Nishi’s hand, took photographs of Nishi and the other surrogates, and left with the signed contracts.

As Nishi related this story to me, I realized that she must have met Eben on the day she signed the contract—the same day Eben and I met to discuss his international surrogacy business. I was struck by the coincidence that Nishi, with whom I had been meeting regularly over the past several months, happened to also meet Eben, who was visiting for only a few days and whom I had just met earlier that week. Moreover, I thought about how Nishi’s narrative revealed connections and absences—connections with a “client,” the future father of the child she was carrying, who nonetheless remained distinctly absent throughout her pregnancy and, later, recovery from childbirth via cesarean section.

I found that further connections and absences would unfold in various ways in the course of my research. That same week, I met with five white South African women who had traveled to Mumbai as “traveling egg donors,” four of whom were returning as second-time egg donors in India (all had previously donated multiple times in South Africa). As they regaled me with their stories of egg donation, shopping, and tourism in India, they also posed thoughtful queries about the lives of surrogates and intended parents, whom they would never meet. Several months later, I met a Middle Eastern gay couple who had recently become parents to twin girls. I learned they were clients of Eben, and that their children were conceived with the help of a white South African egg donor and an Indian surrogate. This couple, too, were profoundly curious about the

⁶ All estimates of fees, payments, or money exchanged are based on the 2010 average exchange rate of 1 U.S. dollar to 45.68 Indian rupees.

impact that surrogacy had on the lives of surrogate women, and lamented that they could not follow-up with their surrogate personally, as their doctor strictly forbade any contact.

Throughout my fieldwork, I noted how the lives of surrogates, commissioning parents, egg donors, and brokers converged in Mumbai at distinct moments, sharing a common “quest for conception” (Inhorn 1994). Yet while these varied actors in far-flung locales were connected through the process of surrogacy, they were effectively absent in each other’s everyday lives. Though the fates of these wide-ranging reproductive actors might intersect in Mumbai at one point or another, they do not always meet face-to-face, and when they do meet, their interactions are often brief and stilted. Nonetheless, their lives are intimately intertwined through the conception of human life, and they negotiate these connections with each other in various and unexpected ways.

This dissertation is about the ways in which surrogates, parents, egg donors, and agent/brokers, among other actors, navigate such connections and absences. It is about the means through which various actors develop and negotiate relationships with each other in the process of gestational surrogacy, particularly across social, economic, ethnic, and national boundaries. It is about space and social stratification, and the ways in which actors differentially experience movement and mobility through transnational surrogacy. At its broadest level, this dissertation is about how such forms of transnational reproduction reflect and reinforce local and global inequalities.

In the chapters to come, I approach these themes by examining the ways in which notions of kinship, connection, movement, and mobility are imagined and experienced within broader structures of inequality. Across transnational and local socioeconomic hierarchies, how do these varied reproductive actors come together, and how do they understand and articulate their

relationships with one another as they collaborate in the creation of babies? I address this question by focusing on the ways in which previously “inalienable” entities (such as sperm, eggs, and wombs) become alienable and available in the global reproductive market. In doing so, I suggest that actors make sense of this process through concealment or, to use Bourdieu’s term, “misrecognition” of the commodification of reproduction and family making. I argue that this process of misrecognition ultimately obscures broader patterns of stratification, while reinforcing hierarchies of ethnicity, class, gender, and nation, though in complex and unexpected ways. My goal in this dissertation is to shed light on the constellation of relations formed through transnational gestational surrogacy, revealing the shifting complexity of stratified reproduction. I illustrate this argument by analyzing ethnographic data through several intersecting theoretical lenses: anthropology of kinship, critical race theory, feminist and urban geography, and theoretical analyses of agency and power.

While processes of human reproduction have become increasingly commodified and disaggregated, a new spatial division of labor has surfaced as laws in different countries facilitate or impede various fertility treatments. In recent years, India has emerged as a global “hub” of transnational surrogacy arrangements, in part because of lower costs but also due to minimal legal or regulatory frameworks for the provision of assisted reproductive technologies (ARTs) such as in vitro fertilization, egg donation, and gestational surrogacy. In this dissertation, I detail how these variables—the absence of laws governing ARTs in India, the relatively low cost of services, and the transnational clientele—influenced the expansion of ART services in India aimed specifically at global consumers, and the attendant implications for understanding kinship relations within global reproductive networks.

The Indian case is important not merely because it is interesting, but because it is instructive. At present, only the Indian Council for Medical Research (ICMR) has developed guidelines regulating the provision of ARTs. These guidelines, however, are not legally binding and reproductive rights activists, physicians, bioethicists, and legal experts have called for the creation of laws governing gestational surrogacy and ARTs. Yet, while the “Draft ART Bill and Rules” legalizing surrogacy in India is pending, the current absence of any ART or surrogacy laws has raised questions about potential immigration and citizenship issues for babies born to Indian gestational surrogate mothers and “commissioned” by foreign couples.

For instance, while many European nations rely on the principle of *jus sanguinis* for determining citizenship, in which one or both parents are citizens of the nation, conflicts have arisen when contradictory definitions of “parent” collide. Indian doctors and policymakers, for example, insist that the “mother” of the child born through surrogacy is the “intended” mother (who may or may not be genetically related to the child), regardless of who gives birth. Countries such as Norway, on the other hand, define the mother explicitly as the woman who gestates and gives birth to the child, and several Norwegian couples I interviewed have found themselves at the forefront of battles to gain citizenship and parenthood rights for their children born through surrogacy in India.⁷ Clearly, the demand for ARTs in India by global consumers signals dramatic reproductive entanglements with kinship relations as well as governmental regulation at the local and international level. Within this context, policymakers find themselves without precedents in dealing with the contemporary social, political and economic issues involved in parentage and family.

Moreover, as ARTs are made available in an ever-expanding range of contexts, they introduce a broader range of parenting patterns, and families now grapple with the implications

⁷ For further discussion, see Chapter 6.

of having multiple “mothers,” potentially including the biological mother who donated her egg, the surrogate mother who loaned her womb, and the intended mother who will raise the child. At the same time, ARTs are challenging traditional notions of heterosexual parenthood by creating previously inconceivable offspring for same-sex couples, as several doctors in Mumbai actively market gestational surrogacy services to gay men from other countries. At issue are the wide-ranging concerns surrounding ideas of kinship, in particular at the intersection of globalization and assisted reproduction, as well as legal questions regarding citizenship and belonging in broader transnational contexts. As such, this dissertation holds particular relevance for social policy, by providing insights into the motivating factors, experiences and concerns of reproductive tourists, surrogate mothers and gamete donors.

In addition to examining ideas around kinship, race, movement, and mobility, this dissertation spotlights transnational aspects of reproductive tourism, drawing critical attention to relations between and among countries, systems of commerce, and global regulatory systems. In doing so, it reveals the myriad ways in which transnational reproduction sustains social stratification at local, regional, national, and global levels. Without such an analysis, ongoing debates around policy and bioethics remain problematically focused on abstract principles or rigid rules; instead, I call for a practice-oriented approach that accounts for the multiple perspectives and experiences of those involved in transnational surrogacy. This dissertation contributes a fine-grained ethnographic study of surrogacy practices in local Indian contexts as well as transnational spaces, illustrating how social and structural inequalities provide the framework within which people make decisions about reproductive health and wellbeing.

While scholars have argued that commercial surrogacy disrupts traditional Western conceptions of family, kinship and nature, gestational surrogacy in India includes other

disruptive boundary crossings, namely, the technological implantation of genetic parts of the couple's (or donor's) body into the surrogate's womb; the racial, ethnic, religious and economic boundaries between the multiple actors involved; and the national boundaries that intended parents will cross in order to create babies. Within this context, relationships between intended parents and surrogate mothers are not clear-cut; indeed, given the lack of any laws regulating ARTs, the role of physicians comes to the fore as they negotiate their own moral and professional boundaries about how they decide to organize and facilitate relationships between intended parents and surrogates. By focusing on these relationships among doctors, intended parents, egg donors, and surrogates, I show how actors conceive of and make sense of their connections with each other, in order to illuminate the ways in which kinship ties are challenged, transformed or reinforced in the context of transnational gestational surrogacy.

Reproductive Tourism, Stratified Reproduction, and Surrogacy in India

Patients have long traveled around the world seeking medical services; recent anthropological work suggests that the new transnational world order has increased medical migrations (Thompson 2011). Several recent special issues of anthropology journals have been dedicated to the theme of medical travel, highlighting empirical studies of transplant tourism, plastic and sexual reassignment surgery, stem cell tourism, and vacation travel to various healing spas (Mazzaschi and McDonald 2010; Naraindas and Bastos 2011; Roberts and Scheper-Hughes 2011; Whittaker, et al. 2010).

Reproductive tourism, a form of medical tourism, refers specifically to the transnational consumption of assisted reproductive technologies (ARTs). Such tourism centers on individuals who seek a range of reproductive products and services. It includes people who travel abroad to

procure gametes (sperm and eggs) and embryos, to contract with surrogates, and/or to obtain services such as IVF, intracytoplasmic sperm injection (ICSI), artificial insemination, sex selection, and diagnostic tools including amniocentesis and preimplantation genetic diagnosis (PGD). The providers of these reproductive tissues and services may also undertake travel in order to make their bodies “bioavailable” (Cohen 2005). Although “tourism” implies the travel of people from their home country to an unfamiliar destination for leisure purposes, I take reproductive tourism to include all forms of transnational interactions and consumption patterns involved in assisted reproduction, including the cross-border movement of bodily materials.⁸

Patterns of reproductive tourism reveal uneven distributions of assisted conception and related technologies across the globe. Scholars have demonstrated that structural and cultural constraints influence how developing countries assimilate ARTs (Bharadwaj 2006; Bharadwaj 2009; Bharadwaj Forthcoming; Handwerker 2002; Inhorn 2003a). While people in high- and middle-income nations tend to have the most access to ARTs, a combination of policy, religious, and cultural values also influence the number of fertility clinics and availability of services (Roberts 2012; Spar 2006).

Anthropologist Marcia Inhorn’s work on reproductive tourism in the Middle East sheds light on the global economy that enables rapid deployment of ARTs (Inhorn 2011b). Building on Arjun Appadurai’s theory of global “scapes” (Appadurai 1996), Inhorn develops the concept of

⁸ There has been some debate regarding the accuracy and appropriateness of the term “reproductive tourism” (also known as “fertility tourism” or “procreative tourism”). The concept draws on the original term “medical tourism,” which is used to describe vacationers to “exotic” locales where they could also obtain some medical treatment. In recent years, however, some scholars have objected to the portrayal of reproductive tourism as travel that might be considered leisurely or frivolous, thus trivializing the serious nature of infertile couples’ quests for conception. Several scholars have suggested “reproductive exile” as a more accurate term, highlighting the plight of couples who travel involuntarily due to constraints in their home country (Inhorn and Patrizio 2009; Matorras 2005), while others prefer the more neutral “cross border reproductive care” (Blyth, et al. 2011). Following Monica Casper, I have found more productive the term “transnational reproduction” to refer specifically to the bodies, practices, technologies, and forms of capital that cross national borders (Casper 2011). Foregrounding transnational aspects also calls attention to how reproduction is stratified. Throughout this dissertation I use transnational reproduction and reproductive tourism interchangeably.

“reproscape,” which calls to mind a “distinct geography traversed by global flows of reproductive actors, technologies and body parts” (Inhorn 2010a: 183). Indeed, Inhorn goes further to suggest that researchers might productively replace Appadurai’s non-gendered language of “scapes” with the notion of “reproflows,” which bespeak global movements of reproductive technologies developed in one country that then “flow” to others through commercial means; of embryos “flowing” from one country to another with the assistance of embryo couriers; of women and men “flowing” across national borders in pursuit of reproductive technologies; and finally, of surrogates and egg donors who “flow” and are “flown” to other countries.

As reproductive technologies become more widely available throughout the world, governments face policy challenges regarding the extent to which reproductive technologies should be regulated. Legislative regulations in individual countries may prohibit certain technologies or procedures, such as PGD, sex selection, or egg donation. Others have imposed limits on who should have access to reproductive technologies, in terms of marital status, age, sexual orientation, and infertility status, while other guidelines aim to regulate the anonymity or compensation of gamete donation. As U.S. sociologist Arlie Hochschild has written, transnational surrogacy reflects a “highly complex legal patchwork” (2009); at one end of the spectrum are countries such as the United States, which imposes no federal regulations regarding reproductive technologies and where only 17 (out of 50) states have enacted surrogacy laws. At the other end are countries such as Germany, whose parliament has authorized strict guidelines regarding access to and use of reproductive technologies.

Within a broader discussion of technology and inequality, such variations in policy approaches reveal how politics and social power relations permeate technology and science.

Scholars of science and technology studies (STS) have argued that technoscience is neither inherently objective nor neutral, rather, it is reinforced and imbued with the prevailing worldviews, desires, and fears of the society in which they are generated (Gould 1981; Harding 1991).⁹ Further, social studies of technoscience demonstrate that social inequalities are reproduced, reinforced, and perpetuated by unequal access to technologies.

The same holds true for reproductive science and technology. While assisted reproduction has brought increased freedom and opportunity for some people, making parenthood possible for infertile couples, single men and women, and gay and lesbian couples through artificial insemination, surrogacy or IVF (Agigian 2004; Layne 1999; Mamo 2007; Ragoné and Twine 2000), advances in reproductive technology, too, have promoted and maintained certain power relations, notions of gender, and particular constructions of the family. Some scholars, for example, argue these technologies re-essentialize women by reinforcing patriarchal roles and objectifying women's reproductive potential (Rothman 1989). Others reveal how ARTs strengthen the traditional patriarchal family, by enabling infertile heterosexual couples to reproduce while many clinics have barred single people, gay or lesbian couples, welfare recipients, and other women who do not conform to patriarchal ideals of motherhood (Roberts 1997).

Embedded within reproductive technologies, then, are problems of social inequality. With ongoing advances in reproductive technology, feminist scholars have paid close attention to stratified reproduction and the ways in which certain power relations empower some people to nurture and reproduce, while disempowering others (Ginsburg and Rapp 1995b). Originally coined by Shellee Colen in her 1986 study of West Indian childcare providers and their female

⁹ Following Latour (1987), I use the term “technoscience” to acknowledge the entwined relationship between technology and science.

employers in New York City, stratified reproduction describes the ways in which political, economic, and social forces structure the conditions under which women carry out physical and social reproductive labor. This labor is differentiated unequally across hierarchies of class, race, ethnicity, gender, and place in a global economy (Colen 1995). The concept of stratified reproduction both derives from and builds on feminist concerns with shifting childbearing (biological reproduction) and domestic labor (social reproduction) from the sphere of the “natural” to the center of social analysis (Rapp 2001). As such, researchers of stratified reproduction continue the feminist project of interrogating gender relations and gender inequalities, particularly within the arena of social and biological reproduction. Stratified reproduction is central to this study as it provides a lens through which to examine how systems of inequality influence individuals’ reproductive practices, their experiences with and access to ARTs, and the choices available to them.

Since the 1980s, many feminist social scientists have adopted stratified reproduction as a theoretical framework within which to investigate issues connected to the intersections of reproduction and stratification. Analyses of reproduction within such a framework shed light on the ways in which reproductive practices define certain racial, ethnic, and class groups as, for instance, more or less “modern,” “responsible,” or “worthy” (Colen 1995; Kanaaneh 2002; Maternowska 2000; Mullings 1995). Many researchers have used this concept productively to describe the dominant patterns in how reproduction is stratified, particularly by race, class, and sexuality (Kanaaneh 2000; McCormack 2005; Mullings 1995; Roberts 1997; Roberts 2002). Others have focused on the power relations and discourses of motherhood, family, and childbearing that create opportunities and allocate resources, enabling some women to reproduce and care for their children while inhibiting others. These studies have examined, for instance,

population policies (Greenhalgh 2008; Kanaaneh 2000; Lopez 2008; Maternowska 2000; Petchesky and Judd 1998), the criminalization of women who use drugs while pregnant (Roberts 1997), and dominant representations of poor women and women of color as mothers (Davis 2009; Mullings 1997; Roberts 2002).

In the past two decades, there has been an expansion of scholarship on stratification in the context of ARTs (Franklin and Ragoné 1998; Pollock 2003; Ragoné and Twine 2000; Roberts 2009). Such work, for example, examines media framings of and public discourses around women's use of ARTs (Davis 2009; Markens 2012); how sperm and egg donation industries perpetuate a form of gendered eugenics (Daniels and Heidt-Forsythe 2012); and how ova, sperm, and embryos are stratified-marketed according to gender, place of origin, and the characteristics of the donors (Whittaker and Speier 2010).

Transnational surrogacy in India reflects many of these inequities; in India as elsewhere disparities in gender, race, class, and nation place some women's reproductive projects above others' (DasGupta and DasGupta 2010; Gupta 2006; Gupta 2012; Pande 2011). Certainly, the global "reproscape" in which Indian surrogacy occurs is highly uneven, offering a powerful exemplar of stratified reproduction. This dissertation builds on the concept of stratified reproduction by elucidating the complex and unexpected ways in which transnational surrogacy reinforces stratification. For instance, while some scholars argue that ARTs enable infertile couples to reproduce heterosexual, white families (Quiroga 2007), in fact, most commissioning parents in this study sought Indian egg donors with skin tones darker than their own. While these moves might challenge hierarchies that privilege white skin, they simultaneously strengthen essentialist understandings of race, culture, and ethnicity, thus maintaining and reinforcing racial

and national hierarchies.¹⁰ Surrogate women's experiences, too, reflect the complicated ways in which transnational surrogacy enables some women to challenge traditional gendered roles and responsibilities, while simultaneously buttressing the hierarchies that make surrogacy in India possible.¹¹

Surprisingly little research discusses the experiences of women involved in surrogacy, though an emerging scholarship explores commercial surrogacy in India. Helena Ragoné's study of surrogacy agencies in the United States and Elly Teman's work on surrogacy in Israel demonstrate how women involved in surrogacy rely on narratives of "gift-giving" to downplay the commercial nature of their relationship with one another (Ragoné 1994; Teman 2010). In India, two documentary films, *Made in India* and *Google Baby*, highlight the experiences of couples who journey to India to hire gestational surrogates (Frank 2009; Haimowitz and Sinha 2010), while another, *Can We See the Baby Bump, Please?*, spotlights surrogate women's experiences and ethical challenges to commercial surrogacy (Sharma 2012). Meanwhile, Amrita Pande and Kalindi Vora make a major intervention into theorizing transnational surrogacy in India. Pande and Vora examine the socio-cultural implications of surrogacy among women who live in "surrogacy hostels" in the western state of Gujarat, where they remain separated from their families and communities throughout the course of their pregnancies (Pande 2009a; Pande 2009b; Pande 2009c; Pande 2010a; Pande 2010c; Pande 2011; Vora 2009; Vora 2011; Vora 2012; Vora Forthcoming-a; Vora Forthcoming-b). My research extends this scholarship by providing contrasting data on surrogacy from other regional contexts in India, in which clinic practices vary widely and surrogates may or may not live in surrogacy dormitories.

¹⁰ See Chapter 3.

¹¹ See Chapter 5.

While there is a growing literature on transnational reproduction around the globe (Bergmann 2011; Inhorn 2010b; Inhorn 2011a; Martin 2011; Nahman 2008; Nahman 2011; Whittaker and Speier 2010), including several special journal issues (Gürtin and Inhorn 2011; Kroløkke, et al. 2012), the Indian case represents a unique opportunity to examine how social relationships unfold within the uneven terrain of transnational reproduction. For instance, reproductive tourism to India occurs not only along north-south pathways, but also within the global south. While major cities such as Mumbai and Delhi cater to North American, Australian, and European clients, a growing number of IVF/surrogacy clinics in metropolitan cities throughout India cater to regional clientele from Bangladesh and Pakistan, as well as clients from within India, who travel from regions where ART infrastructure remains undeveloped (Kashyap 2011). In my own field research I found that many Indian fertility clinics cater to clients from African countries such as Tanzania, Nigeria, and Ethiopia, who travel to India in search of experienced IVF practitioners and advanced medical facilities that are either unavailable or unaffordable in their home countries. Paradoxically, as ART consumers travel from around the world to access India's flourishing fertility industry, Inhorn has found that many infertile South Asians seek ART services in Dubai, unable to obtain affordable, high-quality services in their own country (Inhorn 2012). These examples of transnational reproduction provide additional case studies through which to think about the complexities of stratified markets of reproductive tourism.

Ethnographic study of ARTs also expands our understanding of the intersection of gender and kinship and builds on literature that examines the mutual constitution of the two fields (Collier and Yanagisako 1987). Of all the anthropological work on ARTs, the most substantial is that which explores the effects of these technologies on notions of kinship and family. Strathern

(1992b) paved the way for the new kinship studies (Carsten 2004; Edwards, et al. 1999; Franklin and MacKinnon 2001; Strathern 1992a) while stimulating interest in how ARTs might expand ideas of relatedness (Franklin 1997; Franklin and Ragoné 1998; Thompson 2005). Moreover, much of the surrogacy research challenges Western ideologies that presume a natural mother-child bond (Markens 2007; Ragoné 1994; Teman 2010), gradually deconstructing motherhood into genetic, adoptive, and surrogate maternities (Cussins 1998). At the same time, given that Euro-American notions of kinship are biogenetically based (Schneider 1980), ARTs have enabled many infertile couples to “chase the blood tie” (Ragoné 1996) in pursuit of biogenetically related offspring. Recent research reveals how ARTs have created new forms of kin-like alliances, as in the case of women who donate eggs to relatives (Tremayne 2009) as well as those among unrelated women (Bonaccorso 2008; Konrad 2005). Yet, less is known about how such relationships emerge in the transnational contexts in which reproductive tourism takes place. This dissertation addresses this lacuna to show how actors experience and understand their relationships with intended parents, genetic donors, gestational surrogates, and children conceived across race, class, and national lines.

However, while this dissertation is concerned with transnational movements of people seeking ARTs, it also must grapple with the specific institutions, discourses and practices in which women’s reproductive health came to hold meaning in India. This research builds on historical and ethnographic studies of childbirth, reproduction, and reproductive politics in South Asia (Ahluwalia 2008; Arnold 2006; Hodges 2006; Jeffery, et al. 1989; Papreen 2000; Ramasubban and Jejeebhoy 2000; Sundari Ravindran and Balasubramanian 2004; Van Hollen 2003a; Van Hollen 2003b; Van Hollen 2013) by examining how gender and reproductive politics both structure and are structured by a wide set of social relations (Sangari and Vaid 1989: 3).

Much scholarship has focused on the images of colonized India as a mother debased by the British, and on images of nationalist men who defend and set her free; this work has illuminated the ways in which women in colonial India were symbols and subjects of nation, as well as mothers who bore sons for the nationalist struggle and later, the independent state (Chatterjee 1989a; Chatterjee 1989b; Sinha 2000; Sinha 2006). Concurrently, in the late nineteenth and early twentieth century, colonial and nationalist discourses began to focus on the control and management of childbirth (Van Hollen 2003b). Pronatalist fears of depopulation and colonial anxiety about a shrinking labor force in the colony contributed to the growing interest in maternal and infant mortality. As a result, the colonial state encouraged professionalization of obstetrics; this move was part of a larger trend that positioned the dominance of modern medicine and attempted to suppress indigenous healers and *dais* (midwives) in the colonized world (Malhotra 2003).

Yet narratives of pronatalism coexisted with antinatalist campaigns by the Indian elite who believed that fertility had to be restrained, and the nation's population control agenda has been one of the most central factors influencing women's experiences of childbirth and reproductive health since the early 20th century. Historically and globally, apart from condoms and vasectomies, modern contraceptive technologies (e.g., the pill, the diaphragm, intrauterine devices, tubal ligations, Depo Provera, and Norplant) have been designed primarily for women's bodies. In India, moreover, the development and distribution of contraceptives is not only gendered, but also classed. From its inception, the contraceptive pill received little attention in India, as it was viewed as suitable only for women in the global north and for upper class, educated Indian women, while in state discourse, the lower class female could not be trusted to control her own fertility. As a result, female sterilization (i.e., tubal ligation) remains the

foundation of family planning in India. In the 2005-06 National and Family Health Survey (NFHS), female sterilization was cited as the most widely known method of contraception among women (97 percent), while only 61 percent of women reported knowledge of the IUD, pill, and condom (IIPS 2007: 113). Within this context, scholars have explored women's experiences with government hospitals and public maternity wards, key arenas in which the government implements its birth control programs (Van Hollen 1998; Van Hollen 2002).

Thus, the expansion of ARTs in the context of aggressive population control programs illustrates a paradox: while government expenditure on public health infrastructure shrinks and population control programs target poor women, Indian scientists invest their efforts in the profitable and growing ART industry.¹² Building on these historical and theoretical debates, studies of assisted reproduction in India shed light on evolving notions of caste, kinship, and gender, and scholars have begun to theorize the ways in which ARTs are received and negotiated in Indian infertility clinics (Bharadwaj 2002; Bharadwaj 2003; Bharadwaj 2006; Bharadwaj Forthcoming). Given the rapid increase in the number of IVF clinics in India, to an estimated 700 to 800 such clinics across the country (Outlook India 2009), this dissertation contributes to a growing literature that analyzes ARTs in the South Asian context in which policymakers have only recently begun to draft ART laws and regulations.

Gifts, Commodities, and Inalienable Possessions

While the literature discussed above illustrates the social and cultural implications of ARTs and transnational surrogacy, particularly with respect to kinship and social inequality, this dissertation is also concerned with the ways in which kinship theory intersects with theories of commodification and gift giving. Scholars of medical anthropology and science and technology

¹² See Chapter 1 for expanded discussion of the growth of the ART industry.

studies have significantly expanded the study of the commodification of the body and its parts—for the purposes of reproduction, organ transplantation, surgical transformations, and medical research (e.g., in genetics and embryonic stem cells) (Cohen 1999; Cohen 2002; Lock 2001; Lock 2002; Rabinow 1996; Rabinow 1999; Scheper-Hughes 2000; Scheper-Hughes 2002; Sharp 2000). Bodily fragmentation and commodification are central to ARTs, in which reproductive actors remove sperm and eggs from bodies, transfer embryos into bodies, and at times donate embryos to other bodies or for the purposes of medical research (Franklin 1995; Kahn 2000; Konrad 1998). The ever-finer subdivision of reproductive parts and processes has created endless opportunities for profit making. Despite national and international appeals to oppose the commercialization of ART services, gamete donation agencies increasingly sell sperm, eggs, and embryos on the open market through internet websites and college newspapers (Shanley 2001; Spar 2006), while scholars engage in debates about whether women donating eggs for the purposes of human embryonic stem cell research should receive payment (Thompson 2007).

Within this context, anthropological scholarship on property, gifts, and commodities is foundational to this dissertation. Anthropologists and other scholars have productively contributed to this literature on topics related to personhood, private property, and tissue exchange (Everett 2007; Ferry 2002; Parry 2008; Radin 1987; Verdery 2003), and Annette Weiner's work on reciprocity and gift giving is particularly instructive.

In her book, *Inalienable Possessions* (1992), Weiner refers to a classification of Roman property law that Henry Maine first examined in his work, *Ancient Law* (1875). The term *res Mancipi* (chained things) referred to “immovable property” that is symbolically identified with its owners, and thus cannot be permanently separated from them. *Res nec Mancipi* (unchained, or free, things), on the other hand, were objects that could be transferred easily through sale.

Weiner broadened the application of these concepts to studies of property outside the European context, using the concepts to explain, among other examples, the Kula ring in the Trobriand Islands. In doing so, Weiner challenges the simple “gift”/“commodity” binary for exchange, arguing that exchange should be understood as having the capacity to create lasting social difference and social hierarchy. This hierarchy is produced or sustained in social agents’ struggles to assert one’s identity through keeping valued objects or forms of property. Paradoxically, these inalienable possessions are simultaneously used to construct and challenge hierarchy, providing new theoretical and methodological tools for understanding social inequality. Weiner views such possessions or “immovable property” not as a class of objects but as a set of social processes in which the capacity to keep or give is a marker of social strength and identity. These possessions, as Weiner elaborates, are at the root of many Polynesian kingdoms, and her theorizing of inalienability is important for researchers of exchange and gift giving. Weiner’s analysis also importantly introduces a consideration of gender in the gift giving debate, and places women at the heart of political process.

In the context of ARTs, Weiner’s work prompts critical questions regarding the ways in which certain “inalienable” or “chained” reproductive parts and processes become unchained in the process of commodification. For instance, some forms of reproductive labor (e.g., childcare, domestic work) have long been found in the global labor market, while other forms of reproduction, such as childbearing, were considered inalienable and “naturally” connected to mothers and motherhood. Yet, as the expansion of ARTs around the globe has commodified sperm, eggs, and wombs, things that were once considered inalienable to reproductive bodies are now rendered alienable and available on the global market. Thus, sperm, eggs, embryos, and the reproductive labor of gestation and childbirth become the valued objects through which

hierarchies are produced, contested, and reinforced. How do actors comprehend these intertwined processes of alienation and commodification, particularly as they embark on the intimate process of family making through ARTs?

Together, Bourdieu's (1977) concept of "misrecognition" and Rapp's (1978; 1987) examination of family as an ideological concept shed light on this question. Similar to the idea of "false consciousness" in the Marxist tradition, but more cultural than ideological in approach, Bourdieu's misrecognition signals "denial" of the economic and political interests extant in a set of practices. In analyzing the subject of gift exchange, Bourdieu states:

If the system is to work, the agents must not be entirely unaware of the truth of their exchanges, which is made explicit in the anthropologist's model, while at the same time they must refuse to know and above all to recognize it. In short, everything takes place as if agents' practice...were organized exclusively with a view to concealing themselves and from others the truth of their practice (Bourdieu 1977: 6).

In other words, the operation of gift exchange presupposes misrecognition of the reality behind that exchange: the logic of economic and political self-interest. This logic is misrecognized as a logic of "disinterest," legitimizing social and symbolic acts and perpetuating the social hierarchies in which they are embedded. For example, working class children may view the educational success of their middle class peers as legitimate and the result of hard work or "natural" ability, rather than based in class inequality. In the context of transnational surrogacy, as I will elaborate, commissioning parents "misrecognize" the commodification of kinship and reproduction for notions of rescue and humanitarianism.

Rapp's examination of family as an ideological concept further illuminates this analysis. In her earlier work on kinship and class, Rapp notes, family "is presumed in America to carry a heavy load of affect," as we rely on expressions such as "blood is thicker than water," "till death do us part," and "you can choose your friends, but not your relatives" to describe our kin

relationships (Rapp 1978: 280-281). Rapp complicates this construction in order to call greater attention to the “heavy load of ideology” embedded in kinship, detailing how in fact, family “is a socially necessary illusion which simultaneously expresses and masks recruitment to relations of production, reproduction, and consumption” (Rapp 1978: 281). Thus, families are not simply comprised of relationships of love and emotion; rather, they are conditioned by the demands of household formation and transactional relations. In other words, while dominant notions of family are understood (and misunderstood) as based in affect, in fact much work goes into this construction, as families are rooted in the exigencies of material, class-structured relations of production and consumption. As I will explain, in the context of surrogacy, so, too, do commissioning parents labor to construct intimate, affective relationships with surrogates, egg donors, and children, despite their families’ foundations in transactional exchange.

This dissertation builds on these theories to explain how reproductive actors make sense of family in the context of ARTs and the commodification of reproduction. I examine how and when reproductive labor is rhetorically distanced from commodification processes and when it is explicitly linked to these processes. Central to this process of distancing, I argue, are narratives of charity and rescue. Indeed, as Marilyn Strathern has written, “The language of the gift conceals commodification of the body” (Strathern 2012: 401), and in the context of transnational surrogacy, commissioning parents rely on language of rescue in their efforts to obscure commodification. This process of misrecognizing commodification, however, effectively reinforces essentialized constructions of women as poor, backward, culturally oppressed, and in need of saving.¹³ By foregrounding the ways in which reproductive parts and processes have

¹³ As I will discuss further in Chapter 2, Western feminists have previously constructed third world women as victims in need of rescue. Victorian feminists in Britain, for instance, positioned Indian women as helpless and oppressed by backward cultural traditions (Burton 1994). Similarly, the Coalition Against Trafficking in Women portrays “third world prostitutes” as “injured bodies” or victims in need of rescue (Doezema 2001).

become alienable and available in a global market, this dissertation elucidates the ways in which efforts to “misrecognize” and make sense of the transactional exchanges underlying family formation ultimately uphold stratified reproduction.

Methodology and Data Collection

Field research in India was carried out over thirteen months between 2008-2010, with the majority of the research completed during 2010; I also conducted several follow-up interviews in the U.S. in 2011. The bulk of my fieldwork was done in Mumbai; I made additional research trips to Delhi and Anand, Gujarat. While I designed my research to enable long-term immersion in the cultural settings in which gestational surrogacy occurs, I also was concerned with the transnational processes that drive the surrogacy industry in Mumbai. Thus, the prospect of how to define a given “field,” access research participants, or limit my scope of inquiry remained daunting.

Within anthropology, there is a marked shift toward multi-sited research and away from narrow “area studies” approaches (Marcus 1995), and this study represents, quite literally, a border-crossing topic that requires mobility as well as online and “deterritorialized” research (Gupta and Ferguson 1992). As others have argued, the “field” as a discrete, bounded, and geographically specific site is a problematic construction in anthropology, and as anthropologists shift their focus to the processes of globalization and transnationalism, they, too, must confront the challenge of defining the scope and sites of inquiry (Gupta and Ferguson 1997). Thus, this dissertation illustrates a shift from a focus on single nationalities and locations, going beyond binary constructions of sending and receiving locations, to examine multiple hierarchies of sites and subjectivities.

I opened this chapter with the stories of Nishi and Eben because they not only reveal the remarkable contours of reproductive tourism, but also the various spaces in which reproductive tourism occurs. Eben, cosmopolitan and financially secure, stayed in upscale hotels when traveling to Mumbai. Nishi, on the other hand, lived in a simple one-room dwelling in a working class area on the outskirts of the city. I regularly traveled between such spaces throughout my fieldwork. Consequently, my methodological approach was organized around the attempt to trace “networks” of actors involved in reproductive tourism in Mumbai. The actors in my study, whom I will describe in more detail below, include doctors, commissioning parents, surrogates, egg donors, and medical tourism brokers, among others. The spaces through which these actors moved included fertility clinics, private hospitals, commissioning parents’ accommodations in India (often in high-end hotels or full-service apartments), and surrogates’ homes (typically in working class areas of the city).

I faced the significant challenge of figuring out how to enter such networks, particularly in a city with a population of over 18 million inhabitants. I turned to the same solution that many commissioning parents and doctors rely on to establish initial connections with each other: the Internet. I drew on a variety of online sources in order to make initial contacts in the field, including doctors’ websites, online surrogacy forums, and public blogs chronicling intended parents’ surrogacy experiences. After initiating contact via e-mail with an intended parent or medical tourism agent, for example, we would often set up a video interview via Skype, where we would “meet” for the first time. In many cases, these initial Skype interviews were followed by face-to-face meetings in Mumbai or Delhi, or, in some cases, at the family’s home in the northeastern U.S., as several participants lived in the region where I was based post-fieldwork. Thus, it is worth highlighting how online spaces themselves became a primary “location” in

which I conducted research, and how online relationships often set the stage for subsequent in-person meetings in India or the U.S (and vice versa).

Once I made initial contacts with parents (either online or in person), they were fairly generous in connecting me with other intended parents they knew. Indeed, the online community of intended parents is strong and tight-knit, and parents' recommendations of me as a credible researcher frequently led to new introductions with intended parents at varying stages in the surrogacy process. One parent, for example, posted a description of my research on her blog, noting, "I spoke with her last week, and enjoyed pouring out 'the whole story' to her (hey, who doesn't like talking about themselves for an hour!)" Postings such as this, as well as word-of-mouth recommendations, made meeting parents increasingly easy as my fieldwork progressed.

I also used the Internet to identify and contact doctors who practiced surrogacy in Mumbai, Delhi, and Anand. For these doctors, the Internet and word-of-mouth recommendations were the main strategies by which commissioning parents would learn of their businesses, therefore many of these doctors had developed websites advertising their surrogacy plans to international clients. I made initial contact with doctors via e-mail or phone, and set up meetings with doctors during my first field trip in 2008. Interviews with doctors primarily focused on the structure of their surrogacy practices, the clients and surrogates they encounter in their work, the challenges and rewards of practicing surrogacy, and their thoughts on the ongoing policy debates around the regulation of ARTs. When I returned to Mumbai in 2010, I followed up with most of these doctors to understand how their surrogacy practices might have changed in the two years since my previous visit. During my main period of fieldwork in 2010, I focused my research on four clinics in which doctors allowed me to meet surrogates and intended parents. I should note

that the clinics included in this study are self-selected by doctors who welcomed the presence of a researcher.

As Inhorn (2004) has noted, fieldwork in infertility clinics depends heavily on the goodwill of their gatekeepers. Thus, I recruited surrogates, egg donors, and intended parents in several ways. With respect to commissioning couples, clinic staff initially approached clients to see if they wanted to participate in the study; staff would then make introductions between interested clients and myself. Following an informed consent procedure, I conducted interviews with intended parents either at the clinic or another location convenient for the parents (often their hotel or a nearby restaurant) lasting approximately one hour. In many instances I was able to meet with intended parents several times during the course of their trip. These trips would typically last one or two weeks if they were at the beginning of their surrogacy process (which would involve the coordination of sperm/egg collection and embryo transfer). If the child was recently born and the parents awaited the travel documents necessary to leave the country with their child, their stay in Mumbai might last longer, anywhere from several weeks to several months, depending on the parents' country of origin.

Since I interviewed parents at distinct moments and in various locations throughout their surrogacy process, I was able to capture how parents' perceptions and experiences of surrogacy shifted over time. My interviews with intended parents followed a semi-structured interview protocol, with questions focusing on topics related to personal and reproductive histories, decision-making around aspects of surrogacy and/or egg donation, thoughts on their relationships with the various actors involved, and opinions on assisted reproduction in the context of racial, ethnic, national, and class differences. My goal in these interviews was to elucidate the social histories, biographies, and motivations of parents pursuing surrogacy in India, their ideas about

biogenetic and social kinship, and their thoughts on the ethics and debates surrounding gestational surrogacy in India.

I also made initial contacts with many surrogates and egg donors through my relationships with doctors in the clinics. Clinic staff would first explain who I was and the topic of my research to women visiting their clinic; they would then introduce me to women who agreed to participate in the study. With the assistance of a translator, I followed an informed consent procedure and conducted interviews in Hindi or Marathi, the languages most commonly used by the women. I found that, similar to intended parents, many of the surrogates or egg donors I met in the clinic were eager to meet again outside of the clinic, and these meetings often led to introductions to other surrogates and egg donors.

Thus, I recruited a significant number of participants outside of the clinic in women's homes. Indeed, one of my most enthusiastic interlocutors, Antara, herself a former surrogate and now a surrogate agent/caretaker,¹⁴ introduced me to many of her "patients"¹⁵ in her home over the course of my fieldwork. Often, as many as six or eight women would congregate in Antara's home during my visits, and our meetings frequently resembled more of a focus group, community-like atmosphere than individual interviews. These women would sometimes bring their sisters or children to the meetings; in a few cases, women brought their husbands. In other instances, I would travel with or without a caretaker to the home of a surrogate, where I would

¹⁴ I use the term "agent/caretaker" to describe women who take on the dual roles of agent and caretaker: women who both recruit potential surrogates and egg donors for fertility doctors, as well as care for surrogates during the duration of their pregnancies. In some cases, distinct women may occupy these roles, but in many, the agent and caretaker are the same woman. While many of the women in this study are native speakers of Marathi and/or Hindi, they use the English terms "agent" and "caretaker" in conversation to describe these positions. See Chapter 5 for a more thorough investigation of the role of the agent/caretaker.

¹⁵ Agent/caretakers like Antara often referred to the women they cared for as their "patients," "surrogates," or "donors." While our interviews were conducted in Hindi or Marathi, they used the English terms in conversation.

meet with the surrogate, her husband, children, and perhaps her parents or her husband's parents.¹⁶

Here, it is useful to note that there is very little privacy in Mumbai. My interviews with surrogate women and egg donors often included mothers, sisters, children, husbands, neighbors, and any other friends or family members who might be present in the home. Indeed, it would have been awkward to request privacy in the context of a one-room dwelling; there was simply no other place to go. Moreover, had I insisted on private interviews, it would have removed women from their cultural context to some degree, assuming the internal, individual self to be more genuine than their socially embedded self.

As Halliburton has shown in his study of mental illness in South India, such encounters reveal how a person is embedded in her social relationships; in contrast to the egocentric or individual self, in South Asia it is more accurate to speak of the socially dispersed or socially embedded self (Halliburton 2009). In my own study, women identified themselves in relation to others in their social networks: they were mothers, sisters, wives, and friends. Indeed, in interviews with families and groups of women, I noted that it was not just the women undergoing surrogacy but a “therapy managing group” of family, friends, caretakers, and fellow surrogates who are close to the patient.¹⁷ However, while such interviews proved cathartic at times for women who opened up about family, marriage, and the challenges of surrogacy, I also noted several disadvantages to this method. Some women, for instance, would take my translator and me aside after an interview to express their “true” feelings about a surrogate, a family member, or their caretaker. Others might have felt hesitant about speaking critically about their family or

¹⁶ While there is a shift toward nuclear-family living arrangements, particularly in urban areas, some families continue to live in extended family arrangements, including the husband's parents.

¹⁷ Janzen (1978) uses the term “therapy managing group” to refer to the network of family, friends, and others who are involved in dealing with a person's ailment.

their husband in front of others, particularly in a society where family unity is highly valued. I sought to mitigate these disadvantages by interviewing women multiple times over the course of my research, in order to build trust and to gather their opinions and experiences over time and in different settings.

By visiting women at their homes, I was able to observe how women interacted with each other and with their families outside of the watchful eye of the doctor and clinic staff. This allowed me to grasp how surrogacy affected their everyday lives, in their homes and with their families, over the course of their pregnancies. My interviews with surrogate mothers were open-ended and semi-structured, and focused on their personal biographies and motivations for becoming a surrogate or egg donor, their experiences with doctors and intended parents during the course of pregnancy, their thoughts on their relationship with the intended parents and the child conceived through surrogacy, and the ways in which surrogate pregnancy affected their everyday lives.

Given the transnational nature of this research, my interviews spanned several languages. The majority of commissioning parents, doctors, medical tourism brokers, and other actors (including lawyers, reproductive rights activists, traveling foreign egg donors, etc.) spoke English fluently, and I conducted these interviews myself in English. With permission of the interviewee I recorded the interviews, and I either completed interview transcriptions myself or hired a professional transcriber to complete selected transcriptions for me.

For my interviews with Indian surrogates, agent/caretakers, egg donors, and their families, I conducted interviews in Hindi or Marathi with the assistance of a translator, primarily in the city of Nadipur, in Mumbai hospitals and infertility clinics, and in surrogate housing in suburban Mumbai. I found the presence of a translator to be crucial for developing relationships

with surrogates and their families. Though I am conversant in basic Hindi, my knowledge of the language cannot compare with that of a native speaker. Moreover, I found that while most women in my study could speak Hindi, they felt far more comfortable speaking in their native language, Marathi, making essential the assistance of a Marathi-speaking translator. The translator's presence made our interviews richer as the families with whom we spoke felt more at ease, particularly in a community where foreign researchers are uncommon. Like my interviews with English-speaking interlocutors, I requested permission to record the interviews from all Hindi or Marathi speakers; native speakers and professional transcribers/translators translated and transcribed all interviews.

Because of their important role in interviews and interactions with surrogates, egg donors, and their families, I should briefly introduce my translators, Prachi, Mrin, Kaveri, and Vasudha. Each of these translators had some interest in gender and health issues, and had good rapport with the women and families we interviewed. In addition to assisting in interviews as translators, these women revealed aspects of culture and everyday life in Mumbai that a foreigner might find confusing, and interpreted issues that emerged in interviews and other aspects of fieldwork. They raised critical insights regarding the lives of the people we spoke with; for instance, with respect to issues of caste and stratification, my assistants offered vital observations that illuminated women's lives, particularly when it was not appropriate to ask direct questions about caste. Finally, all of my assistants were women, which facilitated interviews and rapport with female informants.

Prachi, my primary translator, worked with me in the majority of interviews. Together, we interviewed 23 women (out of 35) and many of their families, and Prachi facilitated the bulk of the interviews that took place in Nadipur. Born and raised in Mumbai, Prachi was a native

speaker of Marathi and also spoke Hindi and some Gujarati. Prachi was keenly interested in language learning, and held a Masters degree in English and also studied French, Japanese, and German. At the time of my research, Prachi was 35 years old and based in Pune (approximately 95 miles from Mumbai), but traveled frequently to Mumbai in her work as a freelance journalist; she had previously worked on a variety of stories, on topics ranging from farmer suicides to Indian cinema. She also had extensive experience as a “fixer,” which is journalism slang for a local coordinator—someone who assists a visiting journalist or researcher with translation and logistical arrangements, among other tasks. Prachi’s experience as a fixer proved to be extremely useful in my own fieldwork; she had excellent communication and translation skills, and, with her knowledge of the local culture and customs, provided astute observations and insights into the lives of the women we interviewed. Our long journeys through Mumbai were no doubt smoother, and more entertaining, with Prachi’s company and assistance. Prachi had an easy-going personality and bright sense of humor, but was also sensitive to the difficult stories related by so many women; she knew when to keep a light-hearted tone, and how to be respectful of women’s personal stories of hardship. Although married, Prachi had no children by choice (an unusual situation in India), and her insights on marriage and family in India also deeply enriched this research.

While Prachi assisted with the majority of interviews, her residence in Pune made it necessary to call on other translators in Mumbai when she was occupied with other work or when interviews were scheduled on short notice. Thus, I relied on the help of Mrin, Kaveri, and Vasudha when Prachi was unavailable. Mrin, also a freelance journalist, translated interviews with eight women for this study, primarily at surrogate housing in a Mumbai suburb and in

Sankara Hospital,¹⁸ one of the main hospitals in which I conducted interviews. Mrin, married and in her late thirties at the time of my research, was born and raised in Mumbai and spoke Marathi, Hindi, and English fluently. As a mother to two school-age children, Mrin illuminated many questions I had about the challenges of educating and raising children in Mumbai, a recurrent topic in many of my interviews with surrogates and egg donors.

Kaveri assisted with interviews with four women in Nadipur and in Sankara Hospital. Also born and raised in Mumbai, Kaveri spoke Marathi, Hindi, and English, and had recently completed her law degree when she started working with me. Single and in her early 20s, Kaveri displayed a keen sensitivity to issues of class and stratification, and her observations of Nadipur and Sankara Hospital shed light on the vast disparities in health access and quality of health care for Mumbaikars of different class status.

Finally, though Vasudha was the first research assistant I met in Mumbai, she translated interviews with only two women. This was unfortunate, as she was a competent and careful translator, however, Vasudha was from Jharkhand (in eastern India) and moved to Mumbai in order to complete her Master's degree in social work. As a result, Vasudha did not speak any Marathi, which was necessary for the majority of my interviews. Vasudha, single and in her mid-20s, assisted in interviews with two women who were native or competent Hindi-speakers; she also provided key research assistance in the early phases of fieldwork, collecting materials and translating Hindi-language media coverage of surrogacy.

I also conducted participant observation throughout the encounters and spaces described above, which included extensive note taking on scenes, interactions, gestures, snippets of conversation, and detailed sketches. Within clinics and hospitals, doctors generally did not

¹⁸ Sankara Hospital is a pseudonym for one of the primary hospitals in Mumbai in which surrogates receive prenatal care and give birth.

permit me to observe clinical practices, consultations, or procedures with patients. However I did spend substantial periods of time in waiting rooms and clinic meeting spaces, waiting for the doctor or anticipating a meeting with a surrogate or parent. Through these visits I became familiar with the staff and activities of the clinic, and these visits served as the springboard for interviews and relationships with participants outside of the clinic.

Participant observation also included accompanying foreign visitors in their hectic travels across the city. For instance, I witnessed a “day in the life” of a traveling foreign egg donor, as she moved from hotel to clinic waiting room to the ultrasound room in which I observed the technician count how many eggs were developing in her ovaries. I also found that much of surrogate women’s medical experience of surrogacy occurs outside the clinic, as I occasionally observed a caretaker administering hormone injections to a surrogate on the floor of her home. Field visits to surrogates’ homes also offered opportunities to participate in activities not only as a researcher, but also as a guest or visitor. Visits to Antara’s home sometimes included an impromptu cooking lesson or an invitation to the wedding celebration of their landlord’s daughter. These experiences generated much insight into the day-to-day lives of women in Nadipur.

In addition to in-depth interviews and participant observation, this dissertation draws on online surrogacy blogs, archival documents, and media debates around pending ART legislation in India. Since 2008 I have monitored more than one hundred online blogs, authored by commissioning parents from all over the world, that explicitly deal with the experience of traveling to India for ARTs in general, and surrogacy in particular. These online journals illustrate the range of legal challenges and constraints that travelers face when seeking ARTs in India, the varied concerns and experiences of intended parents traveling to India, and their

perceptions of biogenetic relatedness in the context of gamete donation and gestational surrogacy across racial or ethnic lines. I also monitored public discourse on surrogacy in India by reviewing local English-language newspapers, television programs, and films.

Data analysis for this project proved to be a challenging task as I culled through the large amount of data collected through fieldwork. Following data collection, I conducted a close reading of interview transcripts and field notes, coding for major themes and discovering points of connection between previously unrelated stories and experiences. One of the greatest challenges was deciding which themes to expand as part of the dissertation, and which to leave out. In the end, I selected themes that seemed both salient in the lives of intended parents and surrogates, and had the potential to contribute more broadly to anthropological discussions about kinship, race, movement, agency, and social stratification.

Finally, it is important to note how my positionality as an Asian-American female anthropologist in the field affected my research. My Indian interlocutors often mistook me, a Filipina-American, for a native of Nepal or the northeastern region of India. Thus, although I was a foreigner in India, many did not view me as “American,” and this sometimes narrowed the perceived social distance between research participants and myself. Indeed, I believe this affected the willingness of some doctors to allow me to visit surrogate housing, which typically was located in areas where foreign researchers were uncommon and conspicuous.

Yet my U.S. nationality also positioned me as something of a curiosity for many participants, particularly the surrogates and their families, who, over time, felt comfortable posing questions about social life in the U.S. Once my interlocutors accepted that I was indeed from the U.S., the conversation often turned to all manner of questions about marriage, family, children, where my parents lived, how I met my husband, and whether he was from the same

caste as I. I should also mention that in many cases, women shared intimate details about their surrogacy experiences that would not have been considered proper to share in male company; thus, my position as a woman, with a female translator, was also advantageous. I also found that many intended parents visiting India welcomed the opportunity to speak with a fellow American or foreigner in the country. Many of these parents had no prior experience traveling in India, and they often appreciated the opportunity to speak with me and share experiences and thoughts about culture shock, life in India, and cross-cultural misunderstandings.

Lastly, I should indicate how my positionality as an anthropologist affected my reception in the field. During the years of my field research, there was a surge in media coverage of surrogacy in India. Thus, many doctors and commissioning parents were wary of speaking to a stranger about their surrogacy experience, as they did not wish to be profiled in any media outlets. I took great care to explain my position as an anthropologist (not a journalist) and I assured all participants that their comments would remain confidential. I also provided copies of consent forms bearing the institutional review board approval stamp for my research, as well as letters from my home institution in the U.S. and host institution in Mumbai. In many cases, I found that these documents convinced participants, particularly doctors and parents, that I was not a journalist, and they subsequently felt more open to share “the whole story” of their experiences with surrogacy.

Profile of Study Participants

As noted above, I collected ethnographic data primarily through participant observation and in-depth interviews with a wide range of actors. Below I will briefly describe the different

groups of actors who participated in this study, providing broad demographic background information on the research participants.

Commissioning Parents: During the course of this research, I conducted interviews with a total of 46 intended parents (representative of 29 couples and two single intended parents)¹⁹ who traveled to India for either IVF or surrogacy. Intended parents who traveled to India solely for IVF were all heterosexual married couples and hailed from Tanzania, Ethiopia, Nigeria, and Myanmar. Intended parents who traveled for gestational surrogacy (with or without egg donation) came from primarily high income countries: 19 intended parents from the United States and nine from Australia, with the remaining parents traveling from Norway, France, Canada, Israel, and the Netherlands (in rare cases, individuals held citizenship in countries other than those in which they lived, e.g., one British national lived in the Netherlands, and sought British citizenship for his children). Of the 39 intended parents (comprising 24 couples and two single individuals) who pursued Indian surrogacy, 19 identified as gay. Of the 26 couples/single individuals who undertook gestational surrogacy, 19 did so with donor eggs. With regard to racial and ethnic background, the majority of parents interviewed identified as white, with the exception of one African American, two Latinos, three Asians, and one of mixed racial background. With the exception of two individuals, all commissioning parents had attended some college or earned at least a Bachelor's degree (see Appendix 1 for chart of characteristics of commissioning parents who used surrogacy).

Here I should note how this sample relates to the broader universe of couples who travel to India for surrogacy. Because surrogacy is unregulated, there is very little reliable statistical data on the numbers of couples who travel to India and from which countries they originate.

¹⁹ I interviewed intended parents under a variety of circumstances: in some instances, I interviewed couples together, while in others, I interviewed only one member of a couple. With the exception of two single males, all intended parents were either married or in a live-in, committed relationship.

Most of the statistics available address numbers of Australian couples traveling to India, and a survey conducted by Surrogacy Australia, a not-for-profit agency, found that in 2012, 200 babies were born via surrogacy in India for Australian couples, compared with 179 in 2011 and 86 in 2010 (Arjunpuri 2013). Another report claims that approximately 250 babies are born each year via surrogacy in India for Australian commissioning parents (with 40 born in Thailand, a growing surrogacy market, and 35 in the U.S.) (Miller 2013). These figures could be even higher, however, as Immigration Department statistics show that the number of babies born to Australian citizens in India jumped from 170 in 2008 to 394 in 2012. While it is difficult to know precisely how many of those children were born via surrogacy, the number of Australians living in India has not risen significantly in the same time period (Whitelaw 2012). Meanwhile, different media reports suggest that approximately half of overseas commissioning parents contracting with Indian surrogates are Australian (Arjunpuri 2013), contradicting reports claiming that Britain sends the highest numbers of people seeking surrogacy services in India, accounting for as many as 1,000 births in India (Bhatia 2012). In a study recently published in the *Journal of Social Welfare and Family Law*, researchers found that increasing numbers of couples from the United Kingdom register children to foreign surrogates (Crawshaw, et al. 2012). With respect to U.S. commissioning parents, media reports offer mostly vague statements regarding “hundreds of Americans” who travel to India each year for surrogacy (Williams 2013a; Williams 2013b). Clearly, reliable statistics are hard to come by, and what numbers are available are mainly found in journalistic sources, and difficult to verify.

Given the lack of statistical data, it would be challenging to analyze to what extent my sample reflects the broader universe of individuals seeking surrogacy services in India. However, the available statistics suggest that most commissioning parents travel from Australia, the UK,

and the U.S. My sample is not representative of this trend; because I relied partially on introductions through personal networks, my sample includes primarily Western participants, with most of the participants hailing from the U.S. or Australia.²⁰ However, the sample is varied enough to reflect the range of experiences of commissioning parents from different countries, and based on my interviews with doctors, I found that this sample nonetheless broadly reflects the population of people traveling to India for ARTs, particularly gestational surrogacy. Doctors in Mumbai clinics reported that most of their clients seeking surrogacy services came from abroad, and while some doctors claim growing numbers of Indians and non-resident Indians are seeking gestational surrogacy, I encountered none in my fieldwork. This is due in part to the high cost of surrogacy; while the costs of surrogacy are comparatively lower for foreign clients (particularly in comparison with costs in the U.S.), they remain quite high for local Indians. Moreover, according to the doctors I interviewed, Indians who did have the means to pursue surrogacy preferred to keep surrogacy matters private, in part due to the stigma that continues to swirl around surrogacy (though some doctors claim the stigma is receding due to the increase in media exposure on the topic). In contrast, many of the international parents I interviewed were remarkably open with their family and friends about their surrogacy experiences.

Similarly, very little data exists regarding the numbers of same-sex couples seeking surrogacy in India. One journalistic source claims that 30 to 40 percent of Australians seeking surrogacy overseas are gay (Miller 2013). The Mumbai clinics in which I conducted research tended to attract and actively market their services to primarily foreign clients and especially gay male clients (in contrast to clinics that restricted ART services to heterosexual married couples), accounting, in part, for the large proportion of gay clients in my sample.

²⁰ Rather than focus on a single nationality, I aimed to recruit commissioning parents from a diversity of countries and nationalities in order to illustrate the range of motivations and experiences of individuals seeking ARTs in India.

Finally, I should note that my sample reflects a higher proportion of parents who are successful in having children through surrogacy in India. In this study, of the 26 couples/individuals interviewed, 21 had one or more babies through surrogacy in India. However, pregnancy rates with IVF hover around 30 percent, thus, my sample is not representative of the majority of couples who travel to India and are ultimately unsuccessful in their attempts. Rather, this dissertation primarily examines the experiences of the minority of commissioning parents who have successfully reached the goal of a “take-home baby” through gestational surrogacy.

Parents cited a wide range of reasons for pursuing ARTs in India. For many intended parents, traveling to India was only one step in a long history of fertility treatments and miscarriages for infertile couples, or disappointments for gay couples who had sought a child through adoption or foster care. Still others came to India after repeated attempts at surrogacy in other countries, including the United States. I will discuss specific cases in more detail throughout this dissertation, but I found that motivations for traveling to India depend largely on the country of origin and background of the client. These motivating factors, broadly speaking, include: cost of services, legal constraints (in which commercial surrogacy might be tightly regulated or illegal), availability of services in home country, and discriminatory practices (in which practitioners deny services to certain groups of people based on age, marital status, or sexual orientation). Of the 39 commissioning parents interviewed in this study, only 9 individuals explicitly mentioned a desire to have a genetically related child as a reason for pursuing surrogacy in India. Instead, the majority of intended parents framed surrogacy as a

method of “last resort” for infertile couples who were unable to pursue other strategies for family-building such as adoption.²¹

Surrogates and Egg Donors: In this study, I interviewed 35 Indian women who were surrogate mothers and/or egg donors, including six agent/caretakers (see Appendix 2 for chart of characteristics of surrogates and egg donors involved in surrogacy). I was able to speak with many of these women several times during the course of their experiences with surrogacy. I also gathered observations from women who were at distinct points in the process of surrogacy: I interviewed eight women who were in the preparatory stages for embryo transfer, 15 who were pregnant at some point during my fieldwork, four who were former surrogates, and four who underwent embryo transfer but did not become pregnant. I also interviewed four women who were egg donors and/or caretakers only. Women’s encounters with ARTs indicated the varied ways in which they become entrenched in the industry; often, women held simultaneous positions as surrogate or egg donor and agent/caretaker. That is, participation in one area (surrogacy, egg donation, or caretaker work) often led to further work in another area.

Women came from primarily low-income families, and most pursued surrogacy as a solution to their financial hardships such as debts or lack of housing. The majority of the women (29) were married, with the exception of three widows, two divorced women, and one unmarried woman. All of the women had previously given birth, with the exception of one childless woman. Women completed varying levels of education, from primary school to high school. Nearly all of the women identified as housewives, and those who worked outside of the home typically did domestic work, factory work, or work in the garment industry. With regard to

²¹ The reasons for rejecting adoption as an option varied depending on the home country of the intended parents. Typically these couples claimed they were unable to pursue adoption for various reasons, including: medical histories that precluded them from being selected as “fit” parents; advanced age; a decreasing number of domestic adoptions available in the home country; discrimination against same-sex couples; and the long waits and bureaucratic processes associated with international adoption.

religious background, most participants identified as Hindu or Buddhist, with several women identifying as Christian or Muslim.

Figure 1. Interior of a surrogate's home



Prachi, one of the author's translators, poses next to photos of Buddha and Dr. B. R. Ambedkar in a surrogate's home. Photograph by author.

Caste remains a sensitive issue in India and I followed my translator's cues as to whether and when it was appropriate to discuss. In most cases, it was considered an inappropriate and sensitive topic, so we did not include caste in our list of background questions for women. Religion, however, was a somewhat less sensitive question than caste, so I was able to discern to some degree women's caste and class background through their religious background, particularly for women who identified as Buddhist converts. Many of these families continued to practice Hindu rituals and they often identified as "Hindu Buddhist," and I noted that some women had framed photos of Dr. B. R. Ambedkar in their homes, indicating Dalit, or low caste

status (see Figure 1).²² As one of my translators informed me, these are clear signs of caste and class background, and are significant with respect to notions of caste and substance in the world of ARTs. Though only 10 out of 35 women (less than 30 percent) identified as Buddhist (suggesting Dalit status), several of my translators believed that the proportion of Dalit women in this study was significantly higher. While most foreign clients expressed no preference regarding caste in egg donation or surrogacy, caste remains an implicit organizing criterion within assisted reproduction in India. Indeed, Indian consumers of ARTs frequently take into account caste background in their decisions regarding gamete donation and surrogacy (Rai 2010; Tewary 2012). As I will discuss further in Chapter 3, Indian doctors influenced the ways in which certain women participated in assisted reproduction; while some women could be both egg donors and surrogates, they were typically from a lower caste or class. Women who were higher caste, on the other hand, could donate eggs but rarely became surrogates.²³

When asked their reasons for wanting to become a surrogate or egg donor, all women reported financial need as their primary motivation. In general, women commented that they needed funds to pay for their children's education, housing, debts, or their daughter's marriage (indicating that the dowry practice, though illegal, continues in practice). However, it is important to note that while all cited need for income, women represented a diversity of class backgrounds. The women came from mostly working class and middle class families, with few in dire poverty. Visits to women's homes confirmed the diverse class backgrounds of women in my study, as I noted the wide differences in housing and living arrangements. In one example, my translator noted that while making plans to visit a surrogate and her family, the surrogate's

²² Dr. B. R. Ambedkar, a leader of the Dalit movement, called for the conversion of Dalits to Buddhism, as an act of rejection of the caste-based system that considered them at the lowest position of the hierarchy.

²³ The foundational work of Marriott (1976) and Dumont (1980[1970]) theorizes notions of substance, purity, and pollution in relation to the caste system in India. This work contextualizes the ways in which women of different caste and class backgrounds participate as egg donors or surrogates in the ART industry.

husband inadvertently texted a shopping list intended for the local provisions store, instead of the directions we needed to travel to their home. The list included items such as brand-name household supplies and chocolate malt drink mixes, “items we would buy ourselves,” my translator commented, indicating that the family was closer to middle class status than working class.

Doctors: I interviewed a total of 21 doctors in 16 clinics over the course of my research, including: 17 doctors representing 14 clinics in Mumbai, two doctors in one clinic in Anand, and two doctors in one clinic in Delhi. While I conducted many first-time and follow-up interviews with these doctors throughout my research, I carried out more focused research with doctors in four Mumbai clinics in 2010. All but one of the doctors spoke fluent English and most had received some medical training abroad, either in the U.K. or U.S. Of these doctors, ten were male and eleven were female, representing a fairly even gender balance. The doctors in this study represent a range of specialties, and include reproductive endocrinologists, psychologists, obstetricians, gynecologists, and occupational health physicians.

As with other aspects of assisted reproduction in India, there is no systematic data available on clinic practices or the number of clinics throughout the country. The Indian Society for Assisted Reproduction (ISAR) boasts more than 600 members, and there are over 350 member IVF clinics in India with several centers dedicated to commercial surrogacy. However, not all operating clinics are ISAR members, and Dr. R.S. Sharma of the ICMR estimates there are 700 to 800 IVF clinics across the country (Outlook India 2009), while the National Commission for Women, on the other hand, suggests approximately 3,000 clinics are in operation (Kannan 2009). Within this context, it is difficult to situate the clinics in which I conducted research, however, while many IVF clinics cater to the Indian and non-resident Indian

(NRI) population, the clinics in my sample that offered surrogacy services attracted primarily foreign clients. One doctor I interviewed estimated that approximately 80 percent of her surrogacy clients traveled from abroad, while another estimated he received around 15 to 20 couples per month, primarily from abroad. Indeed, all the doctors in this study who offered surrogacy services indicated that most of their surrogacy clients came from abroad (while IVF clients tended to be Indian). Moreover, as mentioned above, doctors in these clinics welcomed gay clients (while others refused services to same-sex couples), thus affecting the sample of commissioning parents in this study.

Other Actors: Finally, there were a number of people whom I interviewed that do not fit neatly into the groups described above, but occupy an important role in the surrogacy industry in India. These include traveling egg donors from South Africa, ART legal experts, medical tourism agents and brokers, and American adjudicators involved in processing citizenship requests for babies born outside the United States.

The “Island of Good Life”

In order to situate the experiences of the participants described above, it is important to introduce the sites in which I conducted fieldwork, particularly Mumbai and Nadipur. While Chapter 1 discusses in more detail the ways in which India’s history of public health influenced the country’s emergence as a global destination for consumers of ARTs and transnational surrogacy services, here I wish to provide broader historical, political, and demographic context on India. This background informs the narratives of the participants I discuss in the chapters to come, illuminating the ways in which Mumbai’s particular social, cultural, and historical

contexts influence the growth of the country's surrogacy industry, as well as how actors comprehend their experiences with reproductive tourism in India.

It makes sense to begin by briefly describing the broader context of Mumbai and its history of colonization. In May 1498, Vasco de Gama landed in Calicut (now in Kerala) seeking spices and Christians. Though the ruler, the zamorin of Calicut, rebuffed him, Gama returned for two more voyages, initiating the era of European conquest and trade. In 1502, the Portuguese empire established the first trading post at Kollam, Kerala, and throughout the early 16th century, continued to establish a chain of outposts on the island of Ceylon and along the west coast of India, including Goa and Bombay (now Mumbai). In Bombay, which then comprised seven separate islands, people lived by fishing, trading, and rice and coconut farming. They worshipped a number of different goddesses, including Mumba, the goddess who inspired the names Bombay and Mumbai. The islands were filled with lush groves and the Portuguese called the island *a ilha da boa vida*, or the island of good life.

In 1661, the Portuguese gifted Bombay as a dowry to the English when Catherine of Braganza married Charles II. Seven years later, the Crown leased Bombay to the East India Company, opening a new chapter in Bombay's colonial history—its expansion as a port city. Under the British, Bombay acquired a reputation as a city of commerce, a dynamic center of trading and banking operated by merchants of different communities. It is an apt reputation that rings true even today; in any bazaar in the city, one will find a variety of communities and castes readily transacting business. The British cultivated the town as a commercial center by inviting Gujarati merchants to migrate to their settlement; among these, the most prominent were the Parsis. Hindu, Jain, and Muslim merchants from various communities in Gujarat quickly followed, all attracted to the opportunities that the new colonial settlement offered.

While Bombay swelled with the influx of immigrants, it became a major trading town by the middle of the 19th century. However, conditions for Indian merchants were changing as British managing agencies, profiting from official patronage and access to international finance networks, eclipsed indigenous merchants. Indian merchants, ever resourceful, turned to cotton mills. While Parsi merchants began exporting cotton to Lancashire in the early 19th century, the boom in cotton trade would come in the 1860s in response to the American Civil War. Suffering from a shortage of cotton supplies from America, England turned to Indian cotton. This sudden turn boosted the city's economy, and between 1854 and 1875, the number of cotton-spinning mills in the city grew from one to 28. Two decades later there were 70 mills employing nearly 76,000 workers, and by 1925, there were 82 mills with 148,000 workers (Chandavarkar 1994: 250).

With the development of the cotton industry in Bombay, thousands of migrants from around the country flocked to the city and by the early 20th century, the city's population was nearly a million, of whom only a quarter were born in the city. Religious and linguistic diversity characterized this immigrant population; in 1901, Hindus were dominant, constituting 65 percent of the population, followed by Muslims (20 percent) and smaller percentages of Christians, Zoroastrians, Jains, and Jews. Slightly more than half of the population spoke Marathi, 27 percent Gujarati, followed by 15 percent Hindi and Urdu speakers. This dazzling array of communities and languages imparted a sense of openness and promise to the city, and Bombay teemed with industrialists, merchants, bankers, brokers, shipping agents, shopkeepers, artisans, clerks, mill hands, dockworkers, and casual laborers (Prakash 2010a: 43).

As Bombay underwent its rise as a hub of colonial trade and industry, India witnessed a rise in organized movements for independence. In 1885, 73 Indian delegates met in Bombay and

founded the Indian National Congress, and the city became a strong base for the independence movement in the 20th century. At its inception, however, the Congress had no well-defined ideology and was comprised mainly of western-educated urban elites. Congressmen saw themselves as loyal to the British Raj, but wanted an active role in developing their own country; in the early part of the 20th century, the independence movement was an elitist movement unconcerned with the masses of India. This changed with the return of Mohandas Gandhi to India in 1915, and in 1920, Gandhi encouraged Congress leaders to start a non-cooperation movement in support of self-rule. During this same era, a new generation of Indians within the Congress Party would emerge as the prominent voices of the Indian independence movement, including Jawarharlal Nehru, Vallabhbhai Patel, and Subhas Chandra Bose. From the 1920s onwards, the independence movement saw Congress adopt Gandhi's policy of nonviolence and civil resistance, and Muhammad Ali Jinnah's (leader of the All-India Muslim League) struggle for the rights of minorities in India. Finally, on June 3, 1947, Viscount Louis Mountbatten, the last British Governor-General of India, announced the partitioning of British India into India and Pakistan. Barely two months later, Pakistan was declared a separate nation just before midnight on August 14, 1947; India became an independent nation just after midnight on August 15, 1947.

The partition of India caused one of the largest population movements in history, as Hindus, Muslims, and Sikhs crossed newly drawn borders to reach their new homelands. In the space of a few months, approximately twelve million people moved between the new, truncated India and East and West Pakistan. The largest proportion of refugees—more than ten million—crossed the western border, which divided the state of Punjab, with Muslims traveling west to Pakistan, and Hindus and Sikhs east to India. It also prompted a wave of communal violence, in which approximately one million people died. There was widespread sexual violence:

approximately 75,000 women were abducted and raped by men of religions different than their own, and indeed, by men of shared religious background (Butalia 2000).

Bombay, however, escaped the bulk of this violence that affected the state of Punjab the most. Yet, in the 1960s, the rise of regionalist politics in the city would set the stage for some of the most violent communal clashes in the country since Partition. In 1966, the Shiv Sena party emerged out of a feeling of resentment about the relative lack of power of the native Marathi people in Bombay. The Bal Thackeray-led party expressed their discontent in nativist, anti-immigrant terms, and rose to power in alliance with the Hindu nationalist Bharatiya Janata Party (BJP) in the 1980s. Many blame the rise of Hindu nationalism and regionalism for the rise in communal tensions in the city, culminating in the Hindu-Muslim riots of 1992-93, in which approximately 900 people died. The riots were followed by ten bomb blasts on March 12, 1993, in which more than 300 people perished (Prakash 2010a: 299-300). For a metropolis that prided itself on its cultural diversity, the communal violence and explosions left many wondering if Bombay's cosmopolitanism had been just a façade. When the Shiv Sena-led government officially renamed Bombay Mumbai in 1995, the new title seemed to formalize the transformation that had already taken place.

Figure 2. Map of India



Source: New York Times

Today, the city of Mumbai, the capital city in the state of Maharashtra, remains home to a remarkably diverse population. Located on the west coast of India (see Figure 2), the island city's position as the hub of manufacturing, trade, finance, advertising, media, and the film industry continues to draw people from all over India. They speak distinct languages—Marathi, Gujarati, Hindi, Urdu, Tamil, Malayalam, Bengali, English—and observe different faiths—Hinduism, Islam, Christianity, Jainism, Judaism, Zoroastrianism. Clearly, despite the presence of regionalist politics and communalism, the metropolis remains among the most culturally diverse in India, and its residents widely tout Mumbai as the most cosmopolitan and “modern” city in India.

Figure 3. Map of Greater Mumbai



Source: Wikimedia Commons

Greater Mumbai, which includes Mumbai city and its suburbs (see Figure 3), boasts a population of just under 12.5 million, making it the largest city in the country and the fourth most populous in the world. It is also the wealthiest city in India, with a per capita income of Rs. 125,000 (approximately US\$2,736), Rs. 8,000 (US\$175) higher than Delhi (Lewis 2011). Yet despite its healthy economy and its reputation as a “modern” city, the sex ratio in Mumbai illustrates a sobering reality for women and girls. Some experts blame the low sex ratio, the lowest in Maharashtra at 838 women per 1,000 men (which is lower than the national average of 940), on the large number of male migrants to the city. Others, however, caution that Mumbai’s position as a financial hub may actually exacerbate the imbalance. Women’s activist Sonya Gill says, “With affluence and medical technological advances, comes the power to determine sex. While people are driven in the economic race, they don’t bother about socio-ethical aspects such

as sex selection. People want a smaller family, which inadvertently becomes boy-oriented following myths that ‘he’ earns while ‘she’ is a burden” (Times News Network 2011).

Moreover, while the city is home to some of the wealthiest Indians (among its more famous residents is Mukesh Ambani, as of 2013 India’s wealthiest man and the second wealthiest in Asia), it also contains some of the country’s poorest residents, and Mumbai holds the dubious distinction of being home to Dharavi, “Asia’s largest slum.” However, a 2010 report by the Asian Development Bank lauds the rise of the Indian middle class and projects it as the engine of economic growth (Asian Development Bank 2010: 10-11). The report defines the middle class as those earning between \$2 and \$20 per day (adjusted for purchasing power parity, with \$1 PPP equal to Rs. 17.256) and splits the middle class into three subsections: lower middle class (\$2-\$4), middle (\$4-\$10), and upper middle (\$10-\$20). But according to the definition used in the report, the majority of this middle class (82 percent, or 224 million people) fit into the first category, earning between Rs. 1,000 and Rs. 2,000 per person per month (Shrinivasan 2010). While these figures correspond to the country as a whole (not Mumbai, which has a higher per capita income than the nation’s average) and indicate income per person (as opposed to per household), they are useful to contextualize the data gathered in this study, which indicate that average monthly household income for surrogates, egg donors, and agent/caretakers is approximately Rs. 7,274 (US\$159, not adjusted for PPP).

Metropolitan Region, which has a population of more than 18 million and includes the cities of Ambernath, Badlapur, Kalyan-Dombivali, Mira-Bhayander, Mumbai, Navi Mumbai, Thane, and Ulhasnagar (see Figure 4). According to the 2011 Census, Nadipur has a population of more than 500,000, with males comprising 53 percent of the population and females 47 percent. Nadipur is reachable by road or by Mumbai’s suburban railway system, which is how my assistants and I would travel to conduct interviews. From central Mumbai, the train journey takes approximately one and a half hours.

Figure 5. View from surrogate’s home, “Nadipur”



Photograph by author

Nadipur is an industrial area, known as a hub of the garment industry in which many Western clothing brands are copied. However, parts of the city have a village-like feel; indeed, I often looked forward to my trips to Nadipur, as they were opportunities to leave behind the chaos and crowds of Mumbai, offering rare glimpses of, to put it simply, open space. Upon arrival at

the train station, commuters are once again greeted with bustling crowds, as the area immediately surrounding the station is lined with shops and auto-rickshaws. However, beyond the station, the city is organized according to village names and numbers, and the smaller neighborhoods in which some of my interviewees lived offered clear views of the Haji Malang Mountains in the distance.

Outline of Chapters

The chapters in this dissertation explore transnational surrogacy through several theoretical frameworks and from the perspective of the range of actors involved. Broadly speaking, Chapter 1 provides the historical and political economic context of surrogacy in India, while Chapters 2 and 3 explore the making of kinship, particularly from the perspective of commissioning parents. Chapters 4 and 5 examine more closely the experiences of surrogates, analyzing women's movement and mobility through a geographical lens, and women's modes of agency and resistance in surrogacy. Chapter 6 returns to the narratives of commissioning parents, analyzing the role of kinship and family in their efforts to obtain citizenship for their children born through surrogacy.

Chapter 1 traces the history and context of global medical travel for ARTs in India. I outline the emergence of India as a global surrogacy destination within a broader discussion of public health, assisted reproduction, and medical tourism. I then examine the political economy of medical and reproductive travel in India, including a discussion of ART laws and regulation in order to show how India emerged as a key destination for travelers seeking ARTs. By critically examining the political economic contexts of reproductive tourism, I consider the practice as a “nationally based assemblage” (Ong and Collier 2005) that mobilizes domestic resources to

negotiate relations among capital, states, bodies, and medicine. Finally, I contextualize the practice of surrogacy in India, describing the range of clinics and surrogacy practices. My goal in this chapter is to investigate the context of reproductive tourism “on the ground” in India, demonstrating how the political economy of medical tourism produces certain practices that shore up national capacities in a global marketplace, while reinforcing stratified reproduction.

Chapter 2 examines how intended parents create and make sense of their relations with surrogates, egg donors, and the children born through surrogacy. How do intended parents narrate their family’s origin stories? How and to what extent do these stories build on and reproduce relations of stratified reproduction? I explore how narratives about the kinship origins of families created through transnational surrogacy highlight uneven relations of class and nation, a source of tension among many intended parents uncomfortable with the commercial aspects of surrogacy. I found that intended parents employ various strategies to resolve these tensions, including: relying on rescue narratives that describe surrogacy as a “win-win situation”, and invoking essentialized, one-dimensional pictures of the surrogate as a saint or mother. I argue that these strategies effectively gloss over the more complex stories of inequality that mark transnational surrogacy as a form of stratified reproduction.

In Chapter 3 I explore constructions of race in the process of transnational egg donation through analysis of intended parents’ narratives about the experience of selecting an egg donor. I show how egg donors of different race, class, and national backgrounds are differently valued, compensated, and treated, reflecting and reinforcing social hierarchies. At the same time, I show the diversity of ways that intended parents approach race and skin tone when choosing an egg donor; I find that in contrast to dominant assumptions that intended parents seek donors who match their own racial/ethnic backgrounds, the process of egg donation represented an

opportunity for many intended parents to subvert racial hierarchies by selecting Indian donors with darker skin tones. I argue that such narratives, however, rely on essentialized notions of race and beauty that exoticize Indian women and reflect new articulations of biological race.

Chapter 4 explores the intersections of power within transnational surrogacy in India, using the lens of geography to examine surrogate women's and commissioning parents' experiences and perceptions of space and mobility. By analyzing ethnographic data within geographical framework, this chapter sheds light on the ways in which social and structural inequalities are deeply implicated in global processes of reproduction, demonstrating how geographical analyses broaden our understanding of stratified reproduction in complex and contradictory ways. This chapter traces how both surrogates and commissioning parents experience moments of mobility and movement punctuated by intervals of immobility and stillness, in distinct ways that reveal the power relations inherent in transnational reproduction.

Chapter 5 outlines the complexities of agency, constraint, and inequality in the lives of women who become surrogates in India. I contrast the stories of women whose personal narratives buttress the point that the global surrogacy industry reinforces a broader stratification of reproduction. Concurrently, I show how women resist dominant constructions of surrogates as powerless victims, and I argue that in expressing forms of resistance and agency, women find ways to challenge everyday gender norms and create new opportunities for themselves and their families, albeit within larger structures of power. I also critically examine the roles of women who act as intermediary agents, showing how the creation of intermediary positions reinforces the increasingly refined hierarchies inherent in transnational surrogacy. By revealing the many ways that women enact agency, however limited, I highlight the subtleties of intra-class social

divisions transnational surrogacy engenders, and illustrate how women both exert power and are subject to it.

Finally, Chapter 6 examines the ways in which notions of citizenship and nationality intersect with ideas of kinship and family in the context of transnational surrogacy. With increasing numbers of people traveling from other countries to India in order to commission surrogate pregnancies, there have been several cases of parents unable to obtain citizenship for their children born in India. This chapter explores what happens when incompatible national legal frameworks, policies about surrogacy, and practices of assigning citizenship intersect in the context of transnational surrogacy in India. I focus the citizenship process in two countries that illustrate the range of approaches to transmission of citizenship: the U.S. and Norway. In particular, I analyze how ideas about nationhood, citizenship, family, and motherhood take on new meanings through transnational surrogacy processes.

The conclusion briefly summarizes the themes discussed in the preceding chapters, offers directions for future research, and considers the implications of this research for ongoing bioethical and policy debates surrounding reproductive tourism in India and beyond.

Taken together, these chapters traverse a range of literatures and engage with various anthropological debates. As I demonstrate in the dissertation, transnational surrogacy reveals the ways in which reproductive parts and processes become alienable and commodified in the global reproductive market, and its impacts for notions of kinship, agency, and inequality. With the increasing fragmentation and commodification of reproduction, actors must turn to new strategies to make sense of family, kinship, and intimacy in the global context of ARTs. This dissertation describes the ways in which reproductive actors who participate in transnational surrogacy arrangements make sense of kinship and family, arguing that commissioning parents'

strategies of “misrecognition” ultimately serve to reinforce patterns of stratified reproduction.

Though this study began with an interest in broad transnational processes, it is the specific location of India that reveals the far-reaching impacts of neoliberalism and transnationalism.

Indeed, this particular research could not have emerged in any other place or moment, and it is the sociocultural, political, and historical contexts of India that, I argue, make possible the kinds of transnational relationships I describe in the chapters to come.

CHAPTER ONE

The Emergence of the Market in Wombs and Eggs:

Assisted Reproduction in India

Jan Marks was thirty-seven years old when she first met her husband, Stephen, in 2005. Two years later, Jan and Stephen were married and in the midst of expanding their home from two to five bedrooms; already a step-mother to her husband's sons from a previous marriage, Jan treasured her family and was eager to fill their home with two more children of her own. Aware of the difficulties women of her "advanced age" face in getting pregnant, the Australian couple immediately began trying to have children. After several years of multiple miscarriages and attempts at IVF, Jan learned that she had a bicornuate uterus, commonly referred to as a "heart-shaped" uterus, and that it was very unlikely that she would ever be able to gestate and give birth to a child of her own. Moreover, she learned that if they decided to continue pursuing parenthood through surrogacy, they would have to do so with donor eggs, as her own eggs were no longer a viable option.

Jan was devastated by this news but undeterred in her desire to become a parent. She turned next to adoption, but quickly realized that domestic adoption was "completely out" for them; in their native Australia, she explained, "we don't have adoption agencies that are private—and nobody adopts." Given the low rate of domestic adoption, they considered international adoption, yet grew disheartened when they learned of the long waiting periods and additional barriers due to their age and marital histories:

There are very few domestic adoptions, so we looked at intercountry adoption. And because we had both been married before, our choice was narrowed down to one country. We don't have a good intercountry adoption system here and there are so, so many people wanting to adopt overseas. In our state, there were fifty couples inquiring every

six months. To even get to the first waiting list, it was going to take eighteen months to get to the first interview. If we were successful, if we were allowed to even get into the program, it would have been seven years. And because I was thirty-nine at that stage, they basically said to me, ‘No chance!’

At this point, they briefly considered fostering, but quickly decided that fostering was not a good “fit” for them:

One of the questions we were asked was, ‘Are you entering into fostering with the hope of having a child come to live with you?’ And I could honestly not answer ‘no’ to that because my intentions were that I would hope that I would have the child because I wanted to be a mother. And then we found out that a child would be taken away from us eventually and we’d be told not to have any contact with that child who had been with us—and emotionally we couldn’t do that.

In 2008, believing they had exhausted all of their options for expanding their family, Jan and her husband began to consider surrogacy with egg donation. While altruistic surrogacy—in which a surrogate is paid only for expenses incurred—is legal in Australia, commercial surrogacy—in which surrogates receive financial compensation—is considered a criminal offense. Knowing that there are very few cases of altruistic surrogacy in Australia, Jan looked to the United States, as she had not yet learned about surrogacy in India. Jan and Stephen were not exceptionally wealthy, but both were educated professionals, and while the surrogacy fees in the U.S. were prohibitive for most parents in my study (often costing upwards of US\$80-150,000), Jan and Stephen were financially stable and keen to begin the process. They sold everything except their house, paid off most of their mortgage, and were ready to proceed.

Then, as the economic crisis of 2008 erupted, they realized their costs had grown well beyond their surrogacy budget. With surrogacy in the U.S. now out of reach, Jan cancelled their plans, continued to do more research, and discovered surrogacy in India. Though her initial reaction was of denial and disbelief—Jan’s first thought was, “No way in the world are we going all the way there and plucking poor Indian women out of the slums for surrogacy!”—she

discovered online support forums and blogs that shared successful stories of parents returning home from India with babies born through surrogacy. Eventually, Jan and her husband thought, “If these people can do it, so can we,” and they booked their first trip to India in 2008. Over the next two years, Jan and Stephen would make three more trips to India in order to attend two different clinics in Mumbai and Delhi before they would finally welcome their son, James Alok, into the world in 2010.

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As Jan and Stephen pursued their path to parenthood, another family in Mumbai struggled with dreams of financial stability and someday owning their own home. Twenty-nine-year-old Karishma was married and had two daughters, aged seven and three. She and her husband, Rajan, had both completed high school. While Rajan worked in the hospitality industry after completing a diploma in hotel management, Karishma described herself as a “housewife,” though she had also previously studied nursing and had worked as an auxiliary nurse midwife. Yet, after the birth of her children, she said, “I had to think about who would take care of them,” and she decided to stop working in order to care for her children.

Though Rajan could sometimes earn a monthly salary of up to US\$650, the family’s finances were unstable. Rajan was in the process of starting his own hospitality consulting business with several colleagues, and did not have a steady income. Karishma wanted to help her husband support the family, and suggested that she might earn money as an egg donor or surrogate, which she learned about from Rajan’s sister, herself a former surrogate. Explaining his reaction, Rajan says, “I was against it then, but there were some financial messes. Checks were bouncing, and we were in need, so she said she wanted to contribute and help.” Karishma, too, initially was somewhat uncertain, saying, “I kept wondering how such things [conception

through egg donation or surrogacy] could happen.” But eventually, she realized, “By doing this, we are getting some financial help. And there is no other place where such immediate financial help is available.”

While Rajan was out of town for work, Karishma decided she would sell her eggs in exchange for approximately US\$260. She returned to sell a second time at a different clinic, earning the same amount of money. When she wanted to sell her eggs a third time, however, her doctor, Dr. Singh, suggested that she become a surrogate. As Karishma explained, “The doctor said that donors were not needed; surrogates were needed. ‘Don’t do donation now,’ she said.” Talking it over with Rajan, they decided to move forward with surrogacy: “We thought that if we got good money, we could add to our earlier savings and buy a house.”

In the end, Karishma attempted to become pregnant as a gestational surrogate twice; embryos made from the intended father’s sperm and an anonymous donor’s eggs were transferred to Karishma’s uterus. In both attempts, the client was a Russian man named Seth, whom Karishma met once, briefly. The first attempt ended in miscarriage early in the pregnancy, and the second attempt did not result in pregnancy. She earned about US\$220 for undergoing embryo transfer at each attempt, and the family ended up with little savings. Rajan explained that both times, the couple had to commute long distances and keep both children in day care during Karishma’s hospital stay—fifteen days following each embryo transfer. The costs of travel and childcare consumed a substantial portion of her earnings.

Karishma also described the surrogacy process, which included multiple injections of hormonal treatments over a period of weeks, as physically painful. Karishma explained:

During the process, surrogate mothers alone face the problems. The injections, which you take for about 15-20 days are very painful. We can’t sit; we can’t sleep on one side. There are a lot of cramps after the injections...I took forty injections the first time, which

went on for about two to three months. It failed. There was so much pain. The second time I took 15-20 injections and again there was so much pain.

Furthermore, she was disappointed and disillusioned with the treatment she received from Dr. Singh, who, as I will describe later in this chapter, Karishma believed did not fully inform her of policy changes that would affect her payment. However, when asked if she would ever try becoming a surrogate again, she replied that she would consider surrogacy with a different doctor, telling me, “You go to other hospitals [for your research]. If you hear of a good offer, let me know.”

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For several reasons, I began this chapter by juxtaposing two very different stories—that of a well-off Australian couple pursuing parenthood through Indian surrogacy and a struggling middle-class Indian family that turned to surrogacy and egg donation as a temporary solution to financial hardship. On the one hand, Jan’s story, like those of many parents I interviewed in the course of this research, illustrates the ways in which parents eventually reach the decision to pursue surrogacy in India. Indeed, couples did not reach these decisions easily, and many were initially quite resistant to the idea of surrogacy in India, as was Jan. For many parents, the decision to pursue surrogacy is a difficult one, a decision that often follows long histories of infertility and financial loss, and elucidates the range of ethical, moral, financial, and physical challenges at stake. In Jan’s case, their surrogacy journey included several IVF attempts and miscarriages, explorations into international adoption and fostering, significant financial losses from failed surrogacy plans in the US, and finally, several surrogacy attempts in two different clinics and cities in India. While the parents’ stories uncover a range of motivations and personal histories with infertility and reproductive disruptions, how did they all end up journeying to India to hire gestational surrogates?

At the same time, Karishma and Rajan's story mirrored that of many families who felt ambivalent about surrogacy or egg donation, but pursued it anyway because of financial need. Though both had concerns about the process and Karishma had strong complaints about the physical toll egg donation and surrogacy took on her body, Karishma remained interested in the prospect of becoming a surrogate, with hopes of meeting a new doctor who would pay more. What motivates so many women like Karishma to become egg donors and/or surrogates?

As commissioning parents and surrogates narrate complicated reproductive and personal histories, this chapter asks how India in particular emerged as a surrogacy destination for foreign prospective parents seeking babies and Indian women seeking income. What is the constellation of contexts that makes surrogacy in India possible, for both infertile couples pursuing parenthood and women seeking to become surrogates or egg donors? When and why did India surface as a leader in reproductive tourism?

In this chapter I address these questions by tracing the history and context of global medical travel for assisted reproduction in India. I treat three topics: changes in health care accessibility for Indians, the rise of reproductive tourism, and efforts to regulate assisted reproduction in India. I place in historical context the emergence of India as a global surrogacy destination within a broader discussion of public health, assisted reproduction and medical tourism, showing how the shift in health care priorities from primary health care to high-tech solutions set the stage for the growth of reproductive tourism in India. I then analyze the political economy of medical and reproductive travel in India, examining ART laws and regulation in order to show how India emerged as a key destination for travelers seeking ARTs. By investigating the political economic contexts of reproductive tourism, I consider the practice as a "nationally based assemblage" (Ong and Collier 2005; Wilson 2010) that, following Wilson's

examination of medical tourism in Thailand (2011), mobilizes domestic resources to negotiate relations among capital, states, bodies, and medicine.

My second goal in this chapter is to point to the practices and practicalities that are integral to the experience of reproductive tourism in India. As many intended parents explained to me, one of the most challenging aspects of surrogacy in India is the complex coordination of multiple reproductive actors, including doctors, surrogates, and egg donors. For intended parents, surrogates, and egg donors, the surrogacy journey includes numerous attempts, negative test results, and miscarriages. Commissioning parents also make multiple trips to India, though surrogate women, too, may travel long distances from their homes to reach clinics in the city. As intended parents, surrogates, and egg donors navigate the process of transnational baby making, what is the range of practices that Indian clinics make available to international consumers of assisted reproductive technology? How do these same clinics approach their work with Indian women hoping to become surrogates? As surrogacy relationships are facilitated across transnational spaces through Skype, email, phone, and the Internet, what is the context of surrogacy “on the ground” in India?

Thus, this chapter also contextualizes the practice of surrogacy in India, describing the range of clinics and surrogacy practices that an intended parent or surrogate may encounter. While commercial gestational surrogacy has blossomed into a US\$6 billion dollar industry in India, the current absence of any laws regulating surrogacy has resulted in the proliferation of surrogacy clinics throughout the country, with no governmental oversight regarding surrogacy recruitment, medical care, treatment, and costs. While I argue that reproductive tourism takes place in a transnational context, my goal in this chapter is to investigate the context of reproductive tourism “on the ground” in India, demonstrating how the political economy of

medical tourism produces certain practices that shore up national capacities in a global marketplace, while reinforcing global stratified reproduction. While many actors involved in reproductive tourism, including doctors, policymakers, and intended parents, claim that transnational surrogacy is about creating families for infertile couples and supporting poor, Indian women to help their own families, I argue that it is simultaneously about positioning India as a modern, safe space for foreigners seeking advanced medical technologies in their journeys to parenthood. Ultimately, in scaling up India's participation in the global medical tourism industry, the patterns and practices of surrogacy reinforce the hierarchical relationships that draw medical tourists to India in the first place.

From Public Health to Privatized Health

In order to comprehend how medical travel for assisted reproductive technologies gained purchase in India's private medical market, it is useful to begin with the context of public health in India, particularly with an examination of the ways that public health approaches shifted over time from the period prior to and following independence to the current, neoliberal India.

Public health policy during colonial rule largely reflected an interest in maintaining the health of the Indian Army, particularly from the mid-19th century, following the rebellion of 1857. While the British Government in India established medical services meant for British nationals, armed forces, and a few privileged civil servants, the majority of the Indian population was denied access to Western medicine (Roy 1985). Only gradually did this interest lead to a more general interest in the health of the Indian population, and then only in response to immediate health crises (Amrith 2007). Though provincial health departments were established in 1919, neither health planning nor medical education was related to the health needs of the

people. However, while colonial health policy was limited and focused primarily on addressing epidemics, the most substantial improvements in public health occurred in early 20th century British India. The establishment of panchayats (local governments), responsible for maintaining local sanitation, led to improvements in sanitation and decreased rates of cholera (Tinker 1954). The provision of clean drinking water at major sites of pilgrimage further contributed to the decline in cholera (Arnold 1993).

Notwithstanding these improvements, public health remained a low priority for the colonial state, which justified its sparse spending on public health with references to India's "naturally" high death rate and to threats of Malthusian catastrophe if too much was done to reduce mortality (Arnold 1993; Davis 2001). Yet, while the colonial state was ambivalent with respect to questions of public health, Indian elites began to politicize health in order to hold the state accountable. By the 1920s, India's modernizing nationalists were arguing that only a representative national government could truly care for the health of the Indian people (Amrith 2007).

In the 1930s, then, while still under British rule, the National Planning Committee of the Indian National Congress prioritized the health of the population as part of a broader agenda of transformation from above. Subsequent initiatives, organized by the Health Survey and Development Committee (1946), the National Health Survey and Planning Committee, and the Five Year Plans, highlighted concrete principles for public health in resource-limited settings. These principles emphasized comprehensive, holistic approaches to public health. They maintained, too, that public health must address the problems of the entire population and that the state must focus on issues that caused maximum mortality and morbidity. Finally, these initiatives asserted that public health solutions must account for the availability and costs of

technology, and prioritized building and maintaining infrastructure for providing services (Banerji 2001). Throughout these initiatives, officials considered poor socioeconomic conditions (lack of sanitation, clean drinking water, nutrition, and housing) a major factor in health and wellbeing. Health planners, then, focused on addressing these conditions through development programs and primary health centers, which were intended to cover medical care, control of communicable diseases, maternal and child health, nutrition, health education, school health, environmental sanitation, and the collection of vital statistics (Roy 1985).

Within the Union Ministry of Health and Family Welfare, two technical departments—the Health Department and the Family Welfare Department—were charged with addressing health issues through a holistic approach. Welfare services—land and public housing, water supply, nutrition, and education, among others—were to be addressed together with health issues in order to manage health through overall development (Banerji 2001); this holistic approach gained traction in the two decades following India’s independence from British rule in 1947. Yet, despite an initial emphasis on comprehensive health planning, the health system slowly began to focus on the provision of medical care for specific problems, while welfare sectors were dealt with separately. Scholars have attributed this shift away from holistic approaches to several factors, namely, second-generation public health planners’ emphasis on high-tech solutions, their dismissal of the intersections between living conditions and health, the socioeconomic conditions that fostered rural/urban disparities in health care, the prioritizing of services that cater to the elite, and the overemphasis on training medical doctors rather than paramedical and nursing staff (Qadeer 2002). As a result, the health care system shifted away from free primary health care toward concentrating on population control and techno-centric solutions. This preoccupation

with family planning led to a deep neglect of health services, which had been painstakingly built over the first two decades following Independence (Banerji 2004).

In 1978 the Indian government signed the World Health Organization's Alma Ata declaration that defined comprehensive primary health care as the basic health service that is the core of affordable and need-based development. Yet, despite this declaration to entrust "people's health in people's hands," in 1979 the political leaderships in rich countries persuaded those in poor countries to embrace an alternative approach to comprehensive primary health care: the antithesis of primary health care, selective primary health care. These "vertical" programs, limited to dealing with a few diseases at a time and purported to be cost-effective, were prefabricated, technocentric programs that caused further damage to an already battered health system (Banerji 2004). Later, with the Structural Adjustment Programs (SAPs) and health sector reforms of the 1990s, these were further reduced to primary level care focusing on grassroots services (Qadeer 2002). This shift illuminates the ways in which global economies influenced health planning in India. As neoliberal policies gained purchase around the world, the Indian government abandoned its own efforts to build a welfare state, and accepted structural adjustment policies and health sector reforms that enabled international capital to penetrate its markets and secure new areas of investment, including health care provision and delivery.

These reforms engendered a key shift in public health approaches. While previous conceptions of public health were based on epidemiological needs and the principle of self-sufficiency, new approaches to public health relied on global finance to modernize and refashion health systems. Trade agreements such as the General Agreement on Trade in Services (GATS) and the Agreement on Trade Related Intellectual Property Rights (TRIPS) led to the liberalization of medical markets, privatization of public sector services, and promotion of

technology transfer (Shaffer and Brenner 2004). At the same time, the promotion of medical tourism increased along with the number of medical students abroad, reflecting the attraction of the expanding medical markets for middle class professionals. Meanwhile, doctors moved from the public to private sector seeking higher pay, minimal state interference, control over working conditions, and higher status. Even when in state employment, many doctors continued to maintain private practices (Baru 1998; Venkataratnam 1973; Venkataratnam 1987).

Currently the Indian health system relies on a mix of primary health village centers and government hospitals to provide free medical care for the general population. Primary health care clinics offer services including immunization, treatment of common illnesses, prevention of malnutrition, and pregnancy, childbirth, and postnatal care. Patients needing specialized care are referred to secondary and tertiary care centers (Worthington and Gogne 2011).

However, while the public system seeks to make health care accessible to all, this does not always happen in practice. Parallel to the public sector is a private medical sector that caters primarily to the urban population and those in higher socioeconomic groups. Yet both urban and rural households tend to use the private medical sector more than the public, with nearly two-thirds of all households seeking health care from the private medical sector. The most common reasons for not using public sector health care facilities are poor quality of service and unavailability of a nearby facility. Despite the rise of a number of insurance programs, only five percent of households report being covered by any kind of health insurance (IIPS 2007).

The poor feel the consequences of this decay in government health services most acutely. With fewer government services and with poor coverage, about 70 percent of Indians pay for healthcare and medications out of pocket, in comparison to 30 to 40 percent in other Asian countries such as Sri Lanka (Sinha 2011; WHO 2012). Catastrophic medical expenses can force

patients and their families to go into debt, sell assets, or halt essential medical treatment. Such health care costs lead to the increased vulnerability of the poor and a vicious cycle between good health and malnutrition, as families must choose between food and health care (Duggal and Amin 1989).

The effects are also seen in the quality of and access to maternal health care. In the most recent National and Family Health Survey (NFHS) in 2005-06, many women reported not receiving any high quality maternal health care; of mothers who had a live birth in the five years preceding the survey, only 44 percent reported starting prenatal care in the first trimester of pregnancy. Just over half of mothers (52 percent) had three or more prenatal visits. Ultrasounds were used in one-fourth of all pregnancies, while 39 percent of births took place in health facilities.²⁴ More than half took place at women's homes, and about six in ten women did not receive any postnatal care (IIPS 2007). These data provide important context to the practice of transnational surrogacy, in which women receive high-quality and highly medicalized treatment in their surrogate pregnancies that bear children for other parents-to-be.

In the new market framework, multinational corporations determine health priorities by controlling the availability of technologies. While this framework puts first the individual needs of a small paying minority, the state's responsibility for public health becomes a public/private mix in the name of "plurality of services" and "decentralization." The result is the fragmentation of a complex integrated health system, forcing service institutions to rely on the operational principles of institutional economics and to abandon the holistic, systemic perspective. As health services became increasingly commodified and unequal, institutions invested in services that enhanced profits (such as orthopedic, cardiovascular, and obstetric services). Consequently, the

²⁴ In comparison, in 2002 in the United States, 68 percent of mothers who had live births received ultrasound, while 99 percent of births were delivered in hospitals (Martin, et al. 2003).

poor encountered increasingly difficult access to quality health services. This system set the stage for the expansion of assisted reproduction and the medical tourism industry in India.

A Short History of Assisted Reproduction in India

On July 25, 1978, the world's first "test-tube" baby, Louise Brown, was born in the United Kingdom through the efforts of Dr. Robert G. Edwards and Dr. Patrick Steptoe. Brown was conceived through in vitro fertilization (IVF), an assisted reproductive technique requiring trained medical personnel and specialized facilities. Through IVF, women first take hormonal drugs that induce the production of multiple ova (rather than the single ovum that is produced in each cycle); a trained physician extracts these ova through a surgical procedure. The ova are then fertilized with sperm "in vitro" and allowed to grow into the embryo stage, when these embryos are then transferred back into the woman's body. Often, women may take additional medications to increase the chances of embryo implantation. For Dr. Edwards' role in pioneering this assisted reproductive technology, the Nobel Foundation awarded Dr. Edwards the Nobel Prize in Physiology or Medicine in 2010.

However, few Westerners realize that only sixty-seven days after Dr. Edwards' achievement, the world's second and India's first IVF baby, Kanupriya Agarwal, was born on October 3, 1978 in Kolkata (then Calcutta). A team headed by Dr. Subhas Mukherjee conceived in vitro and delivered Kanupriya, referring to her with the pseudonym "Durga," after a Hindu goddess who embodies the female creative force. Yet unlike Steptoe and Edwards, Mukherjee's achievement was not acclaimed in India. Instead, the Indian scientific establishment challenged his claims and convened an official scientific committee—one that included no specialists in reproductive science—charged with evaluating his work. Dr. Mukherjee, barred from presenting

his work to the international scientific community, humiliated, and professionally harassed by the authorities, eventually committed suicide in 1981 (Anand Kumar 2003).

Several years later, the Indian government established an IVF project within its contraceptive research center, the National Institute for Research in Reproduction (NIRR) in Mumbai. In 1984, the NIRR, an institution of the Indian Council for Medical Research (ICMR), created its IVF program in collaboration with the King Edward Memorial Hospital, a tertiary care center of the Bombay Municipal Corporation. The technology was tested on poor women seeking infertility services in this government hospital, and several years later, the first documented “test-tube” baby in India was born to the wife of a municipal employee, on August 6, 1986. Seventeen years later, and twenty-five years after the birth of Durga, the Indian scientific community finally recognized Dr. Mukherjee’s achievement, largely through the efforts of the doctor previously credited with the birth of India’s first IVF baby in 1986 (2003).

It may seem odd, but the development and promotion of contraceptive technologies occurred jointly with the technologies of assisted conception in India. Yet, as feminists have pointed out, both technologies represent ways to control women’s reproduction, either to prevent them from having a child or to exert social pressure on them to procreate. Puri, Hinduja, and Zaveri offer a curious justification for spending public money on this experimental procedure:

In India, tubal sterilisation is a widely used method for control of fertility. However, due to high infant and child mortality, several women who have undergone tubal sterilization do seek tubal recanalization. . . IVF/ET requires comparatively less surgical intervention than tubal recanalization. If a couple is convinced that pregnancy could be achieved with certainty by the IVF/ET technique, in the event of their losing the existing children, they might readily accept tubal sterilization as a method of family planning. Thus in vitro fertilization could be of great relevance to our national family welfare programme (Puri, et al. 2000).

By arguing that IVF was a simpler, less invasive method of conceiving for couples desiring recanalization, the authors, all researchers previously affiliated with the NIRR, made sterilization

a more acceptable option for many Indians, and an enormous windfall for the Family Planning Programme. At the same time, the Declaration of the International Conference on Population and Development (ICPD) emphasized expanding the scope of reproductive health to include infertility, and thus promoted ARTs in the name of women's choices and rights.

This vision of ARTs—in which IVF represented not only a solution for infertile couples desiring children, but also for couples seeking to reverse tubal ligation—joined promoters of the medical market interested in generating profits through ARTs and the pro-population control lobby of professionals and policymakers. At the same time, fierce infighting and ego clashes led to the demise of the NIRR's public sector IVF program. One researcher, for instance, spoke of the “arrogant” and “uncompromising” attitude of the gynecologists that led to the project's collapse (Bharadwaj 2002: 327). By the end of the 1980s, then, as scientists involved with the program left their government posts to set up private practice, ARTs were almost completely taken over by the private sector. They became part of the “glamour technologies” (Qadeer 2010: 8) projected by India to establish its position in the international medical marketplace.

The setting in which ARTs flourished in India emerges clearly when placed in historical context. With its growth-oriented model of structural adjustment and health sector reforms of the 1990s—which effectively opened up the public sector to private investments and promoted privatization—the Indian state allowed ARTs to proliferate in the private sector and provided open markets for these risky, invasive, and unregulated procedures. At the same time, this arrangement kept the costs of public sector primary health care low, while letting profits flow to the private sector.

As the use of IVF grew apace, surrogacy became a well-known option for infertile couples only in the early part of the twenty-first century. Many acknowledge that the surrogacy

“boom” started in 2004 in Anand, in the western state of Gujarat. A U.K.-based Indian couple, Aakash and Lata Nagla, had been suffering from infertility and Lata’s parents approached Dr. Nayna Patel for help. While Lata suffered a rare genetic condition that causes the uterus to develop abnormally, her eggs and ovaries functioned perfectly. Through IVF, Dr. Patel created embryos with Lata’s eggs and Aakash’s sperm, and then transferred the embryos into another woman’s womb—that of Lata’s 44-year-old mother. In 2004, Lata’s mother gave birth to her own grandchildren, a twin boy and girl. Since then, the surrogacy industry has flourished, and with the dramatic increase in news coverage of surrogacy in India in 2006 and 2007,²⁵ many physicians I spoke with credited Dr. Patel, among other doctors, as responsible for raising the profile of Indian surrogacy.

Commercial gestational surrogacy in India has since grown to attract thousands of foreign couples to India each year. However, due to the lack of regulation, it is difficult to find reliable statistics regarding the numbers of births or numbers of clients who travel to India for surrogacy services; one journalistic source claims that 25,000 couples travel to India each year (Bhowmick 2013), while another estimates that 2,000 surrogacy births occurred in India in 2011 (Bhatia 2012). While these estimates would be hard to verify, the large discrepancy between numbers of clients who travel to India and numbers of resulting births deserves some comment. Here, it is important to underscore the low rates of success with IVF: in 2009, the Indian Society for Assisted Reproduction (ISAR) conducted an estimated 18,000 IVF cycles, averaging a 30 percent rate of pregnancy. Yet the group says that only half of the clinics throughout India are members, making the total number of IVF cycles sought much higher, and actual success rates difficult to predict (Rai 2010). As a result, one can expect the estimates of clients traveling for surrogacy to be significantly higher than the number of surrogacy births. Moreover, the promise

²⁵ See for example Chu (2006); Haworth (2007); and Winfrey (2006).

of ARTs often exploits intended parents' hope and optimism. Though many clients are all too aware of the low success rates (70 percent of clients will receive negative pregnancy test results) they tended to view Indian surrogacy as a smart, financial move in the gamble of IVF and surrogacy. Commissioning parents I interviewed calculated that if they could afford to spend US\$100,000 on surrogacy, their budget would go significantly farther in India, where their funds would cover up to three surrogacy attempts, thus increasing their chances at bringing home a baby.

Today, India is a “global hub” of commercial gestational surrogacy, and the ICMR projects profits will reach nearly US\$6 billion in the next few years (Rudrappa 2010). Infertility clinics can be found throughout the country in urban megacities; in addition, smaller towns and rural areas have infertility centers that work with ART centers located in cities where specialists are available to perform IVF and ICSI (intra-cytoplasmic sperm injection) procedures. While international travelers visit surrogacy clinics in a wide range of cities, including Delhi, Mumbai, Hyderabad, and Anand, a growing number of IVF/surrogacy clinics in metropolitan cities throughout India cater to regional clientele from Bangladesh and Pakistan, as well as clients from within India, who travel from regions where ART infrastructure remains undeveloped (Kashyap 2011).

Medical and Reproductive Travel in India

Amidst the expansion of assisted reproduction, medical tourism, a particular form of travel for medical reasons, has been growing steadily in India. While several countries throughout Latin America and Asia actively promote medical tourism, including Cuba, Jordan, Malaysia, Singapore, and Thailand, India is regarded as one of the world leaders in medical

tourism, second only to Thailand (Pande 2011). The Confederation of Indian Industry predicts the medical tourism business will generate US\$2.3 billion annually by 2012 (Brenhouse 2010).

There are several factors that position India as a desirable destination for such travel: inexpensive costs, well-equipped private clinics, and large numbers of well-trained and English-speaking doctors with training from prestigious schools in India and abroad. Moreover, a significant overseas population of Non-Resident Indians (NRIs) avail themselves of medical care in India, often seeking cheaper medical treatment when they return to India for family visits. Indeed, medical tourism receives full government support; in 2004, the government launched an international advertising campaign and declared that medical treatment of foreign patients is legally an export and eligible for all fiscal incentives extended to export earnings. Most medical travelers to India receive cardiac care, while an increasing number of patients receive joint replacement, plastic surgery, eye treatment, and dental work (Pande 2011).

Interestingly, however, while researchers, news media, and participants in my own study cite low cost as a key factor in international medical travel, the promotion and marketing of medical tourism rarely highlights this issue. In a study of promotional print materials distributed at the first medical tourism trade show in Canada in 2009, researchers found that in marketing India as a global destination for medical treatment, marketing materials downplayed the cost issue in favor of emphasizing safe and advanced treatment facilities, as well as messages about quality of care (Crooks, et al. 2011). Indeed, in order to overcome negative images of health care in developing nations, the Indian government has focused on messages related to accreditation, on-site technologies, overall quality, and patients consulting with highly trained doctors, effectively demonstrating how quality of care is on par with that in developed nations. Such efforts extend beyond the marketing of health care to include the enhancement of travelers'

experiences from the moment they arrive in the country. In 2003, for instance, when then-finance minister Jaswant Singh called for the country to become a “global health destination,” he urged the government to improve airport infrastructures, in order to ease the arrival and departure of medical tourists (Chinai and Goswami 2007).

Within this context, reproductive tourism has mushroomed. Indeed, India represents a particularly interesting site because it is the first developing country with a burgeoning industry in transnational commercial surrogacy. For many nations, surrogacy represents a fundamental cultural anomaly, in that it generates unease by calling into question dominant cultural assumptions about families and mothers, two of the most fundamental conceptual structures of society.²⁶ Consequently, many countries, including China, the Czech Republic, Denmark, France, Germany, Italy, Spain, Sweden, Turkey, and some U.S. states ban surrogacy altogether. Other countries have imposed partial bans, such as Australia (Victoria), Brazil, Hong Kong, Hungary, Israel, South Africa and the UK. Among these countries, Canada, Greece, South Africa, Israel, and the UK permit surrogacy, though it is subject to governmental regulations. There are still other countries with no regulations at all, including Belgium, Finland, India, and some U.S. states (Teman 2010). While there has been a recent surge in surrogacy in India, it is important to note that commercial surrogacy is most prevalent in the state of California and in Israel, where surrogacy is restricted to Jewish citizens and is tightly controlled by the state. Indian surrogacy practices closely mirror the liberal market model of surrogacy in California, where private, commercial agencies manage surrogacy arrangements. These agencies rely on their own criteria for screening, matching, and regulating surrogacy agreements, and in India,

²⁶ See Teman (2010) for a discussion of how surrogacy represents a fundamental cultural anomaly. Drawing on the work of Robbie Davis-Floyd (1990) and Mary Douglas (2003), Teman argues that surrogacy provokes cultural anxieties in relation to the concept of family and the ideology of motherhood.

clinics operate largely without state intervention. They also benefit from the governmental support for medical tourism.

Many clients are drawn by the complete absence of regulations in India. Commercial surrogacy has been considered legal since 2002, yet to date there remain no laws regulating surrogacy in clinics. The first reference to ARTs in a government document appeared in the “Ethical Guidelines for Biomedical Research on Human Participants” published by the ICMR in 2000. In 2002, the ICMR and the Ministry of Health and Family Welfare (MOHFW) developed guidelines on the Accreditation, Supervision & Regulation of ART Clinics in India, which were later published in 2005. These guidelines, however, are not legally binding and the rules and regulations are not mandatory. As a result, with no governing body charged with implementing the guidelines, clinics decide whether to accept or reject the recommendations made in the guidelines, and effectively operate in the absence of any form of regulation of ARTs.

With the growth of medical travel for ARTs and gestational surrogacy, doctors and other stakeholders have pressured the Indian government to pass a law regulating ART clinics. In 2008 the ICMR and MOHFW outlined the Draft Assisted Reproductive Technologies (Regulation) Bill and Rules, which attempted to address many of the issues related to the regulation of ART clinics, semen banks, and research on embryos. The Draft Bill, a 135-page document, lays out the duties of ART clinics (including duties regarding gametes and embryos, preimplantation genetic diagnosis, and sex selection) as well as the rights and duties of patients, donors, and surrogates. The 2008 Draft Bill came under attack from various groups, however, as it seemed to promote the interests of the private sector providers of the technologies rather than regulate them, and included few clauses designed to protect and ensure the health and wellbeing of women and children (Sama 2010; Sarojini and Sharma 2009). The Draft Bill, for example, states

that “ARTs carry a small risk both to the mother and the offspring” (Ministry of Health and Family Welfare 2008: 67), seemingly ignoring the health implications—for both mother and child—of multiple gestation, ectopic pregnancy, and pre-term birth, health conditions for which gestational surrogates are at increased risk.

In 2010, the ICMR released a revised version of the Draft Bill, devoting a substantial section to the regulation of surrogacy arrangements. Yet, as the organization Sama (which means equality in Sanskrit) underscored, significant gaps remain with respect to the protection of surrogate women. Most striking are the changes in the provision for payment to the surrogate woman, which undermines her rights and favors the intended parents. In the 2010 Draft, payment to the surrogate is to be disbursed in five installments (instead of three, as in the 2008 Draft) and 75 percent of the payment is to be paid at the fifth installment, following delivery of the child (in contrast to the 2008 Draft, in which 75 percent was to be made at the first installment). This move not only clearly prioritizes the concerns of the intended parents and doctors, but downplays the risks associated with surrogate pregnancy, labor, and related emotional and physical risks. Moreover, the draft increases the number of permitted live births for a surrogate from three to five, inclusive of her own children. Again, this provision discounts aspects critical to surrogate women’s health: the number of permitted surrogate pregnancies she may undergo (Sama 2011).

Indeed, interviews with doctors tasked with providing medical care for surrogates confirmed the health risks involved. One doctor explained that pre-term labor is common among surrogate women, with most babies born between 30 and 37 weeks:

Very, very few achieve 38-39 weeks. Multiple pregnancies is the most important cause. Also, they are larger than Indian-size babies. These are all Western babies and Western babies are definitely bigger in size than ours. And there are medical complications because these are all multigravida patients. They’ve all been pregnant two or three times before. So the incidence of pre-term delivery, the incidence of pregnancy-induced

hypertension, the incidence of hyperthyroidism, anemia, all of that is much, much higher in these women.

Moreover, she explained, “Most of the deliveries are cesarean because they’re multiple pregnancies and the normal presentation is weaker. Most of them are scheduled, especially with twins.” She went on to say, “Today I’m doing the third one right now. All had severe pregnancy-induced hypertension. All three deliveries were twins.” Clearly, the lack of provisions in the Draft Bill addressing women’s health and the risks involved in surrogacy is troubling.

In addition, there has been much speculation over whether the 2010 Draft excludes single people and gay couples, a subset of prospective parents that have been welcomed in certain Indian clinics. Some have argued that the language in the Draft, which allows “unmarried couples” and “single persons” from India and abroad to have children through gestational surrogacy, opens the path for gay couples and single people (Prakash 2010b). Yet others suggest that because gay relationships are not recognized by the Indian state, gay couples from India or abroad will not be permitted to use ARTs or surrogacy (Wade and Walters 2010).

While debates continue around the language of the 2010 Draft Bill (which still awaits consideration in Parliament), in December 2012 the Union home ministry issued a first step toward regulating the practice of surrogacy and restricting its use to married couples. The ministry, noticing that many foreigners were entering India for surrogacy on tourist visas, stated that such foreigners should enter India only on medical visas. Such “surrogacy visas,” however, would only be issued if the couple met certain conditions: first, they would need to supply a letter from their country’s foreign ministry or embassy in India certifying that their country recognizes surrogacy, assuring that the child or children born to the Indian surrogate would be allowed to enter their country as the child of the couple. Second, only a heterosexual couple married for two years can be eligible for the surrogacy visa (Rajadhyaksha 2013). The ministry

has already come under attack by various groups for its apparent concern with gay couples' use of surrogacy, while women's health risks remain unaddressed.

These guidelines reflect the ever-changing landscape in which surrogacy arrangements take place. During my fieldwork in 2008-2010, many clinics saw a surge in the numbers of single people and gay couples seeking surrogacy; indeed, roughly half of the intended parents I interviewed were gay couples or single people. Yet, amidst the government's concerns about surrogacy for gay couples and feminist concerns about the potential exploitation of surrogate women, surrogacy in India remains a profitable business that many acknowledge is unlikely to end anytime soon.

Thus far, I have focused on the history and political economic context of assisted reproduction and reproductive tourism in India. Within this context, the lack of any legally binding regulations has not only resulted in the proliferation of IVF clinics throughout India, but, as I argue, it has set the stage for the expansion of practices that maintain structures of stratification. Below, I examine the structures and process of surrogacy, as it unfolds across many stages, spaces, and with the participation of multiple actors.

Transnational Structures of Surrogacy

When Jan and her husband booked their first trip to India in December 2008, they had made arrangements with a South African egg donor agency to have a young woman travel to India for the purposes of egg donation. At the time, Jan explained, "I really wanted a child that looked like me: tall, blonde, blue-eyed, that kind of thing." As I will discuss further in Chapter 3, after several surrogate miscarriages Jan would later have a change of heart regarding the particular phenotypic characteristics she desired in her child. But in late 2008, Jan believed that

her unusual path to parenthood would require the assistance of a young, white egg donor from South Africa. Fortunately, Jan had chosen to work with a surrogacy agency in Mumbai that had connections with a South African egg donor agency that coordinated the recruitment of young women willing to travel as egg donors.

But just as their egg donor was about to travel to Mumbai with five other donors from South Africa, the Mumbai terror attacks occurred on November 26, 2008. Throughout the city, attackers carried out twelve coordinated shooting and bombing attacks, killing 164 and wounding at least 308 people. In the wake of these attacks, Jan learned that the South African agency had cancelled the egg donors' trip, thus putting on hold the IVF cycle that was timed for Jan and her husband's visit. Faced with the decision of postponing their trip until their donor could re-schedule her trip from South Africa, continuing with their December travels, or canceling their plans altogether, Jan and her husband decided to move forward with their plans:

Everything was cancelled because it was too dangerous for the donors to go and we were absolutely devastated. But we had all our travel plans ready, so we decided we would go, ourselves. We would go and check it [the surrogacy clinic and process] out for ourselves, and if we didn't like what we saw then we would just quit it and that would be it. So we went to Mumbai and we had a great time. We realized that it was all above board, and we actually met the surrogate²⁷ when we signed the contract, which was a really nice experience. We realized that no, she was not pulled out of the slums, that she was from the equivalent of a working class family. And so we signed our contracts and then our donor flew back [to Mumbai] in February as well. We didn't have to but we thought, 'This is just so weird and crazy, that we would at least like to be in the same country as our child when it is conceived.' Not everyone's got the option to do that but we did because we sold everything and we had budgeted and we had a hell of a lot of frequent flyer points.

At this point, Jan's surrogacy journey, which had only just begun, displays the multiple levels of organization and communication required in order to arrange surrogacy in India. Jan's plan included the travel of an egg donor from South Africa; this meant that the doctors in India

²⁷ To be clear, in gestational surrogacy the surrogate becomes pregnant with embryos that are developed from sperm and eggs from the intended parents (or third party donors), not the eggs of the surrogate herself. Thus, while the egg donor was stranded in South Africa, the surrogate was available to meet Jan in Mumbai.

had to ensure that the cycles of the Indian surrogate mother and the South African egg donor were coordinated so that the egg retrieval, IVF, and embryo transfer could occur within days of each other. With the Mumbai terror attacks leading to the postponement of the egg donor's trip in November, Jan's hopes for a December pregnancy vanished. Yet, while many parents might have considered abandoning the process altogether, Jan was determined to move forward with their surrogacy plans, despite the difficulties and delays she encountered and even in the wake of the devastating attacks in Mumbai.

Why did surrogacy in India remain the preferred option for Jan, despite the many challenges she encountered? What are the surrogacy practices that draw parents to India, even in the context of national tragedy and turmoil? I return to Jan's story because, in order to comprehend why India exists as a global destination for transnational surrogacy, it is important grasp the current context of surrogacy in India, including clinic practices regarding surrogacy agreements and medical treatment that allow women like Jan to organize surrogacy arrangements to their desires. As mentioned earlier, low costs and lack of regulation, among other factors, make India an attractive destination for parents seeking gestational surrogacy arrangements. Yet, economics and the absence of regulation are not the only forces compelling foreign clients to travel to India. In India, gestational surrogacy—in which the surrogate contributes no genes to the makeup of the child as she provides only her womb—is the norm, and this allowed Jan to control the genetic makeup of the child. As a woman who would be unable to provide her own eggs, Jan did what she believed to be the next best thing; she worked with an agency in India that had connections with an egg donor agency in South Africa that would be able to provide white egg donors, at a fraction of the cost in the United States.

Paths to Surrogacy

What are the transnational structures of surrogacy that draw so many foreign couples to India? In this section, I describe the unique context of surrogacy in India, which, in part, allows clinics the freedom to determine their own practices in the absence of any laws or regulation. I suggest that this context is what attracted Jan and many parents like her to India, rather than other countries with burgeoning surrogacy industries, and that clinic practices rely on and reproduce social stratification at local, national, and transnational levels.

While the clinics I visited had many differences in terms of their surrogacy practices and policies (which I will address in the last section of this chapter), the general stages of surrogacy are similar. For intended parents, the first step is to select an agency or clinic, as it is almost unheard of for foreign couples to contract with an Indian surrogate mother independently. For many intended parents, this is one of the most important decisions, as it is often the doctors who select the surrogate, not the parents. Virtually all parents rely on the Internet in order to make their decisions: they email prospective doctors and fellow parents who share experiences of surrogacy in India, they join forums dedicated to surrogacy in India, and they read the many surrogacy blogs chronicling intended parents' surrogacy journeys to India. As they gather information on different clinics in different cities in India, among the strongest factors they take into account are the testimonials of other parents who have attended that clinic. Other key factors include cost, communication with doctors, and perceived treatment of surrogates. In general, parents in this study cited total surrogacy costs ranging from US\$20,000 to US\$40,000, which includes medical procedures, recruitment and care of the surrogate, surrogate housing, and hospital fees. Some parents saw their costs rise above this range when they were responsible for additional fees such as extended hospital care for complications resulting from premature birth,

or longer stays in the country due to delays in acquiring travel documents after the birth of the child. Notwithstanding these additional fees, intended parents viewed surrogacy in India as a bargain when compared to costs in the U.S., for example, where surrogacy costs range from US\$80-120,000, with some agencies charging upwards of US\$150,000.

As clients progress through the initial phases of selecting an agency, agencies are constantly recruiting and screening potential surrogates. First and foremost, women are drawn to surrogacy because of the pay: most surrogates in this study reported receiving payments between US\$5,500 and US\$7,500, equivalent to several years' household income for most families. It is difficult to track the numbers of women involved in gestational surrogacy, and because a high percentage of surrogate births are multiple births, the number of live births (previously cited at more than 2,000 babies per year) is not a reliable predictor of the number of birthing women. Dr. Patel, of the Akanksha clinic in Anand, reports that at any given time, 60 to 65 women are pregnant, carrying babies for couples from all over the globe (Williams and Kress 2012). In my own interviews with doctors, I found that numbers varied widely, with different clinics reporting 10 to 70 women pregnant at any given time. Yet these numbers count only women who are currently pregnant, and do not include the large numbers of women who approach doctors to become surrogates, undergo the medical procedures, and do not become pregnant or have miscarriages early in the pregnancy. Indeed, agents I spoke with indicated that more and more women, perhaps hundreds, were approaching them to learn about becoming surrogates or egg donors.

The screening process of surrogates includes a battery of medical tests that must show they are healthy and free of disease. In addition, some clinics require a screening with the staff psychologist who can attest to surrogates' emotional health and wellbeing. Surrogates are also

expected to be married and to have had at least one but fewer than four children.²⁸ In general, surrogate recruitment patterns reflected a pyramid of sorts: women (typically former surrogates or egg donors) would recruit women in their communities whom they would then bring to another agent who conducted screenings and arranged payments, among other tasks. This higher-level agent, who acted as a broker between the local agents and the surrogacy clinics, would then send surrogates to different agencies and clinics with whom she worked.

Once intended parents selected a clinic (or a medical tourism agency that acts as a go-between among the clients and the Indian agency or clinic), they may also face the decision of how to select an egg donor, if the couple is a gay male couple or an infertile married couple in which the intended mother cannot produce viable eggs. In general, parents who sought to minimize their costs and who did not feel strongly about having a child with a particular phenotype would choose to select a donor from within India, usually through the same agency they were using for surrogacy. Others could choose to fly in an egg donor from another country; in this case, intended parents might choose to go with a clinic that already had a working relationship with their Indian surrogacy agency, or they might find their donor independently through a global egg donor agency. In some cases, prospective parents would travel with a relative or someone already known to them who agreed to volunteer as an egg donor.

When a couple has committed to a particular agency, they plan their first trip to India where they will meet their doctors, and in some cases, the surrogate, for the first time. During this first trip, they will typically tour the facilities and meet key actors; many clients will plan

²⁸ ICMR guidelines dictate that surrogates cannot have more than five live births (including surrogate births), yet they must also have had at least one child of their own to prove fertility. The argument is that if a woman has given birth to children of her own, she will be less likely to bond emotionally with a child to whom she is not genetically related. At the same time, studies indicate that with each subsequent live birth a woman experiences, she will be at greater risk of experiencing complications during pregnancy and childbirth. Note that between the 2008 and 2010 Drafts, the ICMR raised the upper limit of pregnancies for surrogates from three to five.

additional side trips for tourism purposes. They will also sign contracts at this stage, though not always in the company of the surrogate, who may sign the contract at a later date. It is important to note that in most cases I encountered, surrogacy contracts are between the couple and the surrogate, and the clinic rarely enters into this agreement. Though surrogacy is considered legal in India, there remains no law regulating it, and some doctors claim that the contracts are not legally binding.

According to surrogates in this study, contract procedures were often opaque. Contracts are typically written in English, so a doctor or lawyer must be present to explain the contents of the contract to the surrogate. However, many surrogates reported receiving only cursory explanations of the contract's contents, while others were simply instructed where to sign. In general, the contracts included no stipulations regarding payment; the main goal of the contract is to establish the parentage of the commissioning parents, and to ensure that the surrogate will not attempt to prevent the parents from collecting their baby. In addition to the surrogate's signature, husbands were required to sign affidavits indicating their understanding of and agreement to their wife's surrogacy. If the surrogate is not married or no husband is present, then a parent or other relative of the surrogate must sign the affidavit.

In contrast to surrogacy in other countries, treatment often begins before the contract is signed. Because parents often have a limited amount of time to spend in India, they must begin the treatment protocols before they even land in India. If fresh embryos are to be used, the surrogate and the intended mother's or egg donor's (ED's) menstrual cycles must be synchronized: the surrogate receives hormones in injections or pills while the intended mother/ED administers daily hormonal injections to stimulate her ovaries. These treatments must be timed so that multiple eggs will mature in one cycle and be ready for extraction when the

surrogate's uterine lining reaches optimum thickness. The ova are then extracted and fertilized through IVF in a Petri dish with the intended father's sperm; the resultant embryos are then transferred into the surrogate's uterus within forty-eight hours.

In some cases, frozen embryos are used, and then only the surrogate's body is monitored. Clients often choose to freeze embryos when they have "leftover" embryos from previous attempts, and in the event their first attempt did not result in pregnancy, they can turn to frozen embryos (and avoid the hassle of planning additional trips to India). In other cases, clients may choose to work with agencies that facilitate the shipment of sperm, eggs, and embryos to India, so that clients do not have to travel until the birth of their child.

If the surrogate becomes pregnant, she continues to take hormonal medications for approximately the first twelve weeks of pregnancy, at which point her body "takes over" the pregnancy. During the pregnancy, she may move with her family to another apartment (organized by the agency), live in a home with surrogates away from her family, or remain in her community. Depending on the clinic, she may have an opportunity to meet the intended parents, or the parties may remain completely anonymous throughout the process. If clinics do encourage communication, much of the contact is by phone or Skype and mediated by clinic personnel who act as translators. If they do meet face-to-face, it is often briefly, or "by accident" as many parents described to me, in the hospital following the birth of the child.

Parents normally plan their return trip to coincide with the due date of the child, and they often plan longer stays in India at this time, to account for possible delays in processing paperwork and acquiring the travel documents necessary to return home with the child. At the time of my research, many (though not all) surrogacy babies were born at one hospital in Mumbai, in which it was known that doctors would record the commissioning parents' names,

not the surrogate's, on the birth certificate, which facilitated the process of obtaining the newborn's travel documents.²⁹ Once the baby is born, the parents and surrogate may meet once but typically do not maintain contact. In some cases, parents may require further assistance of the surrogate as they plan their departure from India; some countries, such as Norway, require that the birth mother formally declare her intention to hand over the baby to the clients, in order to obtain citizenship and travel documents for the child to return home.

Clearly, these stages and structures of transnational surrogacy require a complex coordination of multiple actors in the conception of a child; notwithstanding this complicated process of conception, the surrogacy industry has thrived in India. In the final section of this chapter, I will briefly discuss the range of surrogacy practices I encountered in India, describing key aspects and differences in surrogacy practices among the clinics included in this research.

Contrasting Practices of Surrogacy

Here, let me briefly return to Karishma's story. As discussed at the beginning of this chapter, 29-year-old Karishma had donated her eggs several times before undergoing embryo transfer twice in hopes of becoming a surrogate. During the course of my research, I noted how Karishma's attitude toward surrogacy changed over time, particularly her feelings about Dr. Singh. Reflecting on her experience signing her contract, Karishma explained,

Dr. Singh changes the contracts every year. She rushed and finished my contract signing in December. I don't feel like going back to her [for surrogacy] now or in the future. Everywhere they change the contracts because the amount increases every year. She did not tell me this and rushed it in December. She did not tell me that there would be an increase in payment if it was signed in January of this year. I learned about this later and now I don't want to go back to Dr. Singh. My contract was signed for US\$3,800 while this year surrogates get US\$5,500. Dr. Singh did not explain this to me; the other women who went to Dr. Singh and signed the surrogacy contract in January 2010 told me.

²⁹ See Chapter Six for a discussion of the ways in which certain definitions of "parent" impact the process of obtaining travel documents for parents from different countries.

In India, where no law exists regulating surrogacy, doctors largely have the freedom to conduct their practices as they wish. Unfortunately, as Karishma found, this may have adverse impacts for women who are uninformed or have little bargaining power when it comes to their earnings as surrogates.

As discussed above, clinic practices tend to follow similar sequences and structures, yet their surrogacy practices may vary widely, offering a range of options to consumers of ARTs. Through my observation in a wide range of clinics and interviews with doctors, intended parents, surrogates, agents, and egg donors, I was able to gain various perspectives on different clinics and their surrogacy practices. The primary differences among clinics I encountered are as follows:

Criteria for accepting clients – As one surrogacy doctor, Dr. Guha, explained to me, “We are giving birth to a non-existing child, we are giving a life to that baby, which never would have been there otherwise. That’s why we screen our parents very strictly.” By asking doctors about their criteria for accepting clients, I gained insights into doctors’ ideas about who they deemed to be acceptable candidates for surrogacy, as well as the range of Indian ideas about what kinds of people were considered “appropriate” parents with respect to age, marital status, sexual orientation, and income. Dr. Guha’s clinic, for example, accepted gay couples, married heterosexual couples, and single intended parents. His agency also required documentation such as bank statements and proof of home residence, noting, “It’s our way of saying you have to funds in the bank and you can’t pay for this in credit.” Yet while some clinics, like Dr. Guha’s, are well-known for accepting gay clients, others reflect more conservative views and refuse gay couples as clients. At the same time, some doctors imposed age limits and did not accept clients older than 45. As one doctor implied, older parents would not be able to give the child a “proper

life,” while other doctors were known for accepting clients in their fifties and sixties. These criteria also revealed many doctors’ belief in their responsibility as gatekeepers in the making of families. Dr. Guha, for instance, strongly believed he had great power to determine what sorts of families should be made: “Here we have a role to play. Here we are creating that baby.”

Treatment and care of surrogates – Treatment and care of surrogates varied widely among clinics, particularly with respect to housing. While some doctors request that surrogates move to different accommodations with their families, others ask them to move to housing by themselves to live with other surrogates. Still others remain at home with their families in their communities for the duration of their pregnancies. Doctors expressed different rationales for these policies. On the one hand, doctors claimed that moving surrogates to new housing without their families allowed them to focus on taking care of themselves during pregnancy, without having to worry about work or family responsibilities. Others argued that in order for women to remain as psychologically and emotionally healthy as possible, they must remain with their families (though some required that they still move as a family to a location more convenient to the hospital). These policies suit different kinds of parents who travel to India for surrogacy. Some parents, for instance, dislike the idea of separating women from their families, while others prefer to know that their surrogate is being closely monitored throughout pregnancy.

Management of relations between parents and surrogates – Communication between surrogates and parents was another area in which doctors held diverse views. Some clinics insist that parents and surrogates must not communicate at all during the course of the pregnancy, and believe that an anonymous relationship is in the best interests of the parties involved. Doctors held a policy of “no communication” for several reasons. Many doctors had a significant number of gay clients, and some of these doctors believed that surrogates might feel uncomfortable with

the idea that they were carrying children for gay couples, as homosexuality remains stigmatized in India.³⁰ Still other doctors insist that it is perfectly acceptable, and creates stronger bonds and relationships among parents and surrogates, thus improving the surrogacy experience for all involved. Yet others are mostly concerned about potential exploitation of the parents; in this case, doctors are concerned that surrogates may learn too much about their clients, and “take advantage” of them by attempting to ask for more money, for instance. Doctors, however, do not always strictly follow their own policies, and often a doctor will claim that they do not believe it is good practice to allow parents and surrogates to Skype, for instance, but will facilitate it if the parents insist. This again serves the parents more than the surrogates; some parents have said that they intentionally chose India because they wanted to avoid close, “touchy-feely” relationships with surrogates that are often expected in the U.S., and they preferred to keep the relationship more distant.

Contracts and payment – I found that contract practices and payment plans varied widely among doctors in this study. With no laws regulating the practice, doctors decided how to structure their own payment plans. Surrogates said they earned a base rate of approximately US\$4,400 to US\$5,500, with additional payments if she was carrying twins (US\$550-650) or cesarean section (surrogates in Mumbai reported receiving US\$1,000-1,700, while one doctor in Delhi said he paid surrogates US\$2,500-3,000). However, I often encountered discrepancies among doctors’ quotes, intended parents’ quotes, and what surrogates actually received. Parents often cited payments that were much higher than what surrogates reported receiving, with some doctors charging parents up to US\$9,850 for surrogate fees, not including housing, recruitment, and other costs associated with care and medical treatment. Doctors also reported varying

³⁰ While doctors commonly cited this as a reason to avoid communication, surrogates generally stated during interviews that they had no issues with gay parenting.

policies with respect to additional payments to surrogates for carrying twins. One doctor told me, “A pregnancy is a pregnancy,” and insisted that payment should not vary whether a surrogate was carrying one or two fetuses. Contract procedures, too, did not always mesh with doctors’ accounts. Many surrogates told stories of not fully understanding the contracts (which were drafted in English), or said that there were blank spaces where their pay should have been listed.

Doctors’ charges for medical treatments and other services also varied widely, and as commissioning parents made inquiries to varied clinics across the country, they reported that doctors’ fees were a major factor in their decisions about which clinic to attend. One Mumbai clinic, for example, charged approximately US\$5,700 for registration, administrative costs, and costs associated with the surrogate’s medical treatments (including preparation, embryo transfer and prenatal care). The clinic charged another US\$6,600 for costs related to IVF (including medications), and this number rose to US\$11,500 if donor eggs were used. Thus, in one clinic, fees for administrative and medical costs alone could range from US\$12,300 to US\$17,200. The same clinic charged parents approximately US\$2,200 for surrogate housing, and US\$2,200 for payments to the social worker, recruiter, and/or surrogate caretaker. In contrast, parents who attended other clinics reported paying substantially smaller package fees (for costs of medical treatment, surrogate payments, and housing, among other costs). Thus, total payments to clinics for surrogacy services could range from US\$20,000 to US\$35,000.

Each of the clinic practices discussed above illustrates the diverse ways in which clinics, parents, and surrogates engage in commercial gestational surrogacy in the absence of any binding regulations. These practices, too, profoundly impact the ways in which actors experience surrogacy. In this research, I noted that several key themes emerged as a consequence of these practices, particularly with respect to kinship (as actors attempt to develop, or not, relationships

with each other), geography (as surrogate women experience mobility and immobility throughout their pregnancies), and agency (as women attempt to navigate and negotiate payments, contracts, and medical treatments throughout their pregnancies). I suggest that the particular structures and practices of transnational surrogacy in India make salient these themes, which are the focus of the chapters to follow.

This chapter situates Indian transnational surrogacy in relation to a broader context of public health, assisted reproduction, and medical tourism in India. I have demonstrated how assisted reproduction emerged in the context of neoliberalism, as public health approaches that focused on free comprehensive primary health care shifted to prioritize privatized health care services. These shifts occurred in a legal vacuum, in which no laws existed regulating surrogacy or ARTs. India, then, was well situated to become a global destination for reproductive tourism. Thus, as the transnational surrogacy industry grew, the range of contexts and practices of surrogacy diverged in multiple directions, each imbricated in structures of inequality. The following chapters examine the various ways in which transnational surrogacy maintains and reinforces local and global structures of stratification.

CHAPTER TWO

Making Families, Saving Women: Narratives of Kinship and Rescue

“To reproduce is the strongest human desire, second only to survival itself. If none of us passed on our DNA and refuse [sic] to become parents, life would end with us. Its [sic] true, having a child is the most innate thing in the world. And so, we take care of you from the time you wish to have a baby, till [sic] your newborn baby fulfills your wishes.”³¹

- Home page of Surrogacy India website

“With an Indian surrogate, you are fundamentally changing the trajectory of her life.”

- U.S. father of three children born through surrogacy

The first epigraph above appears on the home page of the website for Surrogacy India, an agency dedicated to facilitating gestational surrogacy arrangements between Indian surrogates, egg donors, and a largely international client base of would-be parents. As the Indian surrogacy industry expanded over the past decade, this agency was one of the first to market their services to foreign clients, and today Surrogacy India is one of numerous agencies offering surrogacy packages to infertile couples and individuals from around the world. While many reasons are cited for India’s popularity as a destination for reproductive technologies, tissues, and procedures, in this chapter my focus is on the ways in which infertile couples and individuals construct kinship and parenthood in the context of transnational gestational surrogacy. As illustrated in the above quote, Indian doctors frequently use affective language highlighting primordial desires for biogenetically related children in their efforts to draw prospective clients to their clinics and to situate their own ethical and moral positions on surrogacy. Indeed, as one doctor explained, “Every human being has the right to be a parent. Who are we to decide who should and cannot? Surrogacy is not a crime. It is an alternative mode of delivery for all those who are interested in having their own biological children.” To be sure, by and large doctors

³¹ See Surrogacy India, <http://www.surrogacyindia.com/index.html>, accessed May 16, 2012.

argued that it is the couple's desire for their "own child" that motivates them to build their families through gestational surrogacy, while surrogates, egg donors, and the commissioning couples frequently embraced claims to parenthood as an inalienable right and innate to human beings. Yet the unique circumstances of family making via transnational gestational surrogacy in India call into question dominant ideas of kinship and parenthood, and rely on multiple disruptive boundary crossings.

However, as parents negotiated their kinship claims with children who were birthed by Indian surrogates, I observed the ways in which parents' kinship narratives often relied on simultaneous narratives of rescue. That is, narratives of their families' origins were intimately intertwined with narratives of rescue or empowerment of Indian women. As the second epigraph of this chapter suggests, for many parents, the humanitarian aspects implicated in transnational surrogacy—the promise of "fundamentally changing" the lives of poor Indian women—are integral in justifying the remarkable nature of their kinship stories.

In this chapter, I address two key questions: first, I examine how intended parents understand kinship and parenthood as they narrate their family's origin stories. I argue that infertile couples and individuals who pursue surrogacy in India employ a range of strategies to create and make sense of their connections with surrogates, egg donors, and children conceived through gestational surrogacy, where biogenetic and social kinship ties are alternately challenged, transformed or reinforced. While the concept of "lineage" emerged throughout many conversations with intended parents, it rarely was used as a justification for traveling to India for surrogacy. Indeed, throughout my interviews with 39 intended parents, only 9 (or 23 percent) explicitly mentioned desire for a genetically related child as a motivating reason for traveling to

India for surrogacy. Instead, intended parents articulated a wide range of ideas and beliefs about parenthood and kinship, which were deeply informed by hierarchies of nationality and class.

By contextualizing participants' comments in a discussion of current and historical discourses about biogenetic connections, kinship, and rescue, I show how various actors think about these themes when making decisions about building their own families. For example, nearly 90 percent of intended parents interviewed mentioned at some point the importance of genetics in the process of conception. Yet they also expressed variable views about the significance of genes vis-à-vis their own relationship to the child. I focus on the ways in which biogenetic relationships figured into informants' narratives, illuminating how actors build, create, or deny kinship bonds with one another, as well as with the child born via gestational surrogacy. Building on the work of anthropologists who have shown how transracial and international adoption challenges inherited understandings of identity, kinship and belonging (Gailey 2010; Yngvesson 2010), I suggest that the global relationships formed through transnational surrogacy challenge existing notions of kinship in creative and meaningful ways.

This chapter also explores the ways in which relations of power and inequality play out within global reproductive networks, and reveals the shifting complexity of stratified reproduction. My second goal in this chapter, then, is to consider how and to what extent these stories build on and reproduce relations of stratified reproduction through their dependence on narratives of rescue. Commissioning parents' kinship narratives highlight uneven relations of class and nation, a source of tension among many intended parents uncomfortable with the commercial aspects of surrogacy. I found that intended parents employ various strategies to resolve these tensions, including relying on rescue narratives that describe surrogacy as a "win-win situation," in which couples and individuals both gain a child and provide income to a

woman in need. Such narratives invoke essentialized, one-dimensional pictures of the surrogate as a saint or mother, and position the Western family as saving the Indian surrogate, making the woman herself a humanitarian object (an identity that relies on her role as a mother to her own children). I argue that these strategies effectively gloss over the more complex stories of inequality that mark transnational surrogacy as a form of stratified reproduction.

For many intended parents, the practice of “kinning”³² among parents, children, and surrogates relies on narratives of rescue and humanitarianism as a strategy for rendering more palatable the discomfiting commercial aspects of surrogacy. As Marilyn Strathern writes, “The language of the gift conceals commodification of the body” (2012: 401),³³ and in the context of commercial surrogacy, the language of the gift takes several forms. Parents speak of their payments to surrogates in terms of benevolent acts of charity, while also employing language that signals “reciprocity,” or, gestures to make up for the lack of intimate connection between commissioning parents and surrogates.³⁴ Sharp (2006), for instance, has noted that recipients of cadaver organs struggle to make sense of an imbalance between what they received and what they cannot reciprocate (as no recompense can be made to the deceased); what is missing is a personal relationship that allows the recipient to reciprocate the gift.

In transnational surrogacy, parents, too, lack intimate relationships with surrogates, whom they may meet briefly, if at all. I suggest that the language of rescue and salvage³⁵ is a way to compensate for that lack of intimacy. Such language, too, masks and “misrecognizes” the commercial transaction that brings about the life of their child (Bourdieu 1977), and makes surrogacy about “saving” women from poverty or “empowering” them to help their own

³² See Howell (2006) for discussion of “kinning” practices among unrelated family members in the context of transnational adoption.

³³ See Sharp (2001; 2006: 12).

³⁴ See Sharp (2006) after Fox and Swazey (1992).

³⁵ See Anagnost (2000) for discussion of “theme of salvage” in the context of adoption narratives.

families—acts, which, of course, do little to address the underlying structural factors that propel women to surrogacy in the first place. Rayna Rapp, arguing that “it is through families that people enter into productive, reproductive, and consumption relations” (1978: 281), has examined the ways in which the U.S. concept of family as a cultural construction both unveils and conceals gender and class inequality in capitalist urban life (1978; 1987). To be sure, transnational surrogacy similarly brings people together in the name of family making, while simultaneously masking and revealing inequalities of class and nationality.

However, parents did not always resort to narratives of rescue as a strategy to resolve the anxieties related to commercial surrogacy. Indeed, about a third of intended parents (approximately 12) expressed deep suspicion of the “hero myth” and instead viewed surrogacy as explicitly transactional. Ann Anagnost (2000) has analyzed rescue narratives in transnational adoption as “rituals of decommodification,” which transform the commercial transaction into a sentimental possession that must be kept separate from the impersonal contract of market exchange. Such rituals of decommodification exist in transnational surrogacy, too, yet parents confront the commodifying features of family making in distinct ways. As I will discuss, even when parents eschew notions of rescue and view surrogacy as clearly transactional, their narratives nonetheless reinforce imbalances of power between surrogates and parents.

Narratives of Rescue: From Colonialism to Surrogacy

In her pioneering essay, “Can the Subaltern Speak?,” Gayatri Spivak (1988) unravels the ways in which a particular script of rescue, that of “white men saving brown women from brown men,” was vital to the operation of British colonialism. Leila Ahmed (1993), too, illuminates the ways in which British colonial authorities in Egypt relied on the rhetoric of women’s

emancipation for their colonial missions. In doing so, Western feminism came to serve as a “handmaiden” to colonialism. As these scholars demonstrate, political imperial projects relied on the elaboration of rescue narratives in their “civilizing missions,” with women’s emancipation acting as the mobilizing rationale.

These are historically influential scripts that continue to resonate in the twenty-first century, though the objects of rescue are distinct, as are the social contexts in which rescue narratives unfold. More recently, scholars have explicated how rescue narratives emerge in the context of transnational adoption. Eng (2003) describes the original “humanitarian” justifications for transnational adoption, particularly after World War II when overseas adoption began to take hold in the U.S. At this time, images of starving and abandoned children from war zones began to dominate the news media; such images were used to generate support for organizations like UNICEF and to boost the growing practice of transnational adoption (Briggs 2003). After World War II and during the early Cold War, many of the children adopted were European and Japanese war orphans. Later, following the Korean War (1950-53) and the war in Vietnam (1955-75), prospective parents flocked first to Korea for transnational adoption, then Vietnam and Cambodia. More recently, potential adoptive parents have focused on China, and agencies script the adoption of baby girls as a way to “rescue” them from a supposedly sexist culture (Anagnost 2000). Yngvesson (2010), too, examines the rescue narrative in relation to racism and relations between white adoptive parents and non-white children in the context of transnational adoption.³⁶

As Anagnost (2000) writes, this “theme of salvage” permeates many adoption narratives, in which the saving of the child is depicted as a heroic act. As I will demonstrate, in transnational

³⁶ See also Archambault (2011) for a critical discussion of the rescue narrative in the context of media narratives about early marriage among the Maasai.

surrogacy, it is not the child but the surrogate mother in need of saving. Parents rescue her from poverty, as well as from more distasteful work alternatives such as sex work, factory work, or poorly paid domestic work.³⁷ Such narratives of rescue mask the structural factors that motivate women to become surrogates. Moreover, humanitarian justifications efface the need to acquire any in-depth knowledge of history, language, politics, and culture. What counts in the rescue script is simply a desire to “help” women change their lives while simultaneously building their own families. Yet such language veils the fact that parents are not making charitable donations; they are paying women to carry out the labor of gestation and childbirth.

The Epitome of Motherhood?

I first met Adam and Nadine in the waiting room of Dr. Singh’s clinic, a busy infertility clinic in Mumbai. At the time of our interview, Nadine and Adam were forty-three and forty-seven years old, respectively, and they recently celebrated twenty-five years together, having met when Nadine was eighteen. Six years prior to our meeting in Mumbai, Nadine was diagnosed with stage three colon cancer; as a result, she endured rounds of chemotherapy that she says “burned her eggs,” as well as a hysterectomy. Once she was declared “clear” of the cancer, Adam and Nadine decided to move forward on their desire to have children. They looked first at adoption—the first logical step, in their minds—and were immediately turned off by the process, which they found to be invasive and discriminatory. Based in Texas, Adam and Nadine found that many adoption agencies were in fact Christian agencies; staunch atheists, they found their adoption consultant’s religious approach problematic and offensive. When the couple asked whether they would encounter issues because neither Adam nor Nadine were Christian, the

³⁷ Doctors in particular would frequently argue that surrogacy is a “win-win” situation that provides income for a woman without having to resort to sex work, adding a moral spin to justifications of surrogacy.

consultant replied, “It’s ok, as long as you’ve never set foot in a synagogue in the past.”

Moreover, Adam and Nadine (both white) were turned off by the racial politics involved in adoption; in their early conversations with the adoption consultant, they learned that the waiting period depended largely on the child’s ethnicity. As Nadine recalled, “The adoption consultant asked, ‘How quick do you want a baby? Do you want a white baby? A half-white baby? Do you want a Mexican baby? A half-Mexican baby? Do you want a black baby?’” “As if you could just grab one of the shelf,” Adam interjected. “It was complete objectification.”

Then, Adam saw a television special on surrogacy in India and started to do some research. After finding the costs of surrogacy in the U.S. too prohibitive, they chose to work with an agency in Australia that had a relationship with Dr. Singh’s clinic in Mumbai. He learned that this agency also had ties with a clinic in South Africa, through which they would be able to select a white egg donor. Interestingly, while they appeared uncomfortable with making decisions about adoption based on ethnicity, when it came to assisted reproduction Adam and Nadine were clear about their preference for a white egg donor because they wanted to “control the dissemination of information” to their child about his or her origins. According to Adam and Nadine, a child that resembled them phenotypically would not raise questions among strangers. If the child were white, Adam and Nadine themselves could decide when and how they would share the story of how the child came into being. This explanation, however, does not shed light on why Adam and Nadine’s surrogacy process would be very different from adopting a white child, indicating, perhaps, an elaborate rationalization for pursuing surrogacy—and a child that would be genetically related to Adam.

With all the arrangements made, Adam and Nadine embarked on a journey to India that they hoped would result in parenthood. However, as we talked about families and parenthood, it

became clear that Adam and Nadine's own personal histories played a major role in how they envisioned the other actors in surrogacy, especially the surrogate mother. Both Adam and Nadine spoke at length about how they each came from families with histories of abuse and neglect. Indeed, they confessed that their relationships with their own parents influenced their desire to delay having children until they were absolutely ready. This resulted in an explicit denial of the importance of biology in defining kinship or relatedness. As Nadine observed, "For me, having grown up with a mother who was abusive and neglectful, I definitely don't have the idea that the person biologically related to you is the best person to be your mother. That person can often be the worst person to be your mother." She went on to explain, "It's not the blood ties; it's the emotional ties that connect you. It's the emotional ties that connect us to the people we love and care about." Adam agreed and told me, "You're talking to two people who don't put a lot of stock in biology...Being a mom is not about delivering an egg and being a dad is not about delivering sperm. It's like—and I hate to sound a little clichéd—but it's every day, for the rest of the child's life and your life...The thing is, the minute that child can breathe that first breath on their own, parenting starts." While Adam and Nadine preferred a child that resembled them racially, they simultaneously de-emphasized the importance of biogenetic relatedness.

Yet, as we were discussing motherhood, Nadine confided, "I think that there's this beautiful idea of the mother who begins nurturing and caring for that baby when it's still a fetus. She begins teaching it, right from the beginning, by the way they're putting different food in their body." As Nadine was preparing to raise a child that would not be genetically related to her, she asserted that biological relatedness was not what defined parenthood, yet at the same time could not deny the bond that exists between a mother and the growing fetus inside of her. Nadine went on to contextualize their decision to pursue surrogacy in India:

Surrogacy seemed right in India. Women here, they need the money. The doctors were saying they were going to use the money to put their kids in school; it's always for their children, their future. *And talk about a mom—that's the epitome of motherhood.* That this woman is willing to carry someone else's baby inside of her! For nine months! That is an act of selflessness, because she's doing it for her children, to improve the future of her children. *I want to be half that mom. And I would be an incredible mom if I were half that mom* [emphasis added].

Nadine's comments reveal the complexities and contradictions inherent in gestational surrogacy as well as in the meanings she attached to motherhood. In the context of surrogacy, biological motherhood is simultaneously affirmed and denied in Nadine's understanding of her own and the surrogate mother's relationship to the child born through surrogacy.

Nadine's narrative also reflects a common theme among many intended parents I met, where the surrogate's own role as a birth mother to surrogate babies might be de-emphasized while elevating her role as a mother to her own children. Indeed, many women spoke admiringly of their surrogates and their devotion to their children. As Nadine notes, women form an intimate bond with the fetus through gestational surrogacy, yet in order to affirm Nadine's role as the mother, the surrogate's own kinship with the child must be de-emphasized by highlighting her motherhood to her own children. Nadine achieves this by highlighting the surrogate's "need" and her desire to "improve the future of her own children." This discursive move simultaneously shifts the focus from commodification to rescue, while locating motherhood squarely within the surrogate's own family (disabusing any possibility of motherhood to the fetus the surrogate carries).

Unfortunately, many of the intended parents were unaware that surrogacy often separated women from their own children when doctors required surrogates to live in housing closer to the hospital. To be sure, doctors often claimed that they provided better housing for surrogates and their families during the course of their pregnancies. In practice, however, the housing typically

resembled the one-room apartments they rented with their families, and women frequently lived separately from their husbands (who could not move to a new area due to work) and their extended families.³⁸ In other cases women would remove their children from school so that they could stay together in their new housing provided by the doctors. Such cases illustrate some of the many ways in which reproduction is stratified in transnational surrogacy; in order to raise their own children, surrogates take on the reproductive work of gestation, labor and delivery, which all too often required that they endure separation from their own children and extended families.

Despite Adam and Nadine's desire to know the surrogate and to express their gratitude to her, Nadine found their first and only meeting with the surrogate deeply disappointing. As the couple arrived at the agency office to sign their contracts, they expected to meet only the lawyer. Yet when they arrived, they learned that their surrogate and her friend were already there. Instantly feeling awkward, hopeful, unprepared, and excited to meet their surrogate, Adam and Nadine waited for an opportunity to be introduced to the woman who would carry their child. Instead, agency staff bluntly asked the couple, "Do you want her to go?" Adam and Nadine found the question strange, interpreting it as if their permission was needed to give directions to the surrogate. "Of course," Nadine said, "we would have said we would love it if *she* would like to stay," but bewildered, the couple hesitated. Adam noticed that she was sitting in the waiting room and thought with relief that she would stay; then, he says, "The next time I looked up after signing the contract, she was gone."

In their view, the awkwardness and disappointment surrounding this encounter, in which Adam and Nadine never formally met or exchanged words with their surrogate, was largely due to hierarchies of class. Nadine recalls, "She's doing something amazing for us and I wanted to at

³⁸ See Chapter 4 for further discussion.

least show her some sort of gratitude, some sort of civility, and it didn't seem like it was very civil. I don't know if that's because of her social status, in relation to the lawyer. It's hard to tell because everyone is so poor." Adam and Nadine felt deeply conflicted about the hierarchies of nationality and class that permeated their relationship with the surrogate and expressed profound disappointment with the way the doctors and lawyers mediated their communication with her.

“A Variation on the Theme of Your Life”: Blood and Biogenetic Substance

While Adam and Nadine did not strongly desire a genetically related child, Diana felt otherwise. When I first met Diana on a rainy day during monsoon season, she was at the start of her third visit to India within a year. Diana, born in Europe but a resident of the United States for more than a decade, was in the midst of receiving hormone injections to stimulate the production of ovarian follicles in anticipation of her upcoming egg retrieval procedure. Diana's extracted eggs would be fertilized with her husband's sperm, and the resulting embryos would then be transferred to an Indian woman. Diana's previous two attempts at surrogacy in Mumbai did not result in pregnancy, and while she acknowledged the emotional and physical strain of the surrogacy process on both herself and her husband, Lenny, Diana's desire for a genetically related child was strong, and she maintained a positive outlook and embraced her travels to India as part of a grand adventure.

At the time of our interview, Diana was a successful media professional in her early forties. She had met and married her husband several years earlier, and after initial attempts to start a family, Diana learned that she had very large uterine fibroids. Diana's doctors told her that even with surgery, she would have a very slim chance of being able to carry a pregnancy to term. Devastated, it was at this point that Diana learned about surrogacy in India, just as she was

contemplating adoption “with a heavy heart.” I asked Diana why she viewed adoption in this way, and she responded:

Adoption is a very different process. But the fact that you cannot extend your lineage any longer is a very difficult thing to come to terms with. Surrogacy, although it’s quite complicated, and requires a lot of medication and a lot of legal things are involved and it’s very costly—one thing that it definitely offers is the last opportunity to try to extend your lineage so you can actually have your own children. And a lot of people underestimate how important that is.

Diana was part of a minority of intended parents who explicitly noted the importance of lineage, or having one’s “own” children, in their surrogacy journeys. Although Diana acknowledges the high costs, risks, and legal complexities associated with transnational surrogacy, she nonetheless argues that these obstacles are justified by the imperative to parent one’s own genetic offspring. Yet, while Diana argues that surrogacy offers a valid option for infertile parents seeking genetically related children, her comments also reveal the reality that surrogacy is an expensive, high-risk technology, sought after by infertile parents desperate for a “last opportunity” at parenthood and willing to overlook the reality of low success rates of surrogacy.

I asked Diana if she could expand on the importance of carrying forth her lineage, and after lamenting the bureaucratic difficulties of adoption and the anticipated restrictions due to Diana and Lenny’s “advanced” ages, she replied,

There is something to be said for having your own child. Absolutely. Because when the child comes from your own environment, inheriting your DNA, and something of your outlook on life, it’s kind of like a variation on your theme of life. But if you adopt the child, then it’s from a completely different part of the world and it’s a completely different story...Somehow I think that if it is *our* child, Lenny’s and mine, then we’re not only going to be influencing his life from the outside, but also from the inside. From the fact that it is our flesh and blood. Well, just flesh, not blood; *the blood is going to be from the surrogate* [emphasis added].

Here, Diana reveals the complexities involved in negotiating kinship in the context of gestational surrogacy. In contrast to Adam and Nadine, for Diana biogenetic connections are

crucial in passing on “some variation of [their] theme of life.” Yet at the same time, she acknowledges that this will not be possible without the surrogate’s own blood. This is in contradiction to medical and policy language in India, which defines motherhood in terms of genetic or intended motherhood, effectively excluding the work of the gestational surrogate.³⁹

Diana’s feelings about the importance of creating a son or daughter who is following up on the “theme” of her and her husband’s life, too, exemplifies David Schneider’s rendering of kinship in terms of substance: “relatives” are defined by “blood” and “[t]he blood relationship is thus a relationship of substance, of shared biogenetic material” (1980: 25).⁴⁰ Yet, while Diana recognizes the importance of the relationship between genetic parent and child, she also highlights the role of the surrogate; indeed, it is the surrogate’s blood that will nourish the child. When discussing the process of finding a surrogate in India, Diana expresses strong feelings about the importance of the surrogate’s well being:

When I think about it, I want to make sure that my child is developed well, so the woman who is carrying him must be feeling good. I want her to feel happy when she’s carrying this child. Because it’s all connected. The fact that there is a word ‘surrogate’ in front of the word ‘mother’ does not change the fact that it’s her emotions; it’s her well being that’s going into the development of the child.

Diana’s comments are reminiscent of Jeanette Edwards’s (1993) study from northwest England about what is transferred from mother to child through the placenta. Edwards’s informants speculate on how a baby nurtured in an artificial womb would lack connection to its mother or her feelings. Similarly, while Adam and Nadine did not ascribe much importance to the role of genetics in their notion of parenthood, they, like Diana, highlight the enduring impact of the surrogate and her relationship to the child.

³⁹ Throughout my research, medical and policy language consistently maintained that the legal parents of children born through surrogacy should be the commissioning couple or individual. Indeed, the draft Bill states that “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” (Ministry of Health and Family Welfare 2010: 27).

⁴⁰ See Carsten’s (2001) analysis of Schneider’s use of blood and biogenetic substance as analytic terms.

Moreover, Diana felt strongly that if her current attempt resulted in a positive pregnancy, she would make every effort to return to India and spend time with her surrogate. Discussing the policy of several doctors to prohibit any relationship or communication between the intended parent and the surrogate, Diana responded, “I think that’s very wrong...I think that what they think they’re doing is protecting the emotions of the parents and the surrogates. But what they’re doing, in fact, is they’re creating this alienation that everybody’s afraid of.” Diana, who divulged that she “find[s] it easier to connect with Indian surrogate mothers” (as opposed to American women) and that she had “a very special connection” with her surrogate from a previous attempt, found this alienation to be deeply unsettling. While many doctors sought to mediate the emergent relationship between surrogates and intended parents, Diana’s comments illustrate the intricacies of surrogacy in India as experienced by many intended parents. As she grapples with the relationships created between herself, the surrogate, and her child, Diana navigates new terrain as families are formed across socioeconomic and national boundaries.

Anthropologists have demonstrated how surrogacy effectively deconstructs motherhood into genetic, birth, adoptive, and surrogate maternities, with the potential for multiple mothers of a single child (Cussins 1998). However, the relationship between these disparate mothers is complex and varied; as Teman (2003a; 2003b) has shown, the “hybridized fusion” of surrogates with intended mothers can create alliances between women. However, while many women I interviewed shared Diana’s and Nadine’s sentiments about the significance of the surrogate’s role and the desire to build a relationship with her, intended mothers simultaneously acknowledged the limitations of their bond with surrogates, particularly across significant geographical distance and nationality and class difference. Ragoné (2000) also has demonstrated how hierarchies between women emerge, especially when gestational surrogates come from

different ethnic and class backgrounds than the intended parents. As I will discuss in the following narratives, these hierarchies of class and nation provide the framework within which kinship of some sort develops.

Nobility and the Labor of Surrogacy

Aaron and Ben were 38 and 37 years old, respectively, when I first met them at their full-service apartment in a wealthy suburb of Mumbai. Together for 11 years, they had started taking steps toward having a family about six or seven years earlier, when they first explored co-parenting options with a single lesbian friend. Over six months, they discussed what having children together might entail, how the child would be educated, where they would live. “It was a long process,” Aaron explained, and eventually the three drew up a contract and started trying to have a baby. After several attempts, their friend became pregnant, but then miscarried in the first trimester.

Devastated, their friend eventually decided to back out of the deal and Aaron and Ben turned next to adoption. However, they found adoption in Israel (their home country) to be nearly impossible due to the small number of available adoptees, and as a gay couple, international adoption posed too many restrictions. Aaron and Ben eventually decided on surrogacy abroad. As Israel prohibits gay couples from engaging in surrogacy, and surrogacy in the United States proved too costly, they settled on a clinic in Mumbai that was well-known for providing surrogacy services to gay couples from around the world.

The next step in the process—selecting an egg donor—was a difficult task for Aaron and Ben. The couple considered Indian egg donation, but had issues with the lack of available medical data:

We found that India doesn't have a population registry, so we didn't want to do the egg donation here because you couldn't get a medical history. When you do egg donation in the States or another place, you get like three generations of medical data of the donor and her family and stuff like that, which you couldn't do here. So we started by finding egg donations in other places, and we actually ended up having an egg donor in Romania, to which we sent sperm, and they were fertilized and frozen in Romania, then shipped to India.

While Aaron and Ben emphasize the importance of medical history in selecting an egg donor, they simultaneously assume that genetic influences on physical and psychological characteristics are straightforward and deterministic, reflecting a common view perpetuated by donor agencies (Daniels and Heidt-Forsythe 2012; Thompson 2009). In pursuit of an egg provider with a robust medical history file, Aaron and Ben commissioned multiple IVF attempts with frozen embryos. Interestingly, however, the couple's search took them to countries in which the ideal "three generations of medical data" was not always obtainable; instead, the availability of even minimal medical history justified the around-the-world search for suitable eggs. First, the couple pursued one attempt with a Romanian egg donor agency. After this failed effort, they chose to work with an agency that facilitated egg donation in the United States. Following still more failures with frozen embryos, however, they were eventually successful in arranging for a young, white South African egg donor to be flown to Mumbai for egg retrieval and subsequent fresh embryo transfer. Several weeks prior to my first meeting with Aaron and Ben, their surrogate, Sarita, gave birth via cesarean section to twin girls, Tara and Noelle.

One afternoon, while catching up with Aaron and Shari, Ben's mother, who had accompanied Aaron and Ben to India, we touched on the topic of Tara and Noelle's relationship with both the egg donor and Sarita, their surrogate. This was a topic of great concern for Aaron, who had grappled with the ethical and moral issues related to surrogacy from the beginning. At our very first meeting, he reported that they wanted to do everything they could to "minimize the

possibility of the surrogate mother feeling that she was used. And if possible, even to let her finish the process with her feeling that she has done something noble and that she can be proud of herself.” Indeed, Aaron had met with Sarita prior to the twins’ birth, saying, “My emphasis was to try and show her my gratitude and to make sure that she feels that I don’t take advantage, and that I don’t take this as part of a business transaction.” During his stay in Mumbai, Aaron had hoped that he might be able to arrange another meeting with Sarita and her family, in part to get to know her better but also to reassure himself that Sarita was at peace with the experience of surrogacy.

Shari, on the other hand, did not share Aaron’s concern and it was clear the two had already debated this issue. When I asked whether he had been able to meet with Sarita yet, Aaron replied:

No...I haven’t, I still want to do it...but we have different thoughts about it within the family. I think it should be done. But Shari thinks that our desire to keep up with Sarita or maintain contact with her is like some sort of avoidance, like we are avoiding the ‘real’ mother, the genetic mother. Shari thinks that the genetic donor is probably the person that the girls will be more interested in.

When asked to talk more about the egg donor, Aaron continues:

Well, first of all, I think her involvement is much shorter. She comes from a much closer background to us, she’s Western...and she went through a short process. I’m less worried about her well being in a way. I think her experience was less intensive. I think if the girls decide they want to go after her, I’m less worried about it...They will probably be able to track her down and she will probably be just a regular person... I’m not afraid of what they will think regarding us and our relationship with the donor. All that is different from what I’m thinking about Sarita. I think that if they find Sarita, as a low-middle class lady in India, it will be a culture shock. Somehow I think the bond of carrying a baby for nine months is more important than a medical procedure where you have eggs extracted. I think that there is a better chance that Sarita will be contemplating what happened with the two babies, than the donor.

Throughout the course of our interviews, Aaron returned to this contrast between the white woman who contributed her eggs and Sarita, who contributed the work of gestation, labor,

and delivery. Arguing, “With the donor there is nothing I can do,” Aaron repeatedly returned to the image of Sarita as a poor woman in India who could benefit from his goodwill: “There are things I can do. I can keep in touch with her. I can take care of her and see if there’s anything I can do to help her in the future.” Aaron’s comments about his compulsion to act as benefactor to Sarita reveal his awareness of the unequal relationship inherent in his surrogacy experience and the broader stratification of reproduction at work.

Aaron’s narrative also reflects a script of rescue, prevalent among commissioning parents pursuing surrogacy in India. While Shari argues that the genetic material provided by the egg donor signals “real” motherhood, Aaron is primarily concerned with making sure their surrogate feels “noble,” thus making her worthy of saving. He is also careful to avoid the language of commodification, reiterating that his relationship with Sarita is more than a “business transaction.” For Aaron, then, the kinship that exists between Sarita and his twin girls is a complicated one. Aaron viewed the labor of gestation and delivery as stronger and more enduring than the genetic connection that existed between the egg donor and the girls. Yet, feeling deeply conflicted about the hierarchies of nationality and class that permeated this relationship, Aaron sought to mitigate these tensions by relying on narratives of rescue.

The story of Patricia, a 44-year-old mother of a son born through surrogacy in India, makes similar references to the nobility of surrogacy work. Patricia and her husband, Jonas, a white married couple from the U.S., suffered problems with infertility and pursued surrogacy in India with an Indian egg donor, primarily for reasons of cost. While she was very focused on the selection of the egg donor,⁴¹ Patricia says that with regard to the surrogate, “I just let the doctors pick who they thought would be a good candidate. I didn’t really focus on that selection as much because I didn’t really think it was that important; I just assumed that through their screening

⁴¹ See Chapter 3 for further discussion.

process they'd identify anyone who was not fit for pregnancy." In contrast to previous narratives that revere the bond between the surrogate and fetus, Patricia's primary concern was with physical fitness for pregnancy. She soon realized, however, that she did not share their doctor's judgment:

The thing that most struck us about her was how tiny she was. The paperwork said that she was about 5'1" and when we met her in person—I'm 5'1" and I towered over her, so she was about 4'9", maybe. I think the day before she gave birth she weighed 110 pounds, so when we met before she was pregnant she was probably about 85 pounds. We never would have picked her if we had known how small she was.

The surrogate's "fitness" notwithstanding, everything turned out fine, as Patricia explained, and their son was born relatively healthy, if several weeks premature.

When I asked about her relationship with the surrogate, Patricia replied:

We met her when we signed the initial contract. She was a very, very shy woman. The doctors that we were working with offered to intermedate [sic], but it was very awkward. We didn't really know what to say to her or how to talk to her. Through the paperwork we learned that she had been married at about fourteen and had her first baby around that age and a second baby still in her teens. We had one phone call with her during the pregnancy, and again, because the doctors were intermedating [sic], she was very shy and deferential to them. So we really didn't have a direct connection with her.

Patricia's communication with her surrogate mirrors the experience of many couples I interviewed, who noted the awkwardness that permeated their interactions. While parents rely on doctors and clinic staff to mediate conversations with surrogates, who rarely speak any English, they acknowledge the difficulty in nurturing any kind of "direct connection." In the absence of any intimate connection, the rescue script comes to the fore. Patricia went on to explain a subsequent meeting with the surrogate's family:

We had one other interesting interaction with regard to the surrogate: when we came back we brought over some things for her children. Just a few backpacks filled with school and art supplies, nothing major. But I gave it to her husband because she was already being admitted to the hospital. And he fell to the floor and kissed my feet! And that was just such a strange moment for me. We were already very emotional, but I think that really gave us an insight into what impact this was having on their family, this money she was

earning and the opportunity she was earning. In the one photo we got of her when she was pregnant, she looked like she had so much pride in what she was doing. It made us feel good, that she was doing something that she could do very easily and yet it was making an impact on her and her family. I guess we were worried that people might judge us for being exploitative or somehow taking advantage of people who were too poor to be making their own decisions, but we didn't feel that way. We felt like everyone was making out in this situation.

Similar to Aaron's narrative, Patricia projects an idea of nobility and pride onto her surrogate. In foregrounding the surrogate's "pride" in what she could do for her family, Patricia romanticizes the surrogate's role. However, Patricia simultaneously de-emphasizes the surrogate's position as a mother to her own child conceived through ARTs, as she expresses deeper concern in the selection of the genetic material that contributes to her child's conception.

Patricia also divulges her perception of the risks involved in being a surrogate; she seriously downplays the risks and labor involved in gestation and childbirth, describing pregnancy as something that can be done "very easily." While Patricia's comments reflect the views implicit in the ICMR's Draft Bill that diminish the risks and labor associated with surrogacy, surrogates' experiences indicate otherwise, and the labor involved in surrogacy is by no means easy. Yet emphasizing notions of rescue and nobility shifts focus onto the surrogate as an object to be saved, and conceals the physical labor, pain, and risks that she endures.

"It's a Business Transaction": Other Forms of Reciprocity

While narratives of rescue certainly dominated many conversations, not all of the parents in this study relied on rescue scripts in their narratives about family making through surrogacy. Rather than conceal the commodifying aspects of surrogacy through claims of humanitarianism, around a dozen intended parents I interviewed embraced the transactional nature of commercial surrogacy. In some cases, as I will explain, intended parents began their surrogacy journeys with

a strong desire to develop close bonds with their surrogate. Yet, as their surrogates experienced miscarriages or negative pregnancy test results, among other issues, these commissioning parents came to view surrogacy not as an opportunity to “rescue” a woman in need; rather, surrogacy became a straightforward business transaction. These individuals who embraced the transactional narrative of surrogacy tended to be heterosexual married women who had medical histories of infertility and underwent multiple surrogacy attempts in India (although four gay male respondents also shared this view). In contrast, intended parents who embraced narratives of rescue tended to be gay male respondents; of the 15 commissioning parents who highlighted notions of rescue in their surrogacy stories, 11 were gay men, while four were married heterosexual men and women.

Jan, for example, saw her views of surrogacy shift over time, particularly as she encountered conflicts with her doctor over the management of their first surrogate pregnancy in Mumbai. In the beginning, she says, “I was really into the touchy feely thing, ‘Let’s all be extended family, let’s have belly shots, let’s give presents.’” She had attended a clinic that tried to foster relationships between intended parents and surrogates through Skype, phone calls, and shared photographs of the pregnant woman’s growing belly; doctors, too, supported parents’ wishes to give gifts to surrogates during the pregnancy. Here, building a family-like relationship with surrogates is based in part on gift giving, a kind of reciprocity for the reproductive labor. Yet Jan later came to feel that gift-giving “puts so much stress, not just on the surrogates, but their families because they don’t give presents back.” She explained,

We think about the surrogates every day and we wish we could do more. But it’s actually an intrusion on them to receive these crap gifts that we send. I know somebody gave a sterling silver necklace to his surrogate after the baby was born, and that’s an insult in India! Like, 18 carat is an insult; they’re all 22 carat gold. So it’s just not understanding the customs, and the fact is that I know the majority of us, if not everybody, will want to [give gifts], but we have to wait [until after the child is born].

Gift giving across cultural boundaries was a topic of heated debate among intended parents. As intended parents consulted each other over what is an appropriate gift, doctors began to realize that gift giving resulted in competition and jealousy amongst surrogates who compared notes on their clients' generosity. When Jan decided to try a different clinic, she explained that her new doctor did not encourage gift giving during pregnancy:

[The doctor] says, no, give them [presents] later. And we will gift our surrogate later. We've met our surrogate, we've got photos of her, I constantly inquire about her, I constantly think about her. I would love to send her presents, but I know that once the baby is delivered, *she will be gifted very handsomely by us*. Which we don't have to do; we want to do that. But it's the rules to do it this way and I agree with her. After being through it before, and you see on some of the blogs, "Oh, we're extended family..." I know now that's bullshit, that's absolute crap! They're not. You get your baby, you give them a bonus, you go home, you've got your baby. The thing is, it doesn't mean we don't think about our surrogate. It doesn't mean we're not going to send them presents.

Jan, disillusioned with efforts at making kinship with surrogates, came to view surrogacy as a purely transactional relationship, much like one between an employer and their worker, who receives a "bonus" upon completion of her job. Though she did not believe in gift giving during pregnancy, she felt strongly that parents should give gifts after the child is born. "Our surrogate's got a child and I know that she's going to spend a lot of the compensation on educating that child. We're actually going to pay for that child's education so she doesn't have to use her compensation. And that's going to be our gift to her." Here, the gift becomes a reciprocal act not for the surrogate's labor, which takes place throughout the pregnancy, but for the end product, the child.

Similarly, Lucy, a 36-year-old Australian woman pursuing surrogacy in Delhi, changed her views of surrogacy over a period of several months. Unlike most intended parents in this study, Lucy already had two daughters, aged eleven and eight. Lucy and her husband always imagined they would have four children, yet she endured difficult pregnancies with both of her

children, and after post-partum hemorrhaging following the birth of her second child, Lucy had to have a hysterectomy. For years, Lucy said, she and her husband “mourned not having another child.” Yet, after learning about surrogacy in India, Lucy saw an opportunity to achieve her dream of having more children.

Although Lucy did not have a uterus, her ovaries functioned normally, and she and her husband arranged their first trip to India with plans for Lucy to undergo egg retrieval in Delhi. Embryos created with Lucy’s eggs and her husband’s sperm were transferred to the surrogate, and on the first attempt their surrogate became pregnant. But when the surrogate later miscarried, Lucy was heartbroken. The couple quickly regrouped, however, and planned a second trip to India in the month following our interview. As she was preparing to undergo a second egg retrieval and surrogacy attempt in India, I asked Lucy about her perspective on the surrogacy process and her relationship with the surrogate. She replied:

When I met my first surrogate who was pregnant, I loved her. I thought she was beautiful and just wonderful. But I’ve changed my opinion on how I want to know them now. At first, I wanted to know them and everything about them and talk to them. But I think after our miscarriage, I’m probably changing to, “Look, this is a business deal.” I can’t get attached to them; I want the best surrogate I can get. And I probably want to put a little more business relationship into it than last time. I think that I don’t want to get too attached. And I was asked [by the doctor] if I want to use the same surrogate again, and I don’t. I want to broaden my chances of trying something else, and I probably don’t need to meet them this time.

Like Jan, the changes in Lucy’s views are associated with early disappointments and failed attempts at surrogacy. With the low rates of success in surrogacy, intended parents like Jan and Lucy often become increasingly business-like in their approach as they undergo multiple surrogacy attempts. As a result, Lucy believed that it was unnecessary to meet, learn about, or develop a relationship with the woman who would carry her potential child. Instead, she became occupied with the business aspects of surrogacy; in Lucy’s case, her main concern was with

finding the “best surrogate she could get.” Here, Lucy is not concerned with finding a woman she can “rescue.” Rather, her goal is to find the woman whose reproductive body will fulfill the job she is being hired to do: gestate and give birth to a healthy child for Lucy and her husband.

Karen, a forty-one-year-old Australian mother of twin boys born via surrogacy, echoes Jan’s and Lucy’s sentiments about the transactional character of surrogacy. More than a decade ago and prior to meeting her husband, Karen was diagnosed with cervical cancer. As part of her treatment, Karen underwent a hysterectomy. Yet, Karen explained, “I knew I had a need to nurture,” and she and her husband explored international adoption before realizing that “it just seemed impossible” due to the low rates of domestic adoption in Australia and the long waiting periods for international adoption.

Then, Karen learned about surrogacy, and immediately went to an IVF clinic to find out whether her ovaries still functioned. She was thrilled to learn that her own eggs were still viable. At the same time, once Karen started to explore surrogacy options, she knew that she would need to go abroad. While altruistic surrogacy is permitted in Australia, commercial surrogacy is not, and Karen felt strongly about compensating the surrogate: “If I was going to be trusting someone, another woman, to carry a baby for me, I needed certainty that she was going to hand it over. So we wanted to pay a surrogate for that reason. I want to compensate her, I want it to be a commercial relationship, and I want that baby.” Eventually, Karen and her husband decided to work with a clinic in Mumbai, and after one negative result and one miscarriage, Karen’s surrogate became pregnant with twins on their third try.

Yet Karen’s surrogacy experience, which occurred in the year prior to our interview, was far from uncomplicated. Once she learned that her surrogate, Mona, was carrying twins, Karen was overjoyed. Mona and her husband, however, had major concerns regarding the risks

associated with multifetal pregnancy. Moreover, they knew that surrogates who gestated twins often received higher payments, and Mona's husband wanted to ensure they would receive the highest payment to which they were entitled; he argued that they should receive double the amount originally cited in the contract. Karen and her husband had planned to travel to India to see the first heartbeat scan of the fetus (at around eight weeks gestation), and on the day of the scan, Karen learned that Mona and her husband wanted to do a "selective reduction" procedure to terminate one of the embryos. As Karen explained, "We were told that if we didn't approve the selective reduction, the surrogate would disappear and they would terminate the entire pregnancy." Karen turned to the doctors at their surrogacy agency for help in mediating the conflict and managing the pregnancy. Everything they did, as Karen described, "was an effort to buy time, so that they'd get to the stage where [Mona and her husband] couldn't terminate the pregnancy." For the majority of the pregnancy, she says, "We were faced with the fact that if we didn't pay, [the surrogate's husband] was going to take her back to his village and just terminate the pregnancy or leave the babies on the side of the road to die. We had no idea what was going to happen."

Yet, though Karen agreed to pay for Mona's child's primary school education, something she had planned to do anyway, Karen learned that Mona and her husband never received this information. Karen would later become highly critical of the ways in which the doctors mismanaged the pregnancy and bungled communications. She attributed many of these problems to "cultural factors," however, with only Karen's version of the story, it is difficult to know exactly what Mona and her husband were thinking, or to estimate the seriousness of their threats to end the pregnancy. Nonetheless, Karen came to believe that she and her husband were being "held hostage for the entire pregnancy." As she explained:

I don't know how, but my surrogate's husband was in charge of my pregnancy. So my husband went over at 32 weeks because we knew that the twins would be viable and that was the point that Mona could deliver them. He went with her to an obstetrics appointment at the hospital and managed to get the surrogate admitted. And she was threatened that if she left the hospital she'd be arrested for kidnapping. I got there a week later and we tried to work out what was going on.

Eventually, Karen, her husband, and the doctors made plans to deliver the twins via cesarean section at 34 weeks gestation, even though the surgery was not medically indicated. Evidently, Karen and her husband viewed Mona—construed here as a potential kidnapper of children—as a greater threat to their children than the health risks of premature delivery via cesarean section.

Yet when Karen and her husband arrived at the hospital on the day of the scheduled birth, they learned that Mona refused to sign the consent form for surgery. According to Karen, the doctor at the surrogacy agency explained to Mona that she would not be receiving any extra payments, despite the fact that Karen insisted she had agreed to offer more money. Under these circumstances, the hospital did not want to “get involved” and refused to proceed with the surgery. The hospital's fear, Karen explained, was that without Mona's signature on the consent form, Mona could potentially claim that the children were taken from her against her will, thus challenging one of the core claims of Indian surrogacy proponents: that surrogates always and willingly hand over the babies to their rightful parents. Karen went on describe a scene that resembled chaos, as Karen, her husband, and Mona and were ordered to leave the hospital, while their doctors scrambled to find an alternative hospital in which Mona could give birth. While the clinic's lawyers suggested “calling their bluff” and allowing Mona and her husband to leave the hospital, Karen refused to let them “disappear” and insisted, “These children are being delivered now.” Eventually, the twins were born in a local clinic and transferred to a nearby NICU, where one newborn would spend one week, and the other, three.

However, despite all of the tension, confusion, and uncertainty Karen experienced throughout the surrogacy process, she continued to believe that surrogacy in India is “viable.”

But she was clear in explaining how she believed commissioning parents should proceed:

I think you have to go into it as a business transaction. You are not going to make friends with your surrogate. I actually advise people to not even meet your surrogate. Don't meet her; meet her after birth. It's not going to be like if we had a surrogate in America, that we could talk to, Skype with, email, any of that. For example, we were trying to send some extra money to our surrogate at some point, and no one in her entire family had photographic ID to go pick up a Western Union money transfer. They likely have a mobile phone but she doesn't speak English. She wouldn't know how to turn a computer on. And I'm not trying to be rude here; but we're employing her. It's as simple as that. It's a business transaction. She's doing her job, she gets paid for it. Thank you very much; you'll always be dear to my heart, end of story.

Following Karen's experience, in which she believed she was mistreated by the doctors and threatened with extortion by Mona's husband, Karen came to believe that the ideal conditions for surrogacy were those that articulated a strictly transactional relationship. She cautions prospective parents to have no illusions about the relationship they will have with the surrogate; surrogates and clients should not become friends, nor should they meet in person prior to the birth. Yet Karen also signals the wide power disparity between Indian surrogates and women, like herself, from more prosperous nations. With a U.S. surrogate, she argues, one could Skype, email, and hold meaningful conversations. Indian surrogates, on the other hand, might not even “know how to turn a computer on.” Karen's language recalls the ways in which an employer might speak about a poor, uneducated worker. Rather than work to address the inequalities and make the surrogacy process as transparent as possible, Karen believed the best course of action was to completely de-personalize the process and frame surrogacy in purely transactional terms.

Though Jan, Lucy, and Karen reject the rescue script and embrace a business framework for narrating their surrogacy journey, hierarchies remain between parents and surrogates. By championing an employer-worker approach to their relationship with the surrogate, Jan, Lucy,

and Karen still control the terms of the transaction. In this case, the “job” that surrogates take up is not defined by the labor that goes into pregnancy and childbirth, but by the end product of this labor, a healthy child. By devaluing the surrogate’s labor and focusing on the product of the transaction, such narratives place the surrogate in a precarious position should anything go awry during pregnancy.

In her work on adoption in the United States, Christine Gailey highlights the processual nature of kinship through what she calls substantiation:

Substantiation is what I call the process through which people enter and are embraced in a web of sharing, obligation, reciprocal claiming, and emotional and material support that is considered the most sustaining kind of kinship or family. It is a process of naming, asserting connection, and pooling material and non-material resources that, depending on its intensity, can carve out what Richard Lee terms a ‘safety net’ for participants, the closest degree of kinship, regardless of state definitions of ‘family’ (see Lee 1992).

Building on Gailey’s notion of substantiation, I suggest that in the context of transnational surrogacy, kinship is a complex chain of events, something that is located in everyday practices and experiences and informed by dominant ideologies and individual beliefs. As I have shown, many parents interviewed held contradictory views of kinship that simultaneously destabilized and reinforced dominant ideologies of kinship that emphasize ties based on blood. I found that in general, certain groups of parents held similar views of kinship, though these often overlapped. For instance, those who explicitly mentioned a desire to “pass on” their lineage—to have a genetically related to child—tended to be heterosexual individuals who did not use egg donation (though few gay male parents also fell into this category). On the other hand, those who de-emphasized the importance of genetic relationships tended to be equally balanced between gay and straight couples (all of whom used egg donation). There were still others, both gay and straight, who were somewhat ambivalent about the role of genetics. These views of kinship overlapped with commissioning parents’ narratives of rescue; in general, individuals who de-

emphasized biogenetic kinship tended to embrace rescue narratives. Those who sought to reinforce the importance of biogenetic kinship, on the other hand, embraced a more transactional view of surrogacy. Yet this did not always unfold so neatly, with some parents (mostly heterosexual couples who relied on egg donation) adopting at one time or another narratives that reinforced and deemphasized genetic kinship, as well as narratives of rescue and transaction.

This chapter elucidated the ways in which kinship and family are substantiated through the prism of “humanitarianism,” highlighting the centrality of rescue narratives in this process. However, these rescue narratives, which portray surrogacy as a humanitarian act or a benevolent act of charity, do little to actually address structural change. Moreover, I argue, the ways in which ideas of kinship and parenthood intersect with notions of rescue, as well as with narratives of transaction, ultimately maintain and reinforce global structures of stratification.

Taking up Charis Thompson’s (2001) claim that “biological” kinship may be configured in multiple ways, I suggest that there is no “unique template” for kinship within the context of transnational surrogacy. Indeed, as I will discuss further in Chapter 3, understandings of biological, genetic, and adoptive kinship are uniquely challenged and reconfigured by various actors within the frameworks of race and class.

CHAPTER THREE

Race, Nation, and the Production of Intimacy:

Transnational Ova Donation in India

“The womb is like an oven. It merely bakes the cake. Whether you insert a chocolate or strawberry cake is for you to decide.”

- Fertility doctor, quoted in Jaisinghani, *Maid-to-order surrogate mums*

When Jan Marks (introduced in Chapter 1) booked her first trip to India to begin the surrogacy process in December 2008, she arranged for a young white woman to travel to India for the purposes of egg donation. At the time, Jan explained, “I really wanted a child that looked like me: tall, blond, blue-eyed, that kind of thing...I was really concerned—because I’ve never had a baby before—that I wouldn’t love a baby as much if it didn’t look like me.” Jan believed that her unusual path to parenthood would require the assistance of an Indian surrogate mother and a young, white egg donor from South Africa. Fortunately, Jan had chosen to work with a surrogacy agency in Mumbai that had connections with a South African egg donor agency tasked with coordinating the recruitment of young women willing to travel as egg donors.

Yet after several surrogacy attempts ended in miscarriage, Jan had a change of heart regarding the particular phenotypic characteristics she desired in her child. Worried about their shrinking budget, the couple decided to continue pursuing parenthood through gestational surrogacy, but with an Indian egg donor whose fees would be significantly lower than those of the South African donor.⁴² When I asked her about this change, Jan replied, “When I’d flown in this South African donor and it didn’t work, part of the grief was, ‘Oh my god, I’m never going to have a blond, blue-eyed child now!’” But she went on to elaborate that she felt “quite proud”

⁴² In general, parents who wished to purchase eggs from a white woman paid approximately US\$10-11,000, while eggs from an Indian woman cost around US\$700.

of her decision to use an Indian egg donor. While Jan described herself as “quite fair,” she explained that despite her Polish-Scottish heritage, most of her family has darker, olive-toned skin: “A dark child is actually going to fit in well with the family! And honestly, she [the egg donor] is the spitting image of my sister when she was younger...So I carry that donor’s photo around with me in my wallet, because I’m just—I’m going to get emotional—but I’m just so grateful.” Interestingly, as Jan navigated the disappointment of not being able to have a child that resembled her physically, she took comfort in the fact that her Indian egg donor resembled her sister, and that the child would fit in with her darker-skinned extended family.

This chapter explores the ways in which commissioning parents pursuing surrogacy in India negotiate the process of third party egg donation. As the epigraph suggests, Indian medical doctors draw attention to the market-like aspects of gestational surrogacy and egg donation, comparing the process of creating a life (with specified phenotypic or skin color characteristics) to the simple consumer choice of whether to select a “chocolate or strawberry cake.” I examine the ways in which intended parents and doctors navigate such choices through the practice of transnational egg donation. In particular, I analyze the ways in which commissioning parents construct relations with the egg donor—the genetic parent of the child—as well as with the child conceived through egg donation, IVF, and gestational surrogacy. I also explore the means through which doctors organize practices of transnational and local egg donation. While egg donors undoubtedly play a central role in this process as the providers of genetic material, in what follows I focus primarily on the perspectives of doctors and commissioning parents, as I am interested in how these actors, the organizers and consumers of assisted reproduction, deploy notions of race, nationality, and skin color in the context of egg donation. By examining doctors’ and commissioning parents’ narratives, I illustrate the heterogeneity of approaches to egg

donation in the context of neoliberal global forces that place the onus on egg purchasers to “choose” the genetic material of future children.

As Western parents pursue surrogacy and egg donation in India, they make reproductive decisions within a framework of transnational inequalities, including along national, ethnic, and class lines. I found that for many parents, this process is most intense and intimate within the context of egg donation, and their narratives reveal the diversity of ways in which parents address issues of phenotype, genetics, and kinship. In contrast to dominant assumptions that intended parents primarily seek donors who match their own phenotypic or ethnic backgrounds, I found that of the 19 mostly white couples/individuals who used donor eggs in their surrogacy process, 14 commissioning couples/individuals sought Indian egg donors with darker skin tones. I suggest that while such actions appear to subvert dominant hierarchies that privilege white skin, revealing potential spaces of resistance to racialized preconceptions about kinship, they in fact rely on essentialized notions of race and beauty and reflect new articulations of biological race (Thompson 2009).

A Note on Nomenclature

Everyone involved in transnational reproductive services refers to the women who undergo hormone stimulation and egg harvesting for payment as “donors.” Yet, to call these women donors would be a serious misnomer; their explicit task in this global reproductive economy is to sell their ova for a specified sum of money. Indeed, all of the egg providers I spoke with, both Indian and some South African, said they pursued egg donation because of financial need.

Following Nahman (2008), I refer to these women as egg providers or sellers, to call attention to the participation of purchasers and providers of ova in a wider global economy. Doing so confronts the discomfort that egg donation evokes, particularly for those disturbed by the commercial aspects of assisted reproduction. Identifying those who receive eggs as “purchasers” and women who provide them as “sellers” also highlights the positionality of participants. The prospective parents who commission surrogacy arrangements and donor egg IVF typically come from wealthier countries than those from which egg providers and surrogates originate. These distinctions underlie the complex ways in which global ova donation and surrogacy reflect broader patterns of stratified reproduction.

Defining Race and Skin Color: Identity and Notions of Essentialism

Jan’s story of her path to transnational surrogacy and egg donation raises several questions. How do commissioning parents navigate the process of selecting an egg donor, specifically for the purposes of conception via IVF and gestational surrogacy? What factors might prompt a Western couple pursuing surrogacy in India to select a white egg donor from another country? Alternatively, why might a couple select a darker-skinned Indian egg donor? How do Indian doctors convey the various options available to clients, in terms of race, skin color, or ethnicity? These questions point to broader issues about the intersections among race, kinship, and assisted reproduction: What do these stories tell us about how intended parents understand the relationship between race, nationality, genetics, and kinship? What do these narratives reveal about the broader stratification of reproduction?

In addressing these questions, it is important to first clarify how commissioning parents and Indian doctors understand notions of race, skin color, nationality, and ethnicity. In the

context of transnational surrogacy, I encountered a range of systems of racial and skin color classification among non-Indian commissioning parents and Indian doctors and surrogates. These actors, hailing from different nations, often expressed different understandings of race, skin color, nationality, and ethnicity, which at times intersected and overlapped in the process of transnational reproduction. Here, I explain the ways in which these actors defined, and at times, conflated, notions of race, skin color, nationality, and ethnicity.

Foreign commissioning parents traveling to India, for instance, tend to rely on racial categories that reflect Western notions of race based on phenotype. Parents of children conceived with Indian donor eggs and the intended father's sperm often described their children as "biracial" or "mixed-race," meaning they were part Indian and part white, with the understanding that Indians were racially classified as "Asian" as per U.S. census categories. Several parents expressed essentialist views of race in their descriptions of their encounters with Indians during their surrogacy journeys. One Australian woman, for instance, related her belief that Indians "are just an amazing race. They are so kind. They dress so well and look after themselves so well, even when they have nothing." Commissioning parents often conflated this notion of race with ideas of nationality and culture, in ways I will discuss further in this chapter. Some intended parents, for example, believing that eggs from an Indian woman would make their child "part Indian" through conferral of certain skin color and other physical characteristics, simultaneously felt a responsibility to teach their children about their "Indian heritage." These parents spoke of educating their children about Indian foods, culture, and religious rituals. Further complicating this picture is the belief of still other parents that it was not genetics, but gestation, that bestowed on children some degree of "Indian" heritage and identity.⁴³

⁴³ See Chapter 4 for further discussion.

In India, on the other hand, the category of race is a complex issue. During British colonial rule in India, there were various attempts to classify the Indian population according to a racial typology, reflecting the predominant racial theories popular in 19th-century Europe. Following India's independence from British rule, the 1951 Census of India abolished racial classifications, and today the national census does not recognize any racial groups in India. Social conflicts in India are better described in terms of "communalism," in which hierarchies of community, caste, and religion organize social relations. Thus, Western notions of race make little sense in the context of Indian "communal" conflicts. Interestingly, however, with the increase in global consumers of ARTs traveling to India, Indian doctors increasingly adopt the language of race in their interactions with foreign clients. Indeed, elites in China and Japan historically have drawn inspiration from scientific racism, taking up Western notions of race in order to buttress indigenous discourses of difference and in some instances, stratify internal and external populations (Dikötter 1997; Weiner 1997). This adds yet another layer of complexity to understandings of race in the context of India, as Indian doctors, who rely on categories of caste and religion in their own social contexts, utilize Western categories of race in the global spheres of transnational reproduction.

However, while Western notions of race remain unusual in India, preferential treatment based on skin color, or colorism, is widespread. In the context of egg donation, then, skin color, not race, is perhaps the most salient organizing feature. By skin color, I refer to subjective understandings of skin color or tone, which span different terminologies, depending on the context. Many South Asian languages, for example, have terms to refer to different shades of skin tone. In Hindi, *gora/gori* refers to fair or light-skinned individuals, *saanwala* refers to wheatish brown skin, and *kala/kali* means black, or dark skin. In Punjabi, a person's fair

complexion is compared to the color of milk (*dudh waken*) or to the color of the moon; a dark person's complexion, on the other hand, is likened to that of a crow or the back of an iron skillet (Vaid 2009: 148). In one Mumbai IVF clinic, skin color is described on an egg donor profile form along a spectrum of shades, including dark, dark wheatish, wheatish (light brown), light wheatish, fair, and very fair. While individuals of fair and dark skin tone can be found at all levels of caste and class in India, in general, individuals with fair skin enjoy greater wealth and social status.

These categories—of race, nationality, skin color, and ethnicity—and the varied ways in which actors understand, conflate, and define them, hold critical implications for notions of identity and essentialism in the context of reproductive technology. In recent decades, anthropologists have examined the ways in which “identity” is an unstable object of inquiry. Rather than being immutable, identity is not considered to be a fixed essence, and scholars have explored how individuals craft their identity through social performances. However, with the increasing availability of and reliance on reproductive and genetic technologies, essentialist identities have grown ever more powerful. New genetic knowledge, with the cloak of prestige lent by “objective science,” has propelled the notion that one's identity is an innate, natural, and immutable quality. Gamete donation, for instance, has precipitated a return to ideas of genetic and racial essentialism, in which sperm and egg donor profiles are scrutinized for certain traits, with the promise of inheritable phenotypic and skin color characteristics, among other features. This resurgence has startling implications for those concerned with the feminist and bioethical issues at stake. Daniels and Heidt-Forsythe (2012), for example, show how sperm and egg donation practices in the U.S. reflect positive eugenic beliefs in new and more subtle forms.

Reinforcing the belief that idealized (and often nonbiological) human traits are transmitted genetically, gamete donation propagates views of the eugenics movement.

Within donor agencies, there is a marked preference for matching physical characteristics, and the language of “resemblance” and “matching” serves as a neutralized proxy for race.⁴⁴ As Thompson (2006) notes, in the case of eggs, sperm, and embryos, “the cells themselves are raced in ways that affect not just their availability and who can benefit from them, but the market value and the perceived kinship to recipients of the cells, even when detached from the donor” (2006: 548). Campbell (2007), too, explores these problems in the context of gamete donation in three European countries, in which governments require donated gametes to match the physical characteristics of the recipients. By analyzing ethnic matching of gametes, Campbell argues that biology and culture are separated and then reassembled with the intention of creating offspring who resemble their parents. The meaning of race hovers over biology, inherited physical appearance, and culture, harkening back to the eugenic era though reconfigured as consumer choice. This is what Taussig, Rapp and Heath (2008) have called “flexible eugenics.”

This resurgence of genetic essentialism in the context of gamete donation has important consequences for notions of identity and belonging, because to claim a certain social identity always implies particular rights and obligations. For instance, articulating what counts as a mother-child relationship in the world of surrogacy and egg donation determines what mothers and children owe each other. As Brodwin argues, we must ask difficult questions: “[H]ow does new genetic knowledge change the ways people claim connection to each other and to larger collectivities? How, in turn, does this process change the resulting webs of obligation and responsibility: personal, legal, moral, and financial?” (2002: 326). As gamete donation has led to

⁴⁴ See for example Gingrich (2004) and Hervik (2004).

the increasing biologization of race, these questions are of particular import in the context of ova donation across racial and national lines.

Egg Donation Practices in India

Previous studies of surrogacy in India have focused on one Gujarati clinic that to date accepts only heterosexual married couples. In this clinic, surrogates give birth to babies that will be handed over to mainly Indian and non-resident Indian couples, and in many cases both parents are also the genetic parents of the child (Pande 2009b; Vora 2009). In cases where the commissioning mother's eggs are not viable, normally either the doctor or parents will select an Indian egg donor.

In contrast, my fieldwork, based in several clinics in Mumbai, included a diverse sample of 39 commissioning parents (or 26 couples/individuals) pursuing surrogacy, including 12 gay couples/individuals and 14 heterosexual married couples from around the world, primarily Europe, North America, and Australia. Of these 26 couples who pursued surrogacy, 19 couples/individuals (12 gay, 7 straight) relied on the assistance of donor egg IVF in their surrogacy arrangements. For these clients, the process of egg donation represented an intensely personal transaction in which skin color and nationality, among other factors, were considered in their decisions about who would provide the genetic material for their child.⁴⁵ The process of family making thus became a remarkably high-tech enterprise—including egg donation, IVF, and gestational surrogacy—and the process and experience of donor selection proved to be one of the most stressful and agonizing aspects of their conception and kinship narratives.

⁴⁵ It is worth noting that sperm donation is rare in the context of surrogacy. In my study, there were no cases in which sperm donation was necessary; typically, the husband/male partner provided the sperm that would fertilize the donor egg through IVF. In the case of gay male couples, the couple would negotiate which partner would provide the genetic material; I encountered several cases in which both partners opted to become genetic parents through IVF with one egg donor and two surrogates.

Surrogacy guidelines in India dictate that the surrogate may not provide any genetic material in the conception of the child; if the commissioning mother's eggs are not viable, the commissioning parents must purchase eggs from a third party egg donor. These guidelines emerge from the view that without a genetic connection to the child, the surrogate will be less likely to bond with the child and therefore have little difficulty handing the child over to the commissioning parents.

As a result, for couples who pursue gestational surrogacy with donor eggs in India, donor selection typically includes choosing between a "local," Indian donor or egg donor agencies outside India, which may offer for a higher price a white egg donor. Some foreign egg donors travel to India; others undergo extraction in their home countries for fertilization, freezing, and shipping to India. Typically, if they can afford the higher costs, a commissioning couple will opt to fly an egg donor to India in order to achieve pregnancy through fresh embryo transfer (instead of with frozen embryos) as the rates of success with fresh embryo transfer are higher. In rare cases a couple may bring a friend or family member to India as an egg donor. Nearly all parents noted that the options for donor selection—where skin color and country of origin are prominent selection criteria—prompted difficult discussions about race, kinship, matching, and other desired physical characteristics of the child. Race, skin color, and nationality were nearly always a subtext in narratives about egg donation.

Nationality and skin color also influenced payment, though in complicated ways. In the global spaces in which transnational surrogacy occurs, one finds intersecting ideas of race, beauty, and value, emerging in distinct ways at varying local/global scales, revealing local and transnational inequalities. For instance, white donors received higher pay than Indian donors; in my study, Indian donors typically received between US\$180 and US\$360, while white donors

from South Africa received US\$2200.⁴⁶ Yet in a global economy, ova donors of similar racial background, too, are differently positioned to one another in terms of their relationship to the state, power, the global economy and ova recipients (Nahman 2008). Indeed, commissioning parents desiring white donors often opted for donors from countries in Eastern Europe or from South Africa, where donor payments were significantly lower.

In this study, however, a minority of parents opted to purchase eggs from a white egg donor. Of the 19 couples/individuals who used egg donation, only four (approximately 21 percent) chose to use eggs from a white woman. Three of these couples were white heterosexual married couples, and their donors originated in South Africa, Eastern Europe, and Canada; one gay male couple also opted for a white donor from South Africa. One individual (a single, white U.S. gay male) opted for an Asian egg donor from China, the country in which he was then living and working. The remaining 14 couples/individuals who used egg donation opted for Indian egg donors. Of these, the majority (10 couples/individuals) were white, gay males, with the exception of one white/Asian couple and one white/Latino couple. Four heterosexual married couples also opted for Indian donors; these, too, were primarily white, with the exception of one African-American woman (whose husband was white) (see Table 1).

⁴⁶ In contrast, Almeling (2011) found that due to the difficulty of maintaining a diverse pool of donors in the U.S., often agencies will increase the payment for donors of color, particularly Asian American and African American donors. She illustrates how in the U.S. market, race is viewed as biological, and egg cells from women of color are perceived as scarce, contributing to their increased value. Paradoxically, this results in a situation where donors of color are more highly valued than white women, an unexpected consequence given that the reverse is often true in other contexts, such as in transnational egg donation.

Table 1. Characteristics of commissioning parents and their egg donors

Pseudonym	Sexual orientation	Ethnicity of commissioning couple/individual	Ethnicity of egg donor
Aaron/Ben	Gay	White	White (South Africa)
Adam/Nadine	Straight	White	White (South Africa)
Alain/Gaspar	Gay	White	Indian
Andrew	Gay	White	Indian
Carson	Gay	White	Indian
Fred	Gay	White	Asian (China)
Jan	Straight	White	Indian
Jason/William	Gay	White	Indian
Liz	Straight	White	Indian
Lucas/James	Gay	White	Indian
Mark/Lionel	Gay	White	Indian
Marla/Roland	Straight	White	White (Eastern Europe)
Marlene	Straight	African-American (w/white husband)	Indian
Martin	Gay	White	Indian
Matthew/Anthony	Gay	White/Asian	Indian
Patricia	Straight	White	Indian
Sharon/Ahmet	Straight	White	White (Canada)
Simon	Gay	White	Indian
Tristan/Juan	Gay	White/Latino	Indian

As commissioning parents navigate the process of egg donation across racial, ethnic, and national lines, it is important to contextualize these negotiations within the transnational hierarchies in which they occur. Here, I turn to Howard Winant’s (2004) explicit call to link globalization with imperialism:

Globalization is a re-racialization of the world. What have come to be called ‘North-South’ issues are also deeply racial issues. The disparities in status and ‘life chances’ between the world’s rich and poor regions, between the (largely white and wealthy) global North and the (largely dark-skinned and poor) global South have always possessed a racial character. They are the legacy of a half millennium of imperialism (2004: 131).

As Winant argues, globalization is a “racialized social structure” (2004: 131), and it is within this structure that commissioning parents confront the transnational inequalities that privilege their

capacities to become parents while relying on the reproductive labor of women in the global South.

Within this system of transnational social stratification, how do ART consumers make decisions about who will provide the genetic material for their child? As transnational egg donation involves the movement of donors, gametes, and embryos across borders, I found that doctors and commissioning parents dealt with stratification in diverse ways. In what follows, I detail the ways in which doctors organize donor profiles hierarchically along lines of class and skin color, shedding light on how parents understand and negotiate this process. I show that while Indian doctors rely on kinship models that privilege whiteness, Western commissioning parents often rejected such models and opted for Indian egg donors for varying reasons.

Stratifying Donors and Divas

I first came to realize that the system of transnational reproductive services values human eggs by the egg providers' skin color in an interview with Dr. Guha in October 2010. Dr. Guha was the managing director of a well-known agency that facilitated surrogacy arrangements between surrogates and intended parents, the majority of whom are foreign clients who travel to Mumbai from all over the world. We had met several times during the course of my research in Mumbai, and when we finally sat down to have an extended conversation about his work, his interview followed a familiar script. Dr. Guha, like most doctors involved in the surrogacy industry, always emphasized his compliance with government guidelines and transparency when it came to standards of medical practice and care. He shared his international clients' testimonials and told me how much he values making a baby and "completing a family." Like many of the doctors who provided surrogacy services, Dr. Guha shrugged off any criticism of or

challenge to the ethics of his work by repeating perhaps the most important line in doctors' surrogacy script: surrogacy is a "win-win" situation for all actors involved, providing much-needed income for the families of poor women and highly desired children for infertile couples.

Toward the end of the interview, however, the conversation took an interesting and unexpected turn. As we were concluding the interview, Dr. Guha suddenly lowered his voice and said, "Now, I have a personal question I would like to ask you." He continued, "It's just a thought, so don't feel offended or anything—but we get a lot of queries for Oriental donors. *Would you like to be a donor?*"⁴⁷ Somewhat taken aback and unsure I had heard him correctly, I asked for clarification and he continued, "Yes, Oriental donors. You see, the compensation we give is very different from others. We can give a compensation of more than US\$2000. See, if you want a Caucasian donor or an Oriental donor, it's more worth it [to clients] if you are already here—so you don't have to fly them [donors] in to India and pay travel costs." Though he couched his inquiry in terms of my potential financial windfall as a prospective Asian egg donor, I quickly gathered that Dr. Guha was at least partly motivated by the prospect of offering his foreign clients the best deal he can.

I became deeply curious about the egg donation procedure. Two thousand dollars is indeed a grand sum of money in India (though a fraction of what many egg donors might receive in the U.S., for example), and many times greater than what Indian egg donors I interviewed received. I wondered: How do doctors classify their egg donors, and how do they determine

⁴⁷ Dr. Guha's use of the term "Oriental" may reflect the influence of British English in Indian speech, where the term may not be considered particularly offensive, and is generally used to refer to people from East and Southeast Asia. He was the only doctor to use the term, and other doctors I interviewed used racial categories such as "Asian" to refer to people of Asian descent. It is perhaps worth noting that Dr. Guha was one of the few doctors I interviewed who had not received any medical training outside of India. All other doctors were educated abroad, reflecting perhaps a cosmopolitan understanding of the various racial categories used in different contexts.

payment for donors of different racial and ethnic backgrounds? Who are the couples seeking “Oriental donors” and where do they come from?

As Dr. Guha told me of the many inquiries he received from couples in Hong Kong and Taiwan, as well as from Chinese or Japanese couples who live in the U.S., Canada, and Australia, he turned to his computer to show me his confidential database of donor profiles. As I scanned his computer screen and debated how to respond to his query, something on the screen caught my eye: two distinct categories, “Diva donors” and “regular donors” marked each profile. When I asked about this distinction, Dr. Guha responded, “Normally, the donors you would get from India are from the same background as the surrogates. They are not very educated, not very gorgeous or beautiful.... [Diva donors] are highly educated. She’s from a ‘Harvard’ background. She’s highly professional. Their compensation is different.”

Here, Dr. Guha subtly indicates the ways in which the medical establishment determines what kinds of women are appropriate for different kinds of ART labor. While the bodies of lower status women are deemed appropriate for surrogacy, they can also provide the genetic material used in IVF (albeit at a lower price). Eggs of higher status women, however, were more highly valued on the market, and thus received higher compensation than “regular” women. But these women were not considered “good” candidates for surrogacy. One doctor explained the difference between working with women of different class and educational backgrounds in the following way: “The good thing is that they [higher-educated women] can read a prescription. The bad thing is they think they’re smarter than you. The others will take your word as god’s. With simple things, they will not shake without asking if it’s ok. But the one’s who think they’re super smart, they’ll just do whatever they want on their own.” For doctors, lower-class, uneducated women represent docile, submissive bodies, ideal for gestational surrogacy. On the

other hand, upper class women, perceived as strong-willed and insubordinate, are more suited for the shorter-term commitment of egg donation and rarely were recruited as surrogates.

Moreover, photographs accompanied Dr. Guha's egg donor profiles, and I could see that the regular donors who were "not very educated, gorgeous or beautiful" were almost uniformly dressed in traditional Indian wear, that is, a *salwar kameez* or *sari*, with simple, unsmiling mug shots. Doctors described them as having "dark" or "dark wheatish" skin color, and they typically had low levels of education, with "professions" listed as domestic work or "housewife." The diva donors' photos, on the other hand, resembled "glamour shots" one might see in a photographer's studio: the women wore heavy make-up and Western clothing (a shirt or blouse with denim jeans, for instance) and soft lighting framed their smiling faces. Moreover, all the diva donors were fair-skinned with lighter colored eyes and taller-than-average height, and they shared a range of profile characteristics including personality traits, profession, and education.

Dr. Guha's donor database commoditized markers of class, race, skin color, and social status. He recruited low-income, darker-skinned Indian women as the providers of "regular" eggs, while women of higher social status provided the genetic material with highly desired characteristics. At the same time, Dr. Guha's database illustrates the organizing principles of egg donation: notions of beauty and desirability overlap with education, class, and modernity, while his database rates the less attractive, i.e., "not very gorgeous or beautiful" women as, like surrogates, low-status and not ideal sources of genetic material for Western couples. Race, to be sure, is an organizing criterion for egg donation, and medical practitioners perpetually reify race as a valid classificatory system when assessing patients (Garcia 2003). Indeed, I witnessed this firsthand as Dr. Guha informed me that my own Asian/"Oriental" features could fetch high payments and a spot in the diva donor database.

These divisions also reflected regional inequalities and prejudices between north and south India. In a burgeoning surrogacy clinic in Delhi, I found that like Dr. Guha in Mumbai, Dr. Verma categorized her profiles of egg providers hierarchically. When asked to describe her clinic's database of egg providers, which, like Dr. Guha, included only Indian women, Dr. Verma begins by describing the categorization of women's profiles:

I have two categories: the A-list are highly professional, models, absolutely stunning women. I have a doctor who's an egg donor. A lecturer at a university here. They get up to US\$2000. Usual egg donor compensation is around US\$630. See, here (*turning her computer screen toward me*) this is one of my A-list egg donors. She's a model. She was here in the clinic the other day and everybody in the hospital was going gaga. I have a few who are like that. You can't see but she has green eyes. That's very unusual for India. She's a university graduate. Here's another one; she's also a university graduate. Then I have some "Asian-looking" profiles; see, she's Asian-looking, so if we have an Asian-looking intended parent, they can have her.

Dr. Verma continues to show me profiles of engineering students, university graduates, and other donors with professional backgrounds, and emphasizes, "Being in the north of India, you'll see that people here are different from Bombay or the south because people here have fairer complexion, sharper features. They are more smartly dressed. It's just a culture thing in Delhi. So there is a better choice of egg donors here." Eventually, she shows me a few profiles in the less desirable category, the "D-category," where the women are "uneducated, young girls."

Interestingly, caste rarely surfaced in interviews with doctors or intended parents, except in my conversation with Dr. Verma. When asked whether other factors might play a role in egg donation and surrogacy, Dr. Verma disclosed, "Yes, but not for the surrogate. I had one couple who were Muslim and from a Muslim country somewhere in the Middle East. They wanted only a Muslim surrogate and a Muslim egg donor. That was the only case I've encountered." With respect to surrogacy, on the other hand, Dr. Verma indicates that caste became an issue only in relation to the health of the baby:

The only thing people might be concerned about [with respect to caste] is that in India, some higher-caste Hindus are vegetarian. They are concerned with the nutrition of the baby. So we absolutely load [the surrogate] with nutrition. There's this girl who's in charge of nutrition at the home [where surrogates stay during their pregnancies] and she has a goody bag that's filled with biscuits, vitamins, and other snacks. So it doesn't matter if they're vegetarians. Most of our babies are three kilos (about six and a half pounds). In the north, people are taller, broad-shouldered, so they are able to carry the pregnancy just fine.

Dr. Verma's comments illuminate how social hierarchies work in India. Framed in terms of "choice," Dr. Verma places north India, and specifically the cosmopolitan city of Delhi, at the top of the list from which egg purchasers may select "A-list" eggs, due to its culture and reputation in India as well as the prevalence of people with lighter-skinned, "sharper features" less common in the south. She also underscores the role of caste in surrogacy, again highlighting regional difference as she moves from descriptions of nourishing higher-caste Hindus to claims of better physical fitness for childbearing among women in the north of India. Such practices elucidate the ways that physicians work to reinforce skin color and other physical characteristics (attributed to regional difference) as biologically inheritable; doctors, who have culturally sanctioned authority that extends to reproduction (Jordan and Davis-Floyd 1992), are in a unique position to perpetually reify skin color and other forms of difference as valid systems of classification. Here, we see the salience of skin color as a classificatory system in egg donation, revealing hope for or a belief in some kind of biological persistence of skin tone (Thompson 2009).

In India, skin color matters, and donor eggs were valued in an economy of color reflective of a history of colonialism and racism. A light complexion confers symbolic capital in marriage negotiations among South Asians (Vaid 2009), and financial capital in negotiations between South Asians and prospective parents. Most doctors had separate files or databases for

fair and dark-skinned donors, and as doctors' narratives illustrate, in these files skin color nearly always overlapped with education, class, and beauty (Almeling 2011).

In my fieldwork I found that other doctors crafted their presentation of their egg seller profiles in much the same way as Dr. Verma and Dr. Guha, according to their perceptions of what clients would find desirable. In many cases, these profiles do indeed conform to the expectations of prospective parents who favor fair-skinned donors. Yet, at the same time, I found that many intended parents did *not* explicitly desire the fair-skinned, highly-educated egg donor. Moreover, as I will discuss, parents described Indian donors in general as desirable precisely because of their “otherness” or exotic beauty, where racialized perceptions of beauty both opened up a space for resistance to whiteness but also a reinforcement of racial/racist stereotypes.

“Appropriate” Matches and the Reproduction of Whiteness

Ethnographic research on egg and sperm donation indicates that prospective parents commonly seek phenotypic, personal, and cultural “matching”—seeking donors who share a similar racial/ethnic background, personal qualities, and phenotype—between egg donors and intended mother or sperm donor and infertile male partner, and agencies or doctors commonly encourage the practice (Becker 2000; Thompson 2005). Such matching appeared to keep assisted reproduction as “natural” as possible, while also allowing families to be discreet and maintain secrecy regarding donor use, giving parents full control over domestic decisions about disclosure to their children about their “origin stories.”

Infamous ART cases around the world reinforce this presumption of ethnoracial matching and reveal the desirability of racial purity. The media and public reaction in response to

these cases are telling. In response to a 2002 case in which a white couple had mixed-race twins after an Asian man's sperm was mistakenly used to fertilize the intended mother's eggs, the woman was later quoted as saying, "All we wanted was a family. Instead we were landed with a nightmare that will last forever" (NewsCore 2012). Quiroga (2007) has noted how media accounts referred to the case of an African American woman inseminated with the "wrong" sperm (from a white man) as a "dream...turned into a nightmare," "unthinkable," "a fertility screw-up," and a "fiasco" (2007: 143). Drawing on such examples and her own fieldwork on gamete donation, infertility, and race in the United States, Quiroga asserts what while the stated goal of the U.S. infertility industry is to "create families," what remains unspoken is "the desire to create a certain type of family, one that closely matches, and thus reproduces, the heteropatriarchal model of a white nuclear family" (2007: 144). Quiroga ultimately argues, "ARTs's privileging of genetic relatedness is currently deployed in ways that support a white heteropatriarchal model of family in which race and whiteness are reified as inheritable" (2007: 144).

Throughout my own research, I confronted many examples of ways in which IVF, egg donation, and surrogacy in India bolstered white, heteropatriarchal kinship patterns and reflected fears about race mixing. For instance, Dr. Singh, a Mumbai-based IVF specialist, discussed her surprise at how often her clients, particularly her clients in same-sex relationships, opted for Indian donors with darker skin:

I kept pushing the lighter skins [on same sex-couples], because I feel it's hard for a child to go through life with two dads, and then you put the child through color difference in a society. It's something that's going to bother them later. So if they do agree, I can tilt them towards, you know, "These are the options and that's what you can use, but think about it really hard before you choose a darker color skin."... Children do not understand racism, but they do understand color and they do understand difference, like, "Why are you so different from your parents? Why do you have two dads?"

Dr. Singh found it difficult to accept that a couple would want to conceive a child who would be a racial mismatch to its own family. Indeed, as the doctor and facilitator of surrogacy arrangements, she often used her position of authority to attempt to influence prospective parents' decisions in egg donor selection.

Moreover, Dr. Singh found it troubling that same-sex couples in particular expressed preference for donors with darker skin, but same-sex couples clearly have no option of concealing the use of assisted reproduction. I found, just as Dr. Singh described, that same-sex couples rarely made matching racial/skin color characteristics high priority. While Dr. Singh described this preference for non-white donors or donors with darker skin tones as signaling an increased "sensitivity" and openness on the part of her gay clients, she thought that the stigma of being a child of same-sex parents was all the more reason for same-sex parents to avoid dark skinned donors.

Marlene Sawyer, an African American woman in her late forties and mother of a two-year-old son born through surrogacy in India, also reported that her doctor had an opinion about her taste in skin color in an egg provider. Marlene's husband is white, and they needed the assistance of donor eggs. According to Marlene: "I sent her emails and said, 'Here is a picture of me and my husband. As you can tell, I am a dark, black woman. Please give us the darkest donor you have.' What do we get? The whitest donor she has!" I asked Marlene what she thought about why her doctor had taken matters into her own hands, and Marlene said:

I have no idea. I think she probably was looking at it for my husband, because my husband is a white male. So I thought maybe she was thinking, culturally or something, since the men are so dominant, "Oh, we'll give her someone that looks like her husband." I mean, I showed you the picture of Sean [Marlene's son], right? (*shows picture*). He's white as white can be.

Marlene's experience as an African American woman contrasted sharply with the majority of intended parents who traveled to India, who were white. While Dr. Singh expressed concern over the multiple boundary-crossings committed by same-sex parents who seek darker-skinned egg donors—parents who challenge heteronormative models of kinship and resist expectations to reproduce whiteness at the same time—Marlene's doctor ignored her request for a donor who matched her own skin color, a move that Marlene believes has impacted her own experience as a black mother. Marlene divulged, "Even though I love Sean, I don't want to feel like an outsider. Even though he never makes me feel that way, he loves me and he's my baby, I want him to get a little darker!" When asked about challenges or concerns that have come up for her since the birth of her son, Marlene replies:

People don't understand; they think I'm the nanny, or they say, you must be babysitting today. When little kids say it I don't care, but when adults say it, I say *I'm* his mother. And they're kind of caught off guard. I'm like, I don't have to explain Sean's existence to anyone. When Sean is of age and he wants to tell his story, he can tell his story. I feel like, as a black woman, why are you questioning me? That kind of stuff, I'm trying to figure out how to deal with it, where I'll feel comfortable.

Liz's story, like Marlene's, elucidates the problems and anxieties that stem from lack of transparency and trust in the doctors who arrange surrogacy packages from half a world away. A U.S. mother of twins born through surrogacy in India, Liz was fifty-four years old at the time of their birth. Liz had previously been married twice; she had five children with her first husband, whom she divorced after eleven years because of his escalating struggle with alcoholism. With five small children to support, Liz decided to enroll in college, and completed one year before she met her current husband. The couple went on to have eight children together before they decided to adopt an infant from Guatemala. With fourteen children (including the children from Liz's previous marriage), Liz took on the work of educating her children at home, while her husband supported the family through his job in systems management.

Even though they had an already full family, the couple hoped to adopt still another child from overseas. Yet their plans fell apart when evidence of corruption halted their adoption process in Vietnam. Somewhat disillusioned with adoption, it was around this time that Liz learned about surrogacy in India. Though she had heard that most doctors would only accept childless clients with histories of infertility and within a certain age range, Liz had also heard that some doctors did not adhere to this rule. After sending several inquiries and receiving multiple rejections from doctors, they found Dr. Sen in Delhi.

Because Liz was menopausal, the couple would need donor eggs in their surrogacy process. When asked about her experience with egg donation, Liz explains:

We were eager to have the donor be Indian as we had this idea of a sort of transworld cosmic connection through that, since we had really wanted to adopt [internationally]. We did tell them we hoped she [the egg donor] was reasonably attractive and healthy and intelligent, but we did not do any selecting, since they didn't offer it, and we knew that they would be able to select based on medical criteria. We suspect that he did not actually use an Indian donor because they stressed how they needed a picture of me to choose a suitable person, and the babies are very very fair. . . . [Dr. Sen] made mention of how he uses his best judgment on egg donors, and I got the distinct impression that he would do just what he thought best. . . . He wanted LOTS of sperm samples from John, even after the day that they did the egg retrieval and fertilization for our twins. . . . It honestly never crossed either of our minds that any doctor could be so lacking in ethics to do such a thing as "borrow" other people's genetic material without disclosing that it would be given out to other strangers. I don't know how to even deal with this. We were told just about nothing of the egg donor. John asked and was shown an in-distinct photo of an Indian woman.

Liz believed that Dr. Sen committed various offenses—ignoring her request for an Indian egg donor, using John's sperm to fertilize another woman's eggs even after the initial IVF for her twins—and I frequently heard such stories of misdeed circulated among parents pursuing global surrogacy. In the absence of any formal legislation or regulatory mechanism regarding the use or provision of ARTs in India, parents such as Liz—who lived beyond India's borders and thus had little recourse to take any legal action—often resign themselves to speculation about the source

of their children's genetic material. Liz's experience also reflects issues that arose in many of my interviews with intended parents; foremost among these was the issue of trust between client and doctor, and fears about what could happen when the commercial exchange takes places across multiple geographic/cultural boundaries. Many parents, indeed, spoke of the need to "blindly trust" their doctor in order to move ahead with surrogacy in India.

Marlene's and Liz's stories reflect the power that doctors hold in defining what is "desirable" in a donor and creating "acceptable" families. Similar to Roberts's (2012) finding that Ecuadorian clinicians frequently aimed to make whiter children through sperm and egg donation, my study, too, reveals how doctors view themselves as key players in a whitening project and deliberately select donors based on their lightness, regardless of what the intended parent may request.

Yet, what motivates an intended parent to request a donor of a different racial, ethnic, or national background; or, more specifically, what motivates white intended parents to select Indian egg donors? Liz's narrative reveals a common thread among intended parents who explicitly desired an Indian egg donor. Liz and her husband specifically hoped for a child who might reflect and fulfill her desire for some kind of a "transworld cosmic connection," a connection rooted in her desire for a family filled with internationally-adopted children. As I will discuss in the following section, couples more frequently opted to forgo ethnic or skin color matching in favor of donors from non-matching backgrounds (phenotypic, ethnicity, race, culture, etc.). Indeed, of the 19 couples/individuals who used donor eggs, only four parents purchased eggs from donors of matching (white) background. Of those who opted for eggs from Indian women, four couples/individuals took into account the woman's skin color, indicating a preference for fair- or dark-skinned donors, depending on the commissioning couple's own skin

color. The majority (10 out of 14 couples), however, selected Indian egg donors with darker skin tones than their own (see Table 2). This desire reflected in part a “primordial ethnic authenticity” (Thompson 2009: 143), where expressions of desire for children who “looked Indian” were often interchangeable with expressions of desire for a child who “looked exotic.” Such desires reflect the complex dynamics of reproductive tourism, where intended parents’ desires for exotic-looking children tangle with rescue narratives that frame the parents as “saving” surrogate mothers and egg providers.

Table 2. Commissioning parents’ preferences regarding egg donors with matching ethnicity/skin color

Pseudonym	Ethnicity of commissioning couple/individual	Ethnicity of egg donor	Sought egg donor with “matching” ethnicity or skin color
Aaron/Ben	White	White	Yes
Adam/Nadine	White	White	Yes
Alain/Gaspar	White	Indian	No
Andrew	White	Indian	No
Carson	White	Indian	No
Fred	White	Asian	No
Jan	White	Indian	No
Jason/William	White	Indian	No
Liz	White	Indian	No
Lucas/James	White	Indian	No
Mark/Lionel	White	Indian	No
Marla/Roland	White	White	Yes
Marlene	African-American (w/white husband)	Indian	Yes
Martin	White	Indian	Yes
Matthew/Anthony	White/Asian	Indian	Yes
Patricia	White	Indian	Yes
Sharon/Ahmet	White	White	Yes
Simon	White	Indian	No
Tristan/Juan	White/Latino	Indian	No

The Biologization of Race, Skin Color, and Nation

While rates of compensation, doctors' practices, and beliefs about racial matching revealed the stratification of egg providers along race and color lines, in practice intended parents select egg donors based on a range of "qualifications." The process of egg donation in India differs vastly from the process in countries where most intended parents come from. For instance, based on their knowledge or experience with agencies in the U.S., many intended parents expected to receive, at the very least, basic information about ancestry, genetic history, as well as information related to personality characteristics. Practitioners in India made much less information available.

In this context, what "qualifications" did commissioning parents look for? Patricia, a 44-year-old U.S. mother introduced in the previous chapter, would have liked to use an egg donor from a developed country but couldn't afford the higher costs. When she and her husband decided to choose an Indian egg provider, she explained how she sought more information about the women's background:

I did actually try to develop a little questionnaire to ask our egg donors some questions, to try and find out a little more about her potential. It didn't work very well...I tried to ask questions in a way to try to uncover her potential rather than her actual, things she had achieved. But it did make me aware that the circumstances that she lived in didn't really give her any possibility of exploring her potential. It was a little bit of a fruitless exercise and it made me a little bit sad, just knowing how limited her options had been. Basically we picked someone who we thought was pretty. And that's not what you ideally would want to base your decision on.

After asking her doctor to share the questionnaire with potential egg providers, Patricia recognized the social and economic constraints that limited Indian women's access to education. Thus, she accepted that she had to use much simpler criteria for selection, based on beauty.

When asked to expand on her process of selecting the egg donor, Patricia underscored that skin color also factored into her decision:

We picked one of the fairer egg donors that we found. There was something about her face that reminded me of people on my side of the family. It's funny, because even my father, not knowing that, said that he [my son] looks like his brother. And that's exactly the side of the family that her face shape had reminded me of. There were a lot of factors in the looks that we considered, and definitely someone who would "blend" into our family was one of them. We were totally shocked though that he ended up having blue eyes and reddish hair! Of all the things I expected when picking an Indian egg donor, that would have been at the bottom of the list. It's just completely a genetic surprise.

Here, Patricia (like Jan, whose story opens this chapter) engages in a kind of "resemblance talk" (Becker, et al. 2005). Patricia and Jan, among other parents in this study, recognize the cultural significance of resemblance, and searched for familiar qualities in their egg donor regardless of the donor's ethnic background.

Mark and Lionel, on the other hand, an Australian-Italian couple in their early thirties and parents of a son born to a surrogate mother in Delhi, ultimately settled on an Indian donor they felt was "beautiful" and evoked a kind of Indian "authenticity":

Lionel: We received a number of profiles, which basically consisted of age, initials...

Mark: Some of them would have a picture and a few words, others would have all these...

L: ...blank fields. We just sat there and went through and had very distinctive feelings about, "Oh, no way," and "Oh, she's so pretty," or "Oh, she likes confetti, that's quirky." But we both felt that we were attracted to a story.

M: Yeah, we said, "Can we have more information about *her*?"

L: Some of these profiles are, you know, the shots that you take when you're "Miss India," ten superhot gorgeous, over-make-upped –

M: Yeah and the background, everything is like "mistyland" or something.

L: We were like, no, we wanted something *authentic*.

M: All of JM's photos, they were just very natural. Very simple shots, and that's what we like, I guess. That's how we chose, basically. At the end of the day, it was just a sense of warmth...

Lionel went on to explain their desire for an Indian donor: “We actually always thought that, because India is allowing us to do this, it was natural to have the child be...of India. In a way our child belongs to India. The other thing is, Lionel and I don’t care what race the child is. Actually I was surprised to learn that a lot of couples were still seeing egg donors from outside of India.”

Patricia’s, Mark’s, and Lionel’s comments reflect those of many of the parents I interviewed, who cited a variety of reasons for selecting an Indian egg donor. While Patricia cited cost as a major factor, Mark and Lionel cited reasons that reflected an essentialized understanding of race. As they sought a kind of Indian “authenticity” that was “natural” and “simple,” they simultaneously expressed an understanding of race as a persistent biological category, with their belief that their child is “of India.”

Other parents, particularly white parents, articulated racialized notions of beauty in their discussions of Indian egg donation and “mixed-race” children. Marla, a thirty-two-year-old Norwegian mother of a baby girl born via surrogacy in Mumbai, explained:

Since we had to have a donor, I told Roland that I didn’t mind having an Indian donor. But then he said that it would be a lot easier for us to explain to governments and a lot of neighbors – everything – if she’s white. I said, “I don’t mind and I know that it’s good to mix races.” I told him that, “It’s actually not a bad thing. It’s a good thing.” Indian mixes or the Indian and the white mixes that we have seen, the children are so beautiful. They are absolutely beautiful. They are lovely. So, I told him that. To me, it doesn’t matter, but he wanted to try it [donation with a white donor] one time.

Though Marla claims she would have considered an Indian egg donor due to the “loveliness” and “beauty” of children of mixed descent, she ultimately decided to go with a white egg donor from Eastern Europe, mostly due to her husband’s wishes to maintain resemblance and secrecy regarding surrogacy.

As I have discussed in this chapter, transnational egg donation encompasses multiple racial and national projects. In some cases, parents may explicitly seek to reproduce whiteness or

resemblance. In other cases, however, parents sought to subvert dominant kinship models that privilege whiteness, by deliberately selecting Indian egg donors that reflected notions of mixed-race beauty or a kind of Indian authenticity. Such actions, nonetheless, maintain racial/racist structures that rely on essentialized notions of culture and racialized beauty. Moreover, transnational egg donation underscores the salience of donor skin color (often conflated with race or nationality) in donor selection, even though genetic determination of skin color, among other traits, is unpredictable at best. Ultimately, as doctors and parents organize and negotiate the process of transnational egg donation, the social constructs of race, skin color, and nationality become ever more biologized within transnational relations of power.

CHAPTER FOUR

Movement and Mobility:

Gendered Geographies of Reproductive Tourism

I first met Avani in September 2010, at the one-room apartment she occupied with her two children and mother-in-law in suburban Mumbai. Avani sits on the one bed in the modest room so my translator and I can sit on the two plastic chairs she brought in from a neighbor's apartment. In one corner of the bare, rundown room with peeling pink paint are two gas burners and a sink; across the length of the room hangs a clothesline. At the time of our meeting Avani is 25 years old and barely five months pregnant as a surrogate mother for a couple she describes only as "foreign."⁴⁸ The surrogacy agency had arranged her move to these temporary accommodations close to the hospital where she will give birth.⁴⁹ As the children play on the floor in the corner of the room, Avani tells the story of how she became a surrogate mother.

While Avani's family is originally from Nepal, she was born and raised in an industrial city nearly forty miles outside of Mumbai. Avani tells me that she may have completed first or second standard in school, "which is equal to nothing." She had an arranged marriage in 2000, at the age of 15 to a 20-year-old man. His education, too, was "not much, maybe up to a couple of

⁴⁸ Many of the surrogate mothers interviewed for this project knew little about the intended parents who commissioned the surrogate pregnancy. In most cases, they were known only as "foreign," i.e., coming from outside India.

⁴⁹ In this study, I encountered a range of practices with respect to housing for surrogates during their pregnancies. Some doctors strongly encouraged women to move to surrogate housing arranged by the clinic. Others allowed women to remain at home with their families. In this chapter, I examine the experiences of women who were confined to surrogate housing or the hospital at some point during their pregnancies. Among my sample of 31 surrogates, 15 women were pregnant at some point during my main fieldwork in 2010 (others had either already previously completed surrogacy, or were presently undergoing the process of preparing for embryo transfer). Of those 15 surrogates, 6 women (40 percent) were confined to surrogate housing for at least one month during their pregnancies.

standards,” and while his income is not fixed, he generally earns between US\$40-60 per month as a watchman. Avani and her husband have two sons, an 8- and a 5-year-old.

Avani first learned about surrogacy less than a year prior to our interview. A friend of hers had previously “gone through the process”—Avani refers to it in a sterile way—and brought Avani to the doctor to learn more about it. Her initial reaction was one of cautious curiosity about surrogacy: “I wanted to see for myself how it happens because it didn’t seem real.” Assured by the doctor of the safety of surrogacy and compelled by the prospect of earning much needed income for her family—Avani would earn approximately US\$4,700 upon delivery of a healthy child—she decided to become a surrogate mother. However, the surrogacy agency required Avani’s husband’s permission; he had previously refused to allow Avani to get a job as a housecleaner, and he initially refused this, too. After some time, Avani and her doctor convinced him to agree. Avani prepared herself for the rigorous battery of medical exams, hormone injections, and pills that would prime her body for surrogate pregnancy.

Avani quickly became pregnant, and shortly afterward her doctor ordered her to leave her home and move to new accommodations with her family. During the course of my fieldwork, many doctors assured me that surrogate agencies provide housing solely for the benefit of surrogate mothers and the children they bear. This housing was ostensibly an improvement, and, as the doctors explained to me, surrogate pregnancy is a time of relaxation and repose, as women are not burdened by work or household chores in the arranged housing. I was deeply curious about Avani’s experience of the new housing.

As it turned out, Avani lamented her current accommodations and longed to live in her previous home near her extended family:

Of course I like my place more than this one. Here I’m instructed all the time where to sit and what to do. My husband only comes once or twice a week. He works in my old

neighborhood, which is so far from here, so he must stay in our family home. At my place there are so many people living together in my house and every day is nice with them. Here, nobody is around to talk to and there are restrictions on my roaming as well. I get so bored. Our routine is just eating and sleeping. The only work we do is cooking for ourselves.

In my research I found that surrogates' mobility, like Avani's, is quite literally limited.

Within the confined spaces of the home, staff members monitor surrogates' nutrition, health, and daily activities, ensuring that surrogates do not engage in any behavior that may harm the fetus.

One doctor even admitted that she prefers that surrogates remain indoors at all times, leaving the house only if absolutely necessary. Within these small, one-room flats shared with children or other family members, the surrogates I spoke with shared stories of loneliness and restricted mobility. For Avani, feelings of isolation permeated her surrogacy experience in the apartment:

“I live with my mother-in-law and kids but still I feel I'm isolated here. I really don't like to stay without my [extended] family.”

As Greenwood (1989) observed, tourism is “the largest scale movement of goods, services, and people that humanity has perhaps ever seen” (171). Movement and mobility across geographical landscapes—of actors, money, technologies, and human gametes and embryos—are clearly key aspects of transnational reproduction. As ARTs lure people across borders, their stories illustrate the underlying global inequalities among geographic regions and residents, as well as local inequalities based on socioeconomic and gender hierarchies, that enable reproductive tourism. Throughout my research in India, I noted the ways in which notions of movement—across national borders and through dense geographic spaces of Mumbai—underscored commissioning parents' adventures in transnational surrogacy. Conversely, women's experiences of immobility—within temporary housing or at clinics and hospitals—suffused their own accounts of surrogate pregnancy.

While much has been written on the social and cultural impact of assisted reproductive technologies (ARTs), relatively little work takes a geographical perspective. This chapter focuses on the ways in which geographical approaches to space and place shape engagements with advances in reproductive technologies. In particular, I illustrate how transnational surrogacy complicates the concept of stratified reproduction, which differentiates reproductive labor according to one's social class, nationality, and economic status, among other cross-cutting strata. New trends in reproductive travel present a unique opportunity to examine the extent to which technology, global markets, and the declining power of the nation-state have transformed reproduction as a globalized process. Geographical theory together with ethnographic fieldwork provide a critical framework to explore how globalized reproductive tourism creates relationships among places, landscapes, and people, and, therefore, personal and collective identities. From the increasing global demand for reproductive technologies, the willingness of people to travel across geographic spaces to access them, and the readiness of individuals to provide the desired reproductive parts and labor, multiple geographies of reproductive tourism emerge.

In what follows, I examine the narratives of various reproductive actors in order to reveal how notions of space, place, and mobility are implicated in geographical inquiries of reproductive tourism. I focus on the perspectives of commissioning parents and surrogate mothers to explore the ways in which different social groups relate to and experience the differential power relations embedded in reproductive tourism. I particularly engage with the multiple social and spatial boundaries that people will cross—including ethnic, racial, economic, religious, and national—to fulfill their procreative desires. Within this context of globalized reproduction, geographical questions related to space, place, and the body come to the fore, as

reproductive tourism highlights important ways that gender, nationality, and kinship link to shifting social and spatial boundaries, as well as particular notions of space and place. As I will illustrate, a geographic lens reveals how power in transnational surrogacy is not simply about one group limiting the mobility of the less powerful. Rather, I show how both surrogates and commissioning parents experience mobility and immobility, movement and stillness, in nuanced ways that reflect and reinforce global structures of inequality.

Power, Place, and Positionality: Surrogates' Experiences of Movement and Mobility

Because reproductive tourism is geographical in nature—that is, occurring in places and involving movements and activities across space and between places—both geography and anthropology are fundamental to the study of transnational reproductive practices.⁵⁰ Avani's story calls attention to the role of tourism in the social constructions of space through place,⁵¹ illuminating the ways in which the relationship between tourism and constructions of space and

⁵⁰ It is useful to note that until the early 1990s, geographical analyses of tourism had been largely concerned with the spatial laws of tourism geography (Mansfeld 1990; Pearce 1987; Robinson 1976). By applying statistical and quantitative methods, tourism geographers sought to record and describe rather than to explain the processes of tourism. In doing so, tourism was understood and treated as a discrete economic subsystem existing in isolation from other spheres of social, political, and economic life. More recently, geographers have shifted to conduct geographical inquiries into the political economy of tourism. Britton (1991) raised a number of theoretical issues regarding the integration of tourism studies into the wider structures of economy and society, thus revealing "its role in capitalist accumulation, its economic dynamics, and its role in creating the materiality and social meanings of places" (452). Today, economic and cultural geographies of tourism have broadened the "conceptualization of the geographies of tourism—as place, practice, product and philosophy" (Ringer 1998: 9).

Tourism studies in anthropology as well as geography now consider the places of tourist origin, tourist destinations, and the relationships between origin and destination places. Anthropologists began to concentrate on tourism in the 1970s as a legitimate focus of analysis, as destinations off the beaten path increasingly welcomed tourism (Nash 1996); this occurred in tandem with the increasing globalization of the international economy and the improvement of transnational networks of communication and transportation (Lanfant, et al. 1995). Generally, anthropologists' research on tourism have centered on questions about the "touristic process" (Nash 1981), with particular interest on the origins of tourism on one end, and the impacts of tourism on the others. More recently, anthropologists have called for a focus on the incentives and impacts for both tourists and locals throughout all stages of tourism (Stronza 2001). Here, I seek to bring together anthropological and geographical scholarship to shed new light on reproductive tourism practices.

⁵¹ See Hall and Page (2006) and Shaw and Williams (2001) for examples of studies that have examined the role of tourism in the social constructions of space and place.

place must also include considerations of how such constructions are implicated in networks of power and positionality.

Feminist geographers such as Doreen Massey have called attention to the intersections among power, place, and positionality. Power and positionality are at the heart of Massey's analysis of space and time, as "social relations are inevitably and everywhere imbued with power and meaning and symbolism" (1994: 3). These social relations of space profoundly affect the experiences of those occupying different positions in social hierarchies.

The spatial, then, is a dynamic and ever-shifting social geometry of power and signification whereby global flows and relationships affect different social groups differently. According to Massey (1993), "power-geometry" not only describes who moves and who does not, but also the power that one holds in relation to the flows and movement. As different social groups have distinct relationships to this mobility, Massey argues, it effectively imprisons some groups. Human forces configure global networks of power while uneven development and unequal distribution of resources affect mobility and control over mobility. This differential mobility reflects not only an unequal distribution of power, but also the power to "weaken the leverage of the already weak" (1993: 62).

In the context of reproductive tourism to India, what are the implications of Massey's "power-geometry" for individuals who travel to India seeking ARTs and women who volunteer to become surrogates? In interviews with infertility specialists in Mumbai, I learned that many physicians believe that reproductive tourism in India, and surrogacy in particular, creates a "win-win" situation for all parties involved, producing a highly-desired child for the infertile couple and much-needed income for poor Indian women. As one physician stated, "In surrogacy, the person who's actually giving their womb for hire is also being helped. She's poor. She's using

that money for her child's education, to lead a better life—so why not? It's a win for the couple, a win for the surrogate, and a win for the country.” Here, this doctor argues that he is not only helping surrogates and couples achieve their goals, but also the Indian nation-state, through increased tourism and wealth flowing into the country. Clearly, the reproductive capacities of Indian women are valued not for their ability to produce Indian citizens, but rather, for their role as reproductive laborers in the global economy. As India seeks to solidify its niche in the global markets of pharmaceuticals, organ transplants, biotechnology and now, reproductive technology, many Indian doctors explained to me the importance of surrogacy in nationalist terms, emphasizing national economic growth and India's role as a leader in reproductive science and technology.

Doctors also played a major role in determining women's experiences of movement and mobility throughout their pregnancies. Within surrogacy arrangements in India, it is the doctor who holds the power to determine where women may live during their pregnancies. Some doctors strongly compelled women to move to surrogate housing (sometimes with their families, other times without), and within this housing, doctors often dictated whether and how often women could venture outside. Other doctors claimed that women were free to remain at home with their families, if they wished, yet as I will discuss later in this chapter, some women had this “privilege” revoked if they did not satisfy the demands of the doctor or caretaker. Physicians also determined how often women had to travel to the clinic; as one woman disclosed, her doctor commanded her to travel long distances to the clinic two to three times monthly during her pregnancy, in part so that she could undergo sonography scans to send to the foreign clients. Indeed, the power to compel surrogate women to remain mobile or immobile lay squarely within the doctor's domain.

Furthermore, while the narratives of intended parents and doctors primarily reinforced surrogates' identities as "saints" and selfless mothers, many of the women who participated in my research spent their surrogate pregnancies separated from their own children and removed from their family homes. As these women relocated to housing distant from their own communities, their own bodies would be policed within spaces intended to monitor surrogates' actions and behaviors. My examination of such practices extends Colen's (1995) analysis of stratified reproduction to include the ways in which women's bodies are monitored and observed as they carry out their reproductive labor.

Yet, following Massey, this mobility of people and capital to India for the purposes of commercial surrogacy and ARTs ought not be embraced so exuberantly. As she cautions,

[T]he 'time-space' compression which is involved in producing and reproducing the daily lives of the comfortably-off in first-world societies—not just their own travel but the resources they draw on, from all over the world, to feed their lives—may entail environmental consequences, or hit constraints, that will limit the lives of others before their own" (1993: 63).

Thus, while physicians I spoke with argued that reproductive tourism strengthens the economy and financially empowers women and their families, feminist and reproductive rights activists have responded by calling attention to the potential for exploitation of women of lower socioeconomic backgrounds (Sama 2006).

Similarly, many activists have taken issue with the restrictions on surrogates' mobility, and Urvashi's story provides another example of such "spatial imprisonment." Urvashi, six months pregnant at the time of our interview, shared Avani's sense of isolation as she lived in the same apartment building. Throughout our interview, Urvashi spoke quietly yet clearly and sadly, her growing belly visible beneath her floral-patterned *salwar kameez* and orange *dupatta*. Urvashi married her husband at the age of 15 in an arranged marriage. She had completed the

equivalent of an eighth-grade education and worked, as she said, “as a housewife only.” Her husband’s previous job as a watchman earned him a salary of approximately US\$150 per month; however, poor health forced him to leave his job, and the family has struggled ever since.

After seeing Urvashi’s sister-in-law go through the process of surrogacy, Urvashi’s husband urged her to consider it, too. However, in contrast to Avani and many other surrogates I interviewed who needed to convince their husbands, Urvashi felt uncertain. Yet her husband, who had been ill and unable to work for several years, was convinced that surrogacy could help their family’s financial situation. Urvashi eventually agreed, although with some ambivalence. She said, “I was not ready to do it [surrogacy], but my husband has not been well for a couple of years and we need money to treat him. That is the reason I went for the process.”

Prior to Urvashi’s surrogate pregnancy, her life was marked by a series of disruptive moves from her native Nepal. Seeking work and financial stability, Urvashi, her husband, and their two children migrated to Pune, while her eldest daughter remained in school in Nepal under the care of Urvashi’s parents. Transience and insecurity continued to mark their life in Pune, as Urvashi’s husband’s job lasted only several months; at the same time, the family found themselves traveling long distances to the state border between Maharashtra and Gujarat to secure affordable medicine and health care for her ailing husband. Once Urvashi decided to pursue surrogacy, the family again relocated to Mumbai. Six months into her pregnancy, now 24 and the mother of three daughters, Urvashi reflected on the difference between her previous pregnancies and the current surrogate pregnancy: “The main difference is that I’m not allowed to move around and work. That is adding pains to me. I definitely like to go out and have a walk once in a while, but we are not allowed to do it.” Following a wave of movement and mobility, Urvashi was finally compelled to remain immobile in ways that left her powerless and dispirited.

Like Avani, Urvashi's narrative illuminates the ways in which different bodies are differently privileged in transnational reproduction. When surrogate mothers are expected to live separately from their families in unfamiliar neighborhoods, their own desires—to be near loved ones, to walk around their neighborhoods—are devalued against the risk of any behavior that may harm the fetus. While Western intended parents pursuing surrogacy in India may expect the surrogacy agency to provide housing, and assume the surrogate will enjoy living in new housing with few work responsibilities, my research revealed that many women experienced higher levels of stress and anxiety due to restrictions on their mobility and separation from their families. Though doctors suggest that surrogates should move to clinic-appointed housing in order to avoid the demands of household work and responsibilities, in doing so they discount the everyday realities of familial and community support that women receive at home. In this setting, Avani and Urvashi experience immobility as stressful and isolating, not restful, as the doctors suggest.

Likewise, in her research in a surrogacy hostel in the western state of Gujarat, Pande has noted the contradictions that emerge in such closely monitored spaces. While women have fewer work responsibilities in the hostel, their daily activities remain tightly controlled, and women follow a strict daily routine and diet: "Everything works like clockwork," as one surrogate explained (Pande 2010a: 969). Yet, as some women have expressed, the daily timetable can be monotonous and unpleasant.

While the confinement of surrogates to maternity homes could be interpreted as a form of "spatial imprisonment," it is also worth examining as part of the process of place-making. As Harvey (1996) argues, "Place, in whatever guise, is like space and time, a social construct... The only interesting question that can then be asked is: by what social process(es) is place

constructed?” (293). Furthermore, within the context of transnational surrogacy, it is useful to examine the relationship between place-making and community. As Harvey explains,

Places acquire much of their permanence as well as much of their distinctive character from the collective activities of people who dwell there, who shape the land through their activities, and who build distinctive institutions, forms of organization, and social relations within, around or focused on a bounded domain. The collective memory that attaches to places connects to the imaginary of belonging. ‘Imagined communities’ acquire a certain reality through practices that derive as much from imaginary and discursive links between individuals...as from face-to-face contact (1996: 310).

To be sure, surrogates do form small communities in maternity homes with fellow surrogate women, communities that are restrained to a particular place for the duration of their pregnancies. Particular socioeconomic processes connected to transnational surrogacy bring about such places and communities and the social relations within them. Alliances formed with other surrogates made Avani’s temporary home more bearable, but she planned to build a home for her family in Nepal. This community is tenuous and temporary, and surrogates return to their homes and families who frequently have no knowledge of the surrogate pregnancy.

Interestingly, one doctor referred to the clinic itself as a place to which women become attached during their pregnancies:

I have noticed that the women put up a shield—they are constantly told that the baby isn’t theirs so that they don’t connect with the child, but I’ve noticed that they keep returning *to the clinic* to maintain some kind of relationship. They don’t want to separate from the procedure and after some time they want to do it again...It’s like there is this umbilical cord still attached to us.

For this doctor, places such as maternity homes as well as infertility clinics, then, may be constructed as the “locus of collective memory” or identity for surrogates (Harvey 1996: 304). She equates women’s desire to return to the space of the clinic with a yearning for some kind of relationship and another chance to undergo the “procedure,” surrogate pregnancy. Indeed, although some surrogates did not express any desire to repeat their surrogacy experience, many

women I interviewed explained that they hoped they might be able complete multiple surrogate pregnancies. Yet while the doctor perceived this desire as an “umbilical cord” that connected women to the clinic and to the process of surrogacy (rather than to the child to whom she eventually gives birth), surrogates explicated their compulsions in terms of plain financial need. Despite the risks involved in surrogacy, most women felt the imperative to take advantage of whatever opportunity they could to make money in the global reproductive market. Women, then, repeatedly returned to the clinic in order to achieve that goal.

Place construction within the context of capitalism must also be taken into account in analyses of geographies of reproductive tourism. Harvey (1996) considers the ways in which places are constructed within the flow of capital circulation, and geographical expansion is central to the construction of places: “Capitalism is necessarily growth oriented, technologically dynamic, and crisis prone. One of the ways it can temporarily and in part surmount crises of over accumulation of capital...is through geographical expansion...the ‘spatial fix’ to capitalism’s contradictions” (295). Such growth and expansion occurs through the exportation of excess capital from one place to another, and through revolutionizing space relations through technological and organizational changes. In either case,

New networks of places arise, constituted as fixed capital embedded in the land and configurations of organized social relations, institutions, etc., on the land. New territorial divisions of labor and concentrations of people and labor power, new resource extraction activities and markets form. The geographical landscape *produced* in space through the simple logic of uneven capital investment, a proliferating geographical division of labor, an increasing segmentation of reproductive activities and the rise of spatially ordered (often segregated) social distinctions (Harvey 1996: 295).

In the case of reproduction and the globalization of reproductive technologies, the flow of capital circulation influences the construction of the geographical configuration of places. As novel transport, communications systems, and physical infrastructures rework places, new kinds

of reproductive networks emerge between high-income countries with capital and low-income nations with “surplus” reproductive labor. Such configurations of labor power shed new light on geographical understandings of place in the current globalized neoliberal economy, where human gametes, surrogates, and other ART procedures can be paid for or arranged with the click of a mouse.

Figure 6. Residential apartment building, suburban Mumbai



One of several buildings in Avani’s and Urvashi’s apartment complex. Photograph by author.

Avani’s and Urvashi’s stories of displacement, spatial imprisonment, and place-making provide important comparative data for studies of surrogacy in varied locations throughout India. Avani and Urvashi did not live in a shared dormitory akin to other clinics in India. Rather, they lived in a residential apartment building, in which their doctor’s assistant rented several apartments for sheltering surrogates and their families (see Figure 6). While they lived in nearby one-room flats in the building complex, the women remained cautious and visited only each

other, avoiding interaction with other residents of the building and typically remaining in their homes throughout the day. Within this context, as Avani's caretaker explained, up to six women might become acquainted at any given time in the housing, but they would rarely maintain close relationships beyond the duration of their pregnancies.

In contrast, Pande (2010a) has shown how the surrogacy hostel may constitute a gendered space, one that generates emotional attachments and sisterhood among women, and fosters opportunities for resistance and networking. In her research, Pande interviewed women who lived in a three-story hostel, in which up to 45 women in different stages of pregnancy carry out their reproductive labor. Though women's activities within the hostel are strictly organized and monitored, the intensive contact among surrogates in the hostel enables them to share information, grievances, strategies for future employment, and even acts of collective resistance.

However, while communal surrogate housing may be the norm in other parts of India, most Mumbai clinics in which I conducted fieldwork did not arrange housing in shared dormitory-like spaces. Yet, surrogate women who do not live in maternity homes during their pregnancies, too, experience limited mobility. No legislation regulates surrogacy in India, and I encountered a wide range of practices and policies with respect to the treatment, care, and housing of surrogates during their pregnancies. Some clinics simply offered modest stipends for rent and made no arrangements for surrogate accommodations. The mobility of surrogates not bound to live in such housing was far from privileged, as Meera's story illustrates.

Meera, like many others, became a surrogate and strove for an upwardly mobile future under tenuous circumstances. Meera was 25 at the time of our first meeting. When she was thirteen, Meera's father became ill, prompting her parents to arrange her marriage with a man ten years her senior. Meera regretted having to leave school at that time. By the age of 20, Meera

had given birth to four daughters and one son and had undergone tubal ligation, which prevents conception through sex but not pregnancy through IVF, in order to prevent any further pregnancies.

Clearly, Meera's reproductive history, within the broader context of transnational surrogacy, reflects a setting in which Indian women encounter contradictory state messages regarding reproduction. On the one hand, Indian women's bodies are marked as reproductive bodies that require policing, particularly in the historical context of state population control programs that restrict reproduction, most recently in state policies promoting two-child families (Ahluwalia 2008). With a rapidly growing population, India's central government has set population targets while state governments carry out distinct efforts to limit the birthrate. While some states have reacted to population fears with coercion, recalling the government scandal over forced vasectomies during the 1970s, others offer incentives for smaller families or disqualify government workers from certain benefits if they have more than two children. In 2010, for example, a district government in Maharashtra experimented with a pilot program that would pay cash (approximately US\$106) to newly married couples if they waited to have children (Yardley 2010). Yet, at the same time, the Draft ART Bill currently proposes that women may complete up to five pregnancies (inclusive of her own children) for the purposes of transnational surrogacy, thus condoning the use of women's reproductive bodies *for other nations* (Ministry of Health and Family Welfare 2010).

On learning about surrogacy, Meera was determined to convince a doctor to take her on as a "patient." She admitted to the doctor that she was married, despite the fact that her marriage was tenuous and fraught with violence and that she was in the midst of a relationship with another man. Meera told the doctor she had only one son and one daughter, not five, because

admitting that she was a mother of five would have disqualified her as a potential surrogate.

Savvy and strong-willed, Meera viewed surrogacy as a potential windfall that would alleviate her financial insecurity. She seemed willing to do whatever it took to become a surrogate, and she eventually became pregnant with twins for a foreign couple.

Meera's doctor worked with an agency that did not have a fixed policy on housing; some women seemed to move because they wanted to, others were forced to move to the hospital in order to monitor potential health issues, while most were left to their own devices, often remaining in their own homes. Meera was under constant pressure and had strained relations with her violent husband and in-laws. As she rejected and rebelled against the demands of her family, Meera would often escape to her boyfriend's house. Meera's constant movement made it difficult for Antara, her caretaker, to contact her when necessary; she would often disappear for days, sometimes weeks, at a time, during her pregnancy. This freedom of mobility, however, would eventually come to an end when the doctor forced her to remain in the hospital for the remaining four months of her pregnancy at Antara's request. Antara reported, "I told Madam [the doctor] that I'm not ready to take responsibility for her anymore. Admit her in the hospital, otherwise she'll run away again with someone if you keep her in a house with the other surrogates. She is now in the hospital for the rest of her pregnancy and she is not allowed to go out for anything." This spatial imprisonment at the request of Antara, herself a former surrogate, reflects the subtle registers on which the relative power over mobility works.

Though Meera, Urvashi, and Avani experienced profound restrictions on their mobility at home, in their communities, and in the hospital, they also traveled long distances throughout Mumbai during their pregnancies. As Antara often recounted, her job as an "agent" required her to shepherd women throughout the city, often to different clinics for different procedures within

the course of one day. This often entailed long commutes on the local public railway system, because Antara and most of her patients lived in Nadipur, an industrial city some 40 miles from Mumbai. I sometimes met Antara and her “patients” during these harried days, and observed the toll these trips took on the women.

Surrogate women’s experiences traveling to and from the clinic also call to mind Chatterjee’s (1989a) framework for analyzing intersection of space, place, gender, and nation. Chatterjee describes the ways in which nationalism dealt with the “women’s question” (623) through the development of an ideological framework that matched the home/world dichotomy with gendered social roles. Nationalism condensed this discourse into an ideologically more powerful dichotomy between the outer and the inner domain, or, in day-to-day living, between the *ghar* and *bahir*, the home and world, and women became the ideal representation of the home. Chatterjee’s analysis of the nationalist construction of gender illuminates the false essentialisms that locate women squarely within the realm of the spiritual, feminine home. Indian surrogates, too, remain trapped in these essentialisms. Paradoxically, as Indian women traverse material spheres to access the science and technology inherent in gestational surrogacy, they remain fixed in the spiritual sphere of the home, as their reproductive labor is inextricably linked to the inner domain, femininity, and womanhood.⁵²

Finally, I noted the ways in which the geographic space within the clinic reflected broader power relations between doctors and surrogates. As infertility clinics in Mumbai are nearly always privately operated, such spaces typically remain exclusive to clients of middle- and upper-class status. Within these same spaces, working-class women are viewed as secondary and out of place. The clinics reflected such inequalities, which are manifest in their physical

⁵² Similar arguments regarding the paradoxes of women’s location in the home and the more distant location in “scientific” places have been made about women’s labor in early U.S. and European industrialization; see for example Tilly and Scott (1978).

layout and the positioning of different clients of distinct backgrounds throughout. In one clinic, surrogate women recover from certain medical procedures in a storage room that doubles as a makeshift recovery room. The clinics also function as a space in which to reinforce medical authority over any concerns or questions surrogate women may have. Throughout many interviews, women reported they rarely posed questions about procedures or medications, nor were they offered the opportunity; they simply received instructions about medical care and medications and were expected to acquiesce to the doctor's demands. The transfer of authoritative knowledge in the clinic and hospital reinforced already existing hierarchies between women and the medical establishment.

Anticipation, Immobility, and Places of Birth

In contrast to surrogates' experiences of spatial imprisonment and restricted mobility, I was struck by the ways in which intended parents moved with comparative comfort throughout their travels. While women such as Meera, Avani, and Urvashi had little say over where and with whom they might live, many intended parents moved with the ease of cosmopolitan travelers whose higher socioeconomic status allowed them the comforts of luxury full-service apartments or five-star hotels. As a researcher, I experienced these disjunctures first-hand, as my interviews allowed me to traverse distinct geographies of class and privilege that would take me at times to luxury hotel suites in Mumbai, and at others to one-room apartments in working-class neighborhoods outside the city.

Yet at the same time, intended parents' sojourns in serviced apartments indicate more than mobility; they also suggest a spatio-temporality of planning, waiting, and anticipating. Recent work on waiting and stillness sheds light on the spatio-temporality of mobility as well as

immobility, elucidating the nuanced power relations among commissioning parents and surrogates (Bissell and Fuller 2010; Cresswell 2011; Mountz 2011a). Mountz's (2011b) examination of how power operates across sites inhabited by asylum seekers elucidates the connections between places and experiences of waiting, limbo, or suspension, not unlike the experience of surrogate women during the gestational period in pregnancy. However, while the dynamic of "spatial imprisonment" arguably points to the question of immobility or suspension for surrogates during their pregnancies, the experiences of new parents, too, suggest a spatio-temporality of planning and anticipating, particularly for those who spend weeks and months caring for their babies in India while waiting for health issues to be resolved (for prematurely born infants) or for travel documents.

For instance, Marla and Roland, an upper-middle-class Norwegian couple, had traveled halfway around the world in order to meet their newborn daughter born via surrogacy. When I first met Marla, a tall, blonde, blue-eyed woman, she was relaxing poolside at a deluxe, five-star hotel in the suburbs of Mumbai in the company of her husband and their newborn baby girl, Anna. It was a warm, humid monsoon afternoon and Marla and Roland were clearly in ecstasy caring for Anna, the newest member of their family.

However, once in Mumbai, they found themselves in a liminal state of stillness and anticipation, as they awaited the travel documents that would allow them to return home. Indeed, parents sometimes spent months in this transient space, waiting for the bureaucratic process of assigning citizenship to unfold. At the time of our interview, Marla and Roland were approaching their fourth week in Mumbai. As Marla stated, "The woman at the consulate, she is deliberately delaying everything...and we are ready to go home. We want to go home to autumn, our family, our friends, and our animals, and everything." With the exception of trips to the

Norwegian consulate, they rarely ventured outside the comfortable confines of their hotel, and their experience of surrogacy was marked by relative immobility and waiting within spaces of luxury that characterize the stark contrast in economic and social status between surrogates and parents. Like Marla, many parents I interviewed who experienced long stays in Mumbai described waiting, liminality, and disruption to their normal, everyday lives. Yet it is worth noting that as Western parents pursued surrogacy as a way to build their families, these moments of disruption also served as opportunities to bond and care for their children, uninterrupted by the distractions of work and family at home. In contrast, the families of many surrogates, such as those of Avani, Urvashi, and Meera, also experienced disruption and instability, physically separated across space (sometimes across national borders, as in the case of Urvashi and her eldest child) during their surrogate pregnancies.

During these long stays, parents would often reflect on the meaning of “homeland” and “birthplace” for their children. Transnational surrogacy arrangements unquestionably problematize such places for intended parents and their children, as the relationship between homeland and birthplace is called into question. The story of Aaron and Ben is instructive.

As previously discussed in Chapter 2, Aaron and Ben’s surrogate, Sarita, gave birth to twin girls, Tara and Noelle, who were conceived with the assistance of an anonymous egg donor from South Africa. Throughout the course of our interviews, Aaron professed that he viewed the labor of gestation and delivery as stronger and more enduring than the genetic connection that existed between the egg donors and his girls. Despite the genetic material contributed by the young white egg donor, and the acknowledgment that Tara and Noelle share more in common with her in terms of race and class than with Sarita, Aaron insisted that Sarita and his twin girls had a deep relationship. He planned to work to reinforce this relationship through efforts to

“maintain the Indian element in their identity.” “Indian-ness” became something that, in the absence of the Indian “mother” but originating in the girls’ birthplace, Aaron will build and reinforce over time:

We will tell them about their histories, their heritage, the stories of how they were conceived, and we’re using all the pictures and home movies and stuff, and that is playing up the Indian part very much. They will have pictures of India, they will know about this hotel. They will hear stories of Ganpati and Raksha Bandhan.⁵³

As Aaron’s narrative suggests, understandings about a child’s biogenetic origins emerge in tension with a child’s right to identity. In Aaron’s case, his daughters’ identities are inseparable from their “birthplace” in India, the surrogate and *her* ethnic, cultural, and religious background. Here, genetic origins are not as significant as the “Indian element” of their identity, which is rooted in their place of conception, gestation, and birth.

Another expectant parent, Martin, revealed similar sentiments around his child’s connection to India. Martin, a 42-year-old from the southern U.S., and his partner, Richard, were expecting twins conceived with the eggs of an anonymous Indian donor and Martin’s sperm; the resulting embryos were then transferred to the womb of an Indian surrogate. Martin explained that he looked forward to incorporating aspects of Indian culture into their children’s lives:

I’m very open to the idea of it [Indian culture] being a part of the child’s life... Certainly, if the child is very interested in their heritage, I could see us returning to India. We are actually planning on giving the children Sanskrit names. So we’ve picked out two sets of girl names and two sets of boy names that are derived from Sanskrit. I think it’s important. For whatever reason this is the path that our lives have taken us on and I think we need to be respectful of where this became a reality.

For Martin, the journey of building a family through surrogacy in India mobilizes new geographic imaginations that construct and rely on the notion of return. India becomes imagined as a place of origin: origins of family, conception, birth, and heritage. It, too, becomes a place to

⁵³ Ganpati and Raksha Bandhan are two Hindu religious holidays that Aaron and his family experienced during their two-month stay in Mumbai.

which parents imagine a geographic return, in order to shed light on their children's site of origin (despite the very transnational nature of their conception). This was true for both Aaron and Martin, despite the fact that Aaron's children might be phenotypically white, while Martin's might appear more ethnically ambiguous.

Like Aaron and Martin, many parents I spoke with articulated a strong desire to “maintain the Indian element” in their children's identities through naming rituals, accumulation of material goods for the home (such as Indian fabrics, clothes, and decorative tapestries), and most importantly, stories that reiterate exotic details of Indian social life. Throughout many of my interviews, parents of children born through surrogacy conflated the geographic space of India—and the attendant orientalist discourses that construct “Indian-ness” as exotically opposite to Western sensibilities—with the embodiment of the child's identity through its gestation by an Indian surrogate mother in India. Further, such confluences reveal the pedestrian reliance on “multiculturalism” as a universalizing discourse, which ignores the specificity of local contexts. In constructing India as a place of origin and return, parents rely on a geographic imaginary that flattens out the specificity of India's historical and political economic contexts.

In this chapter I have investigated the implications of space, place, and mobility in geographical analyses of reproductive tourism. While technology has provided new ways to conceive and bear children that go beyond the limits of the body, globalization has provided even more ways to conceive and bear children that go beyond the limits of national and cultural boundaries. Assisted reproductive technologies, reproductive tourism, and the kinds of families they make possible have engendered new social relationships, spaces, and places. Geographical analyses provide a useful tool for elucidating these relationships, as reproductive tourism connects to the spaces and places in which it is created, imagined, perceived, and experienced.

Moreover, space is not just an innocent backdrop or stage set in which events occur, but rather a factor in itself that social relations create.

It would be misleading, however, to portray one group with relative power—in this case, commissioning parents from the global north—as always exercising power to constrain the mobility of another less privileged group, the surrogate mothers. Such dichotomous portrayals obscure the continuum of experiences that reveal how different groups experience mobility and immobility, power and resistance. While Massey productively prompts us to ask how “our relative mobility and power over mobility and communication entrenches the spatial imprisonment of other groups” (Massey 1994: 236), I have extended Massey’s formulations to illustrate the subtle registers on which power operates, beyond the act of one group limiting the lives of the less powerful. By highlighting the subtleties of how power operates through space and mobility, we can observe the different registers on which people exercise and are subject to power.

CHAPTER FIVE

Interrogating Women's Agency:

Surrogate Mothers, Agents, and Relations of Power

On a sweltering summer day in 2010, I sat in a restaurant on the outskirts of Mumbai, India, with Nishi, a young woman preparing to become a surrogate mother for a foreign couple outside of India. Nishi told me of how she had separated from her husband four years earlier. Separation and divorce remain unusual in India, particularly among working class women like Nishi, but as one fertility doctor I interviewed explained, "You'd be surprised at the number of separations and divorces that are happening [among lower class women]...After we started doing surrogacy in the past three years, we realized that about 30 to 40 percent of them are separated." This doctor asserted that most of these women walk out of their marriages because of abuse and alcoholism; Nishi's case proved typical.

Following her separation from her husband, Nishi struck up a friendship with Nikhil, a young man from south India who managed an electronics shop in Mumbai. As their friendship evolved into a romantic relationship, Nikhil supported Nishi and her two daughters in times of need. Nishi felt she also should support Nikhil, whom she planned to eventually marry. When she learned about surrogacy, Nishi viewed it as a potential financial windfall for her and her family, and began preparing for surrogacy without telling Nikhil. When she told Nikhil of her surrogacy plans, he disapproved: "He is not agreeing to it. He says don't do this; he thinks it is illegal. Yet I am trying to convince him somehow and I am trying. I also told him that everything has been done. I told him I have done the ET [embryo transfer] and I cannot go back now. So, he is sitting quietly now, not saying anything." In fact, at the time of our interview Nishi had not yet

undergone embryo transfer. She was still in the preparatory phases: taking hormone injections and undergoing tests and procedures to determine her viability as a candidate for surrogacy. Why did Nishi deceive Nikhil?

What are the strategies that Indian women contemplating surrogacy employ to negotiate and respond to the structural and social constraints they face daily? How do women enact agency in their efforts to meet or secure their self-defined needs and desires, even as their efforts may maintain structures of inequality? And what are the consequences of such acts of agency, particularly as they challenge cultural norms and expectations? This chapter addresses these questions by tracing the complexities of agency, constraint, and inequality in the lives of women who pursue surrogacy in India.

The views and experiences of women I spoke with resist reduction to simplistic stereotypes and binary oppositions between agent and victim, rich and poor, East and West; indeed, the more I learned about surrogacy in India throughout my fieldwork, the more inadequate these notions became. I contrast the stories of Nishi and Parvati, both surrogates, and their friend Antara, a surrogate agent, whose personal narratives regarding surrogacy and the circumstances that motivated them to become gestational surrogates buttress the point that the global surrogacy industry reflects and reinforces a broader stratification of reproduction. At the same time, however, their narratives reveal the intricacies of women's lives and fend off the temptation to portray them as victims. This chapter shows how women indeed find ways to resist dominant constructions of surrogates as powerless victims. I argue that in expressing forms of resistance and individual and collective agency, women find ways to challenge everyday gender norms and create new opportunities for themselves and their families, albeit within larger structures of power.

However, such expressions of agency also depend on the particular roles and relationships that women play within transnational structures of surrogacy. I contrast the experiences of women who work as surrogates with those who occupy intermediary positions—particularly surrogate agents and caretakers. Women who act as agents and/or caretakers often share the same socioeconomic background as surrogates and egg donors; indeed, such women are usually former surrogates or egg donors themselves. The distinction between surrogate, egg donor, and agent/caretaker can be a relatively fluid one, and individual women may move back and forth between these positions, or occupy several of them at once. It is not unusual for a woman undergoing surrogacy or egg donation to bring a friend or relative to her doctor; as she receives a commission for this, the woman becomes simultaneously a surrogate or donor and agent. Conversely, agents, too, might take advantage of opportunities to become surrogates or donors themselves.

In what follows, I focus on the experiences and aspirations of women involved in surrogacy, highlighting the nuances of their everyday lives as well as locating their positionalities in relation to local and global hierarchies. I underscore intra-family dynamics and shed light on the ways in which women navigate their changing relationships with husbands, children, extended family, and neighbors. Moreover, I critically examine the intermediary positions of surrogate agents, whose roles to date have been relatively understudied, illuminating additional aspects of surrogates' agency and structural constraint. In emphasizing the uneven terrain beneath transnational surrogacy, I want to avoid and go beyond depictions of women who become surrogates as powerless victims in need of aid. Indeed, in contrast to popular media images of helpless women in need of assistance,⁵⁴ this chapter illustrates the subtle and explicit

⁵⁴ Media coverage on surrogacy in India and around the globe routinely underscores the relationship between poverty and surrogacy, fostering the notion that contract pregnancy offers poor women the opportunity of a lifetime.

ways in which women express resistance and agency within the context of structural factors that limit opportunities.⁵⁵ Indian surrogates may be or may become victims in the unequal relationships formed between surrogate and doctor or intended parent. Nonetheless, I contend that reliance on the image of the oppressed surrogate neglects the local voices and perspectives long sought by ethnographers and feminists.⁵⁶

Challenging Agent/Victim Binaries

In her analysis of the victim/trafficker paradigm used by many governmental and nongovernmental organizations, Warren (2012) has noted how distinctions between sex workers and supervisors are relatively fluid and complicate the image of solo traffickers and victims. From interviews and court cases in Colombia, Warren found that trafficking networks more closely resemble family businesses, in which some daughters do sex work while older women find positions as supervisors, and workers and supervisors in trafficking organizations may share

In *The Times of India*, Bella Jaisinghani reports that “a reed-thin Nafisa” and her child were “the picture of poverty, skin stretched taut over bones, for they were barely able to fill their stomachs on most days.” Jaisinghani goes on to write, “Desperate for that one push that’ll take them out of the hard life, it is the poorest of the poor, the slum dwellers of Mumbai, who are renting their wombs and sustaining commercial surrogacy in the city” (Jaisinghani 2010). In *Der Spiegel Online*, Sandra Schulz writes that Suman Dodia, for example, will earn US\$4,500 for carrying a British couple’s child, a sum that would have taken her fifteen years to earn as a maid (Schulz 2008). Abigail Haworth, reporting for *Marie Claire*, tells the story of Sofia Vohra, a surrogate who previously earned US\$25 a month as a glass-crusher; Vohra says, “This is not exploitation. Crushing glass for fifteen hours a day is exploitation. The baby’s parents have given me a chance to make good marriages for my daughters. That’s a big weight off my mind” (Haworth 2007). These representations of surrogates’ stories highlight opportunity, choice, and fair exchange, yet they do not present the complete picture of Indian surrogacy and fail to address the ways in which gender, race, ethnicity, caste, and class mediate women’s expectations and beliefs about surrogacy.

⁵⁵ For examples of ethnographic research that examine forms of resistance and agency within the context of social, economic, and institutional inequalities, see Brennan 2004; Constable 1997; Constable 2009; Kempadoo 2005; and Parreñas 2008.

⁵⁶ While media coverage of surrogacy has positioned Indian women as oppressed or helpless victims in need of rescue (Chandran 2009; Scott 2007; Subramanian 2007), feminist scholars concerned with the impacts of ARTs have anticipated the growth of commercial surrogacy in the global south. Gena Corea, for instance, predicts that white women will hire surrogates of color in reproductive brothels in *The Mother Machine* (Corea 1985). Janice Raymond, in *Women as Wombs*, describes the growth of reproductive clinics in developing countries that specialize in sex-determination, foreshadowing the use of Third World women as surrogate mothers (Raymond 1993). And Barbara Katz Rothman asks, “Can we look forward to baby farms, with white embryos grown in young and Third World women?” (Rothman 1988: 100). As Pande has argued, these Eurocentric portrayals of surrogacy inadvertently reinforce the image of a Third World surrogate as the ultimate victim—of (patriarchal) technology and unequal global power relations (Pande 2010b).

housing and meals. Similarly, agent/caretakers in my research did not fit the image of the “greedy broker” of whom surrogates were suspicious.⁵⁷ Instead, agent/caretakers were often very close to their patients, becoming intimately involved in their everyday lives and family matters.

Notwithstanding these intimate personal relationships, in this chapter I am concerned with the ways in which surrogates and agents occupy distinct subject positions, especially with respect to power and agency. Such intermediary roles illuminate the peculiar contradictions entangled in transnational surrogacy and further complicate analyses of stratified reproduction. As transnational inequalities breed the conditions for a thriving surrogacy industry in India, global processes reproduce stratification itself at local and community levels, creating new categories of actors whose own agency depends on limiting that of others. While women who act as intermediary agents have increased access to power and opportunities that allow them to boost their own social and financial status, their positions simultaneously reinforce the ever more refined hierarchies inherent in transnational surrogacy. By illustrating the diversity of ways that women enact agency, however limited, through their experiences as surrogates or agent/caretakers, I highlight the subtleties of intra-class social divisions transnational surrogacy engenders, and demonstrate how women both exert power and are subject to it.

Nishi’s story was among several that defied my expectations. While there are reports of husbands or in-laws coercing women into surrogacy (De Sam Lazaro 2011), women like Nishi revealed how they asserted their own decisions about surrogacy, often in the face of disagreement and disapproval of their husbands. My focus is on the experiences of surrogates on a local level, depicting relationships among surrogates and their doctors, families, and caretakers. At the same time, however, it is important to locate these interactions within larger global hierarchies. As sociologist Arlie Hochschild writes:

⁵⁷ See Pande (2010b) for discussion of broker/surrogate relationships in another surrogacy clinic in India.

Person to person, family to family, the First World is linked to the Third World through the food we eat, the clothes we wear, and the care we receive. That Filipina nanny who cares for an American child leaves her own children in the care of her mother and another nanny. In turn, *that* nanny leaves her younger children in the care of an eldest daughter. First World genetic parents pay a Third World woman to carry their embryo. The surrogate's husband cares for their older children. The worlds of rich and poor are invisibly bound through chains of care (Hochschild 2009).

Clearly, transnational flows of capital, technology, bodies, and reproductive tissues signal how the global surrogacy industry reifies and reinforces global inequities. In the words of anthropologist Rayna Rapp, "All of our lives are not only globalized; they are stratified as well" (Rapp 2011: 709). As gestational surrogacy in India necessarily relies on the reproductive labor and bodies of a variety of individuals, it also reveals how stratified reproduction becomes ever more complex with increasing intra-class social divisions among surrogates and surrogate agents.

As Pande has argued, fertility clinics and surrogacy hostels produce the "perfect" surrogate. While a disciplinary project that works to create a "mother-worker subject" brings women together, they simultaneously resist being reduced to their roles as disposable and docile workers (Pande 2010a). This resistance, however, often reinforces the primary identity of these women as selfless mothers rather than as wage-earning workers. While Pande has examined the production of a mother-worker and how the hostel becomes a space for resistance and networking among surrogate "sisters," my focal point in this chapter is the changing relationships between women and their families.

In attending to these experiences of women involved in surrogacy, so, too, must scholars acknowledge their power and agency in the context of constrained opportunities. Building on Foucault's argument that power is everywhere, this work extends anthropological scholarship focused on revealing instances of agency and resistance among the relatively powerless (Martin 1987; Ortner 2006; Parker 2005). As Chandra Mohanty has eloquently argued, viewing Third

World women primarily as victims creates a pattern of domination—a form of discursive colonization—that measures progress against the yardstick of western women (Mohanty 1988). In most popular media accounts of surrogacy in India, expressions such as “womb for rent” merge seamlessly with images of the “poorest of the poor” who readily sign up to become surrogates.⁵⁸ Yet, such homogeneous images of Third World women who are helpless, oppressed, and thus in need of rescue, predefine women as victims and prematurely rule out any possibility of their being otherwise.

Gender and Family Relations in India

In order to grasp the implications of transnational surrogacy for kinship, marriage, and gender relations, I first provide brief context and background on women’s social lives in India. In most parts of India, families remain patriarchal, patrilineal, and patrilocal in structure. Within this context, families regard family dignity, status, and unity as paramount; bringing shame or dishonor to one’s family is perhaps the greatest transgression one could commit. Moreover, children are socialized into gender inequalities from an early age. Boys are considered economic assets, while daughters are trained to become “good” wives and daughters-in-law (Kashyap 2007).

However, aspects of Indian social relations are shifting to accommodate changes in the global economy. Household composition is in flux; whereas families previously lived in extended, joint family arrangements, there is now a gradual change toward nuclear family patterns in both urban and rural India. The most recent National Family Health Survey (NFHS) in 2005-06 reported that three in five households in India are nuclear, with a slightly higher proportion of nuclear households in urban areas (63 percent) as opposed to rural (59 percent)

⁵⁸ See, for example, Desai 2012; Gentleman 2008; and Warner 2008.

(IIPS 2007: 23). While joint family living arrangements previously enabled families to share resources in times of surplus as well as scarcity, changes toward urbanization and industrialization have influenced the shift toward nuclear family living arrangements.

Such changes have significant impacts for gender roles and relations. With the increasing cost of living and the absence of financial security provided by the joint family system, there is a need for family members other than the husband to provide additional income. Changing attitudes toward the previously accepted division of labor—in which women took care of domestic work and men took up financial matters and work outside of the home—reflect increasing acceptance of women taking jobs to supplement family income. Indeed, paid employment of women has been recognized as key to achieving the goal of population stabilization (Ministry of Health and Family Welfare 2000). Yet, data from the NFHS indicate that women are about half as likely as men in India to be employed, and when employed they are only 74 percent as likely as men to earn cash. This varies greatly by occupation: 88 percent of women employed in non-agricultural occupations are paid only in cash, in contrast to 31 percent of women doing agricultural work (IIPS 2007: 76).

Moreover, there are striking gender disparities in income, control over income, and educational attainment. Only 10 percent of women in India say that their earnings are greater than their husband's (IIPS 2007: 454). In the state of Maharashtra (in which Mumbai is the capital city), 41 percent of women who earn money can decide for themselves how to use it, while only 20 percent of women have a bank account that they themselves can use (IIPS 2007: 473). Gender relations, too, remain profoundly unequal with respect to education. Forty-one percent of women aged 15-49, compared with 18 percent of men, have had no formal education (IIPS 2007: 56). Despite the increase in proportions of women receiving formal education, less

than one in three women have completed at least 10 years of schooling in any age group (IIPS 2007: 57).

Finally, with respect to marriage, data show that the mean age at marriage remains below 20, and even though child marriage has declined, 58 percent of women are married before the legal minimum age of 18 (IIPS 2007: 163). Indeed, in my own study, more than half of Indian women interviewed were married before the age of 18. These figures are important to consider in the context of surrogacy, as age at first marriage has a profound impact on childbearing and women's health: women who marry early have on average a longer period of exposure to pregnancy and a greater number of lifetime births.

Young brides, too, are more susceptible to domestic abuse and within marriage in general, domestic violence is widely accepted. More than half of women in India (54 percent) believe it is justifiable for a husband to beat his wife, particularly if a wife has shown disrespect to her in-laws, or if she neglects her house and children. Interestingly, men are slightly less likely to agree, with 51 percent claiming that abusing his wife is justified (IIPS 2007: 475). Women's movement and mobility remains restricted; only 40 percent of women say they are allowed to go to three specified places alone (the market, a health facility, or places outside the community) (IIPS 2007: 470). These findings contextualize the narratives and experiences of women to be discussed in the remainder of the chapter.

Nishi: Surrogacy and Constrained Agency

Nishi was 27 years old when we met in Mumbai in April 2010. She was married at 19 in what she called, speaking to me in English, a "love-cum-arranged marriage." As the story goes, Nishi's husband was "in love with her from afar" though Nishi did not reciprocate his feelings at

first. His mother approached Nishi's family with a proposal for marriage, and while Nishi's mother believed that the family was an appropriate match at the time, she says her mother has come to agree with her that he is "crazy" and has a drinking problem. Following marriage, Nishi quickly had her first child at twenty; she now has two school-age daughters born a year apart. Nishi and her husband are now separated, and she has filed a case for divorce. Since then, she has endeavored to distance herself from her parents and their burdensome financial problems, while working to support herself and her two daughters independently.

Nishi's story reflected the contradictions inherent in transnational surrogacy, which relies on the reproductive potential of bodies that have long been subjected to patriarchy and population control programs. Nishi's first pregnancy ended in miscarriage before she had her first and second daughters in rapid succession. Her fourth pregnancy ended with an abortion. Nishi would have preferred a longer gap between the two daughters, but her husband "wasn't listening" and desired a son. After her abortion, Nishi knew she did not want any more children and underwent tubal ligation, a common sterilization strategy among my respondents; several women mentioned to me the necessity of having the operation, in defiance of husbands who demanded that their wives produce a son.

These decisions complicate debates around reproductive rights and justice: while women like Nishi undergo operations that limit their reproductive potential for their own families, they later become pregnant for other families. Locating Nishi's story within the specificity of India as well as on a global scale reveals the unique contours of stratified reproduction in transnational surrogacy. On the one hand, India marks lower-class women like Nishi as inferior to middle-class women it links with Indian national identity, and the state has historically sought to limit the reproduction of lower-class women (Chatterjee 1989a). Yet the reproductive tourism industry

encourages their reproductive potential when it produces children of “worthy” parents, that is, foreign nationals and upper-class Indians.

Nishi was similar to many of the women I interviewed, with respect to class and social status, household income, and family histories of conflict and turmoil (in Nishi’s case, she struggled to provide for two daughters as a single mother separated from an alcoholic husband, while also shouldering the financial debts of her parents). However, unlike most of the women I had interviewed, Nishi spoke English. She was confident, articulate, and inquisitive, and she made a strong first impression. Yet Nishi’s education was brief, and she attended a school in which Marathi was the primary language of instruction.⁵⁹ In a conversation with her friend, Antara, Nishi lamented the structural constraints that limited her educational aspirations:

Nishi: Actually I wanted to become a doctor but my father told me he couldn’t afford it.

Antara: You can become one now.

Nishi: No, it is financially very difficult. I’ll have to attend the classes, which is not possible for me. I can study hard but can’t attend the classes. I studied very hard in the seventh standard and got first class but I had to give up school after that [due to financial constraints].

Nishi’s seventh grade education allowed her to secure a job at a large telecom company where she earned a monthly salary of US\$200. Her English language skills came from this job.

Nishi exhibited a profound curiosity about the surrogacy process and the risks involved, both physical and legal, particularly in comparison with many women who felt unable to pose questions to their doctors about any aspects of the surrogacy process. Describing how she came to accept surrogacy, Nishi relates:

⁵⁹ In recent years, there has been an increase in student enrollment in English medium schools and a drop in students opting for Marathi medium schools in Mumbai (Chavan 2011). Yet among the working class women in this study, access to English-language instruction was extremely limited due to the costs of education, making Nishi’s knowledge of English even more remarkable. Nishi herself wanted to send her daughters to English-medium schools, but regretted that she could not afford the costs.

My friend, Shanti, told me about the idea of ET [embryo transfer] and I was surprised. By that time, I was aware about the test tube baby but this was new for me. I thought about it for one month. Then I had a quarrel with my brother... That was the decisive moment for me.

Nishi had been staying with her brother; she was hoping that surrogacy would offer the means to move out.

I called Shanti and told her that I'm ready for the process. After visiting the hospital, I went to an Internet café and searched for information about surrogacy to prepare myself for the process. Most importantly, I'm earning a substantial amount for my kids. In India we rarely get the chance to earn this much at one go.

In contrast to many women, Nishi took steps to educate herself about surrogacy. She was the only woman I interviewed who mentioned conducting Internet research in order to learn more about the risks involved in surrogacy.

Yet once Nishi began the surrogacy process, her relationship with Shanti soured. Shanti herself had wanted to become a surrogate; she had undergone embryo transfer three times, with no success. She decided to become an agent herself and her discussions with Nishi were in her mind related to that. After accompanying Nishi to the doctor where she underwent blood tests and ultrasound scans, Shanti demanded a commission—approximately US\$45, which would be deducted from Nishi's payment of US\$220 at the time of embryo transfer—for introducing Nishi to her doctor. Nishi's first reaction, as she sat in the recovery room following her initial blood tests and scans, was "Well, if she hadn't told me about this, then how would I have known? I would have had no idea about this." But she later balked at the idea of paying Shanti out of her own earnings. Nishi explained, "She is such a careless agent. I was dying here in the first two months [of pregnancy] with vomiting and she didn't come at all. That's not done."

Nishi's comments display the impact of agents' intermediary positions on surrogate experiences as well as the subtle ways in which social relationships change in the context of

surrogacy. As Shanti's focus moved toward becoming an agent/caretaker, she alienated Nishi. As I will discuss further in the following section, the agent/caretaker plays a large role in surrogate women's experiences, in ways that both enhance and constrain surrogate's opportunities. In Nishi's case, though she tried to learn about the practical details of surrogacy, she still found herself in a vulnerable position as a surrogate, as her agent demanded payment and neglected to care for her in the early months of her pregnancy.

Throughout our meetings, housing was a constant stress for Nishi. When we first met, she was still staying with her brother; according to Nishi, the house was inadequate and she desperately wanted a home of her own. Then her brother's family kicked Nishi and her children out and they had to move in with her aunt, who looked after her children when Nishi was unable to, and lived in a city approximately 80 kilometers outside of Mumbai. The uncertainty made it impossible for Nishi to enroll her daughters in school.

Nearly all of the surrogates with whom I spoke reported a lack of transparency and power in negotiating contracts. This process perhaps illustrated more than any other aspect of their experience the social and structural inequalities that both propel them into the surrogacy industry and circumscribe their experiences within it. For Nishi, like most surrogates, the experience of signing the contract was confusing and mysterious, and despite her assertive nature, Nishi could not advocate on her behalf:

DD: Can you tell me about the contract process?

Nishi: The contract was in two copies, one is original and the other was Xerox.

DD: Did you ask for a copy for yourself?

Nishi: No, actually I wanted one copy for myself but I didn't dare to ask for one. In fact I don't prefer to sign any contract without knowing it in detail but one page was also blank which I signed; also the amount was not filled in. And most importantly she didn't give us a chance to read the agreement. She was turning the pages very fast. If she had let me

read the document, I would have read it quickly because I can read English and I can read fast.

While Nishi reported these objections to me, she said she could not speak up in front of the doctor and lawyer who were present when she signed. Indeed, this came up again and again in interviews: surrogates would not confront doctors and lawyers on crucial issues related to their payment for fear of losing their contract. They said that doctors often hinted at an ample supply of women ready and willing to take their place as surrogates, clearly signaling the class issues at the core of the Indian surrogacy industry.

These obstacles notwithstanding, Nishi endeavored to express subtle and explicit forms of agency within these larger structures of power, by taking steps to read and conduct research, and independently making her own decisions about surrogacy. Yet despite her own confidence and self-education, Nishi's possibilities for agency remained constrained due to her position in relation to doctors, agents, and other actors involved in transnational surrogacy. In contrast, the story of Antara, whose socioeconomic status was similar to Nishi's but worked as an agent, uncovers a distinct set of possibilities for agency and power.

Antara: Power and Agency in Agent/Caretaker Work

My research took me into the homes and lives of various surrogates, egg donors and caretakers in Mumbai, and as I navigated the anthropologist-informant relationships with each, perhaps the person I am most indebted to is Antara. Though several agents participated in my study, I met with Antara more than any other agent throughout my research. Antara is outspoken and bright, and welcomed me into her home numerous times; a superb host, she unfailingly ensured I was properly fed before "getting to work." She introduced me to the many women she looked after in her role as surrogate agent/caretaker, and I saw how strong a force she was in

their lives.

While her husband, Rahul, had the equivalent of a seventh grade education, Antara had reached the tenth grade, higher than many of the women I had met during my research. In general, the surrogates and egg donors who participated in my study had low levels of education; many stopped school by seventh grade. Yet my study also included a number who had studied up to tenth or sometimes twelfth grade, and some were currently pursuing studies in nursing or cosmetology. Further, while many participants reported financial instability, only a handful of women described themselves as “desperate” for the money; others depicted a solidly middle class lifestyle. Indeed, despite the financial hardships recounted by most of the women I interviewed, they tended not to be the “poorest of the poor.” A few women, like Antara, demonstrated a range of skills that allowed them to capitalize and negotiate their social positions, reflecting the uniqueness of women who participate in the surrogacy industry and then go on to become successful agents.

Antara and Rahul had two children, a 15-year-old daughter and a 13-year-old son, with whom I enjoyed chatting in English, playing games, and discussing books and recent movies. Rahul worked for a private company laying roads; for this work he earned a monthly wage of US\$110, but since such seasonal work was irregular, the family often found themselves struggling to get by. When we first met, Antara was 36 and described herself as a “housewife”; however, over the months I came to know her and her family, I watched as Antara’s work as an agent/caretaker grew into a job that took her all over the city, into women’s homes, doctor’s clinics and hospitals.

Antara’s introduction to the surrogacy industry took place several years prior to our first meeting in 2010. When her sister-in-law, Sumita, told her about surrogacy as an income

opportunity, Antara initially thought, “What are you talking about? I thought it was probably wrong, but then I realized that I’ve had my two children. I’m donating something.” Rahul, however, did not support the idea, and Antara called on her elder sister and sister-in-law to convince him. Confronted by these determined women of the family, saying, “Look at your living conditions; you need something better,” Rahul eventually agreed. Indeed, many women told me similar stories of needing to persuade their husbands to allow them to become surrogates,⁶⁰ contradicting concerns among opponents of surrogacy that husbands or other family members coerce Indian women into becoming surrogates.

Antara became pregnant and gave birth to a boy via cesarean section. For this work, she earned around US\$2700, which, in Antara’s words, “is not enough.”⁶¹ Antara and Rahul put away some of the money for their daughter, and used the rest to repair her family’s home in the village. In Mumbai, Antara’s family continued to live in a rented home.

In 2009, she then came to work as an “agent/caretaker” for Dr. Desai, who originally facilitated Antara’s surrogacy. In her role as an agent, Antara would bring women interested in egg donation or surrogacy to Dr. Desai, for which she would receive a commission of US\$90-180. Antara’s work as an agent, however, frequently overlapped with her position as a “caretaker”; charged with everything from accompanying surrogates to the hospital for medical procedures, to ensuring surrogates receive their medications, caretakers can receive between US\$450 and US\$900 for their work throughout the duration of a surrogate pregnancy. As I learned from Antara about her perspectives and experiences with the surrogacy industry in Mumbai, I found that the absence of any laws regulating surrogacy resulted in enormous

⁶⁰ Among the eligibility requirements for women who wished to become surrogates, doctors required that married women have the permission of their husbands.

⁶¹ Since Antara’s surrogacy experience, payment for gestational surrogates has increased to US\$4,000-6,000 for most of the surrogates included in this study, depending on the clinic they attended.

variability in payment and commercial surrogacy practices. Recruiting agents and caretakers occupy a unique dual position as advocates for their “patients” and as entrepreneurs of sorts, who negotiate their own wages with doctors and patients on a daily basis. Antara herself rarely collected payments directly from her patients. Surrogacy contracts with intended parents typically include a clause that covers recruitment fees; thus, Dr. Desai would distribute Antara’s fees after receiving payment from the commissioning parents.

Initially, Antara would roam around her community and speak with women to see who might be interested in egg donation or surrogacy. Eventually, however, as her reputation as a caretaker spread, I observed a significant boost in Antara’s work. By the end of my fieldwork, all of Antara’s “patients” would come to her through word of mouth, and most of the women she works with are distant relatives or neighbors in her community. Throughout the months that I met with Antara, I observed how she came to identify more and more as “agent” than housewife, and I noted her strength and confidence in this role many times. She typically had between four and seven patients; at her busiest, Antara could be responsible for up to nine or ten patients at varying stages of egg donation and surrogate pregnancy. Antara viewed her work as a full-time job and conscientiously fulfilled her duties; it was not uncommon for her to be out from early morning to late evening, and she meticulously took notes and kept track of all her patients’ medications, payments, and doctor’s visits. Responsible for dispensing medications and administering hormone injections, Antara claimed, “I’m also a doctor by practice; I don’t have a degree so you can consider me ‘half-doctor!’” In addition, Antara grew close to her patients on a personal and social level, and on more than one occasion, I witnessed Antara serve as a mediator and advisor for women and their families, offering advice on how to deal with an abusive husband or mediating between dueling sisters. As Nishi told me, “Antara goes all the way in

helping patients with their problems. She has earned the right to ask for money as an agent.”

During my fieldwork I noted how Antara’s financial situation changed over the course of the year, due largely to her work as an agent. When we first met, she and her family were renting a small, cramped one-room flat; several months later they moved to a more spacious, airy home. She was later able to purchase a refrigerator (with a lock to secure the medications she stored for surrogates and egg donors) as well as a steel cupboard, tangible markers of upwardly mobile class status. Antara and Rahul also saved enough money to send both of their children to college, so that they could receive the education that neither Antara nor Rahul could achieve. These significant details reveal the impact of Antara’s work as an agent; I observed few surrogates achieve similar goals in their post-surrogacy lives.

It was not uncommon for Antara to confront angry or abusive husbands, in ways not typically expected of Indian women. Following Antara’s experience as a surrogate, her sister Asha, too, wanted an opportunity to become a surrogate and earn much-needed income for her family. Like other surrogates in the program, Asha was admitted to the hospital for twelve days after the embryo transfer. Asha’s husband visited her in the hospital, and Antara thought he had been made uncomfortable by the hospital’s policy that he couldn’t go into her room, for the privacy of others, but had to see his wife in a more public visiting room. He suspected he was actually being barred because Asha was committing adultery. While Asha’s husband was fully informed about the surrogacy process and the procedures Asha would undergo in order to become pregnant, he nonetheless became angry, insecure, and jealous, harassing Antara and her family following this misunderstanding. Antara said:

After that we had so much fighting in the house!...He said if something goes wrong I will throw both of you out of the house. He just wouldn’t listen. He said, “My wife would not even go to the shop by herself and all of you took her so far away.” I waited until morning when he sobered up. I said to him, “How did she get so far away? Didn’t she ask

you? And how dare you use such words about me?” I said if you say this ever again to her and if you so much as touch her to harm her, you watch it.

I asked, “You threatened him?” Antara replied:

Yes, I told him not to be a bully. I’m good with those who are good to me but bad to those who are bad to me. This is not wrong. There is nothing wrong in this work. If there was, would I have helped my own sister to do it? Then he started apologizing. He said, “Forget it, I will never say anything about it again.” Then he said, “Please don’t tell her I spoke like that.” But I told her [Asha]. If he could speak to us like that, he would have said things to her too. So I told her this is the way your husband spoke to us. Then she must have confronted him. She is also a very strong woman. And now, he’s quiet.

Antara navigated threats and assertions of power in her family. The sudden increase in Asha’s earning potential as a surrogate prompted Asha’s husband to react strongly to the subtle shift in the balance of power in their relationship. I encountered several women who negotiated tense relationships with husbands who were uncomfortable with the significant incomes their wives earned as surrogates. Moreover, Asha’s husband’s comments hint at persistent misunderstandings regarding surrogacy and its connections to notions of purity and pollution in India. Despite awareness of the medical procedures involved in surrogacy, Asha’s husband insisted that Asha must have committed adultery in order to become pregnant.

Yet, while Antara acknowledged the right of Asha’s husband to have the final say in her embodied affairs, saying, “How did she get so far away? Didn’t she ask you?” she simultaneously resisted her brother-in-law’s threats and called on Asha, too, to confront her husband, signaling subtle and complex expressions of power and agency within the household. While Pande’s work on surrogacy in India sheds light on how women view their husbands’ role in surrogacy, often de-emphasizing their husbands’ contribution and joking about their emasculation (Pande 2009b), she conducted her research mainly with women who lived separately from their husbands in “surrogacy hostels” with other surrogate mothers. In contrast, my study provides valuable insights into the impact of surrogacy within the households of

surrogate women themselves, revealing the complexities and consequences of female agency as they collide with gendered cultural expectations of female submissiveness and dependency.

In another instance, Antara explained how she banded with other agents to demand equal payments for their patients. As Antara described the monthly payment plan for Dr. Desai, one of the several doctors she worked with, she noted how surrogates were to receive approximately US\$65 for monthly expenditures, in addition to monthly payments of US\$110 to cover their rent and housing (these payments would be deducted from the total salary of US\$5500 that Antara's surrogates earn for their reproductive labor). Yet sometimes Dr. Desai would give US\$45 to some patients and US\$65 to others. When Antara and her fellow agents realized this, Antara explained, in an account that called to mind the efforts of labor organizers or activists, "All the agents came together and forced her to give equal payments to everybody. So now everyone is getting \$65 as allowance for other expenses."

Yet Antara's role as patient advocate sometimes clashed with her entrepreneurial side, revealing the nuanced ways in which agents must negotiate the two positionalities. Antara's work as an agent was often tenuous and insecure, and she recounted how she coordinated with fellow agents to approach Dr. Desai when their own payments were decreasing:

Antara: Last month all us agents, around twenty-five, conducted a meeting with her and we confronted her about her decreased payments to us... She is looking to reduce costs as much as she can, and she is deducting from the agent's accounts. Things like injections, traveling from home to the hospitals for different sonographies used to be paid; these are no longer paid nowadays. We demanded the expenses from her.

DD: Did she give you what you asked for, in the end?

Antara: No, she gave us her notebook to write down the demands. And there is the problem of patients becoming agents. If a patient is bringing someone else as a patient, she makes her an agent, resulting in a rising number of agents. It creates problems for us, and we can't pressure her for more money. We have asked her not to appoint new agents anymore.

DD: Do you know all the agents?

Antara: Yes, I know most of them. But when a patient becomes an agent it's difficult to keep track of the agents, as it's difficult to differentiate between patient and agent.

While Antara and her fellow agents demanded higher pay and transparent pay scales, they also raised questions about the doctor's tendency to favor certain agents and patients over others. At the same time, however, their objections stemmed from the fact that patients who sought to become agents challenged their position in the hierarchy among doctors, agents, and patient. In seeking to preserve their own power and positions, Antara and her fellow agents aimed to limit the power of their patients to become agents themselves. Ultimately, however, Dr. Desai did not address any of the agents' demands, and with limited opportunities to find alternate forms of income, Antara continues to work for her as an agent/caretaker.

I was surprised, however, when one day Antara presented me with several pages of computer printouts. With little knowledge of English, and having few opportunities to do research or access the Internet, Antara had approached a local vendor—the person who helped her secure identification cards for her patients—with a request to research payments for surrogates. When I asked why she collected this information, Antara replied:

Antara: I wanted to know the actual payment to a surrogate from the client [intended parents]. If I know the actual payment it will help me to make the process with patients more transparent which eventually helps me to reach more women.

DD: What are you going to do with this information?

Antara: I'm not sure yet but if we contact the clients directly, it will be more beneficial for everyone.

DD: Is this possible?

Antara: Why not? There are a lot of people who have asked me to approach the clients.

Displaying a canny sense of entrepreneurship, Antara imagined that she might eventually be able to reach parent/clients directly, avoiding third parties such as Dr. Desai and increasing financial returns for herself and her patients, however unrealistic this may be.

Yet Antara also understood that particular social and structural factors circumscribed the range of possibilities available for women like her to negotiate their own livelihoods. When I asked her whether surrogates should be able to meet the future parents of the child they were carrying, Antara replied:

It should be absolutely acceptable but the main problem is being capable of having a dialogue with them. The language barrier hampers those who really want to communicate with their couple. Couples from abroad usually speak their own language and it is difficult for many illiterate women to respond. These women are really uneducated. In my sister's case, the couple visited her so many times and really wanted to communicate with her but she didn't utter a word. If a smart and educated surrogate had been there, she would have asked them about the details of the actual payment and other things. But here the patients are totally dependent on the doctor. So any added gifts or payment that might have been given by the client but did not reach its destination cannot be tracked. In another case, Anu's case, the client never showed the courtesy of greeting us or giving good wishes to her after she delivered twins for them and went through caesarean. They just paid their amount and took the kids away. Surrogates really feel bad after being treated in this way. They are not asking you for something extra and they are also aware that you are the original parents of the kids. There is no harm in showing some humanity but they didn't even look at her once.

As Antara's comments attest, lack of education and lower social status in relation to the doctors and commissioning parents largely shapes surrogates' experiences. Indeed, while Antara acknowledges the challenges language barriers between surrogates and intended parents pose, her remarks illustrate the factors that limit access to resources and motivate women to become surrogates (lack of education, low socioeconomic status). These same factors restrict women's ability to confront intended parents and doctors and to ensure transparency in surrogate arrangements. Indeed, Antara was acutely aware of the inequalities at the heart of transnational

surrogacy arrangements as she worked hard to use her own constrained agency to provide opportunities for herself and her family members.

Parvati: Marriage and Gender Relations

I came to meet Parvati several times during my research, as she was a good friend and neighbor of Antara. Thirty-year-old Parvati had been married for sixteen years and was mother to a 14-year-old daughter and 12-year-old son, who were close in age to Antara's children and often would spend time together. Her husband, Kapil, worked as a rickshaw driver and frequently drove my translator and me to the train station after long days in Antara's home. Kapil sometimes earned between US\$130 and US\$150 monthly as a rickshaw driver, yet this was unstable employment, and the family suffered frequent stretches of financial instability. Parvati had completed some primary school education (fourth grade) and worked as a housewife.

Parvati learned about surrogacy through other women in her community, and approached Dr. Desai with hopes of becoming a surrogate. Dr. Desai, however, responded that Parvati's children were too old; "What will your daughter think about you being pregnant now?" Dr. Desai asked. At this point, Kapil was unaware of Parvati's intention; Parvati never mentioned the visit to Kapil.

However, Parvati persisted and eventually convinced Dr. Desai to accept her as a surrogate. When Parvati explained her surrogacy plans to Kapil, he was immediately on board when he learned of the money that she would earn. Parvati, who would eventually become pregnant with twins, would earn more than US\$7000,⁶² approximating the amount that Kapil

⁶² Some doctors paid surrogates more if they carried twins and if they delivered via cesarean section. Rates of cesarean section were very high, and doctors explained that twin births all but guaranteed delivery via cesarean section.

could earn in four years driving a rickshaw. Parvati planned to keep some of her earnings for her daughter's wedding, and use the rest to buy a house for her family.

At one of our meetings, in her second month of pregnancy, Parvati seemed fine and easy-going as always. When I asked how the pregnancy was progressing, she replied that all was well and she had no complaints, except for the fact that she disliked taking so many medications. She went on to describe the day she underwent embryo transfer:

No problems with the process so far, though we enjoyed a flight to Delhi. We had never been on a plane nor to Delhi before. We had some sweets on the plane, but we didn't have an opportunity to see the city because we were there for one day only. We went directly to the hospital where we had to wait until 5:00pm. Then we went through the process [embryo transfer], which was completed by 7:00pm, and we took the return flight back to Mumbai the same night.

When I asked with whom she traveled, Parvati explained that Dr. Desai and another woman undergoing embryo transfer joined her on her trip. She was clearly excited about having been on a plane to Delhi, something neither her husband nor anyone in her family had done before.

Parvati went on to describe how her current pregnancy contrasted with her previous pregnancies with her own children: "This is better than the previous experiences. In my own pregnancies, it was for myself, which was obviously an important moment in my life. But this is something different. And also we are doing this because of our poor conditions. We are going to get good financial returns out of this." When asked how her daily routine might be different and what her husband's thoughts were on her pregnancy, Parvati replied, "Yes, it is definitely different. We are more careful this time whereas we used to do all the work with our own pregnancies. We follow all the doctor's instructions, like avoiding lifting heavy objects, etc. My husband feels good because we'll be getting a lot of money. There's been no difference in his behavior for me. He has accepted the process positively."

Yet as her pregnancy progressed, Parvati's attitude would change dramatically. At a subsequent gathering in Antara's home, Parvati, then five months pregnant, was visibly stressed, unhappy, and annoyed. The tension was apparent on her face, and she seemed to have trouble relaxing as she sought the advice of Nishi and Antara, among others who were present that day. In the middle of a conversation with another woman who was extolling the virtues of her supportive husband, Parvati suddenly interjected, with a bitter tone, "If your husband is nice and supportive, then you don't need anything else in the world." My translator, Prachi, gently replied, "Why do you say that? I'm sensing some problems with you, Parvati." Parvati went on to explain, "My husband is very selfish. Generally husbands are not that bad. Sure, everybody is selfish but he has crossed all limits." At this point, Antara remarked:

He thinks we are planning to send her along with those foreigners. Her husband always thinks I've provided her with some foreign connections. Parvati's health is not good these days. He [Kapil] should understand this and help her with the housework. What she is doing is to benefit his family only. But he doesn't take all these things into consideration and hurts her whenever possible. He always pushes her to handle all the family responsibilities alone. This could create some problems for her in the process. He wants financial benefits but doesn't want to do a single small thing to help achieve that.

Though Parvati claimed earlier in her pregnancy that Kapil remained positive and supportive, clearly her marriage, as well as her health, began to suffer as a result of her pregnancy. In Antara's observations, Kapil's assumptions about her own role in Parvati's surrogacy disclosed a paranoiac belief that Parvati would eventually leave India (a highly unlikely outcome of Parvati's surrogacy process). He also refused to relieve Parvati of the burden of housework and other responsibilities, and Antara was quick to point out that not all Indian men behave as such: "I've given him [Kapil] the example of my husband, too. Rahul also helped me in difficult situations during my surrogate pregnancy. He did all the things like cleaning the floor, washing the clothes, etc."

Later in the day, we return to discuss Parvati's unfortunate situation in more detail, with both Antara and Parvati elucidating Kapil's various offenses. As Parvati's agent and caretaker, Antara had much to say on the matter of Kapil's treatment of Parvati; Antara began, "That guy [Kapil] is so bad and corrupt! Whenever Parvati is picking up her payment, he forces his son to leave school and follow her everywhere like a spy to know actually how much she is getting!" Parvati replied, "He thinks that now that I'm getting so much money, I might run away with it. If he continues to behave like this, one day I'll definitely run away with someone!"

Here, Antara picks up and continues to tell Parvati's story, after sending away the children who were present in the room:

When the actual embryo transfer takes place, the surrogate is keeping someone else's embryo. But he [Kapil] is still under the impression that to do this his wife has to sleep with another person. He keeps taunting her about this. Doctor has told him all about the process and I've also told him everything in detail. I've explained it with as much detail as possible, more than I've had to do with anybody else, but he keeps harassing her.

When asked what she was planning to do, Parvati simply said, "I'm in the fifth month now. There are still four months to go. I'll have to suffer for another four months like I've done so far. I have to take care that the baby is not affected. It's such a waste of time to speak with him. If he doesn't get it after so long and after so much talk, there is no point in talking any more with him." In the background, another woman, Aditi, quietly commented, "She doesn't even eat on time." And Nishi replied, "We are usually at risk of having this kind of problem in our society because people don't understand surrogacy that well." While her pregnancy was clearly taking a toll on her family and her health (she was missing meals, as Aditi revealed), Parvati remained focused on taking care of the fetus she was carrying.

Parvati's situation illuminates the impact that surrogacy can have on a woman's marriage and family. While some women's husbands understood the process and supported their wives'

decision to do surrogacy, Parvati encountered a dramatic shift in her relationship with her husband. As she explained, “We both wished this [surrogacy] for us. He didn’t force me to do this. But I think now the money is making him a little over-conscious. Even now he’s not afraid to raise the question of how can I be carrying the children of only one person, since there are two. I told him in anger that I’ve slept with two men and am having two embryos. What a stupid person he is.” Interestingly, Kapil’s reaction, like that of Asha’s husband, demonstrates not only a discomfort with Parvati’s surge in income, but a lack of understanding of the process of surrogacy. These misconceptions about assisted reproduction—namely, that Parvati must have slept with another man in order to become pregnant—also reveal Kapil’s assumptions about the violation of women’s bodies in the process of surrogacy, and call to mind traditional Indian beliefs about purity and pollution in the Hindu caste system.⁶³

Yet when I asked what she planned to do about her husband’s behavior, Parvati replied,

Women here have to stay with their husbands because they can’t survive without them. Now that I’m getting so much money he is thinking that I may run away with someone. But I don’t think like that. I’m not going to run away and do such things. I have to stay and I want to see my daughter’s wedding and all. He even hits our daughter for not listening to him; he thinks I’m telling her to not follow him. And he is training our son to spy on me all the time. But I told him [Kapil] that he’s not going to obey you forever. Once he’s grown, he will not be yours or mine. He’ll be his own person and will use his own mind.

With Parvati’s remarkable increase in income, the shift in the gendered balance of power in their relationship provoked Kapil’s increasing suspicion and anger, not only toward Parvati but toward their children as well. In the end, Parvati remained, as she predicted, with Kapil and her family. Though Parvati earned a significant sum for her work as a surrogate, it was not enough; in order to have the amount needed for the purchase of a home, Parvati had to sell her family jewelry.

⁶³ See Dumont (1980[1970]) and Marriott (1976).

Indian women involved in surrogacy take up a diverse set of roles and responsibilities, and in contrasting the relative positions of the surrogate and the agent/caretaker, I have shown how these intermediary roles have resulted in intra-class divisions that engender further stratification among women. In Antara's case, her experience as a surrogate facilitated her ascension to her role as a sought-after surrogate agent, and this role afforded her power and agency, however constrained.

Others have briefly examined the relationships between surrogates and agents, or "brokers" as Pande has written. In her work, Pande has described how surrogate hostels can represent a powerful site of resistance against brokers. In her study, surrogate women banded together and complained to their doctor about the fact that they had to pay their broker US\$200 from their own earnings. Eventually, the doctor added a clause to her contracts stipulating that commissioning parents would be responsible for broker payments (Pande 2010a). Yet Pande's study, located in a small town in the western state of Gujarat, focused on women whose agents played a smaller role because they lived in a surrogate hostel for most of their pregnancies. Agent/caretakers played a more significant role in the lives of the women I interviewed, and thus had more power and involvement in surrogacy arrangements. Unlike the agents in Pande's research, they chaperoned women to clinics, administered injections and medications, mediated family quarrels, and disbursed payments. However, while Antara cared about the lives of her "patients," she also sought her own financial future and wellbeing. I found that incentives encouraged women in intermediary roles to improve conditions and foster loyalty by their surrogates; at the same time, incentives prompted agents to protect their own relative positions of power by constraining the agency of others.

In her ethnography of the delivery of prenatal and birth health care in a New York City public hospital, Khiara Bridges (2011) has argued that “the very act of being pregnant” is an act of resistance of poor women who are historically viewed as “undisciplined breeders” but “‘good enough’ nurturers to work as childcare providers for other, more privileged class and ethnic groups” (Ginsburg and Rapp 1995a: 3). In transnational surrogacy, too, the act of being pregnant is an act of resistance to the larger structural forces that constrained their own opportunities as working class Indian women. Indeed, for women in a society in which they are not primary wage earners, surrogacy represents an enormous opportunity to achieve greater power in financial respects. Yet in challenging such gender norms, women encountered varying responses within their families and communities.

Some narratives, for instance, reveal how their efforts at resistance actually recreated structural inequalities. Though Nishi sought to improve her own family’s financial future through surrogacy and took proactive steps to educate and protect herself against the risks involved, she remained unable to negotiate key aspects of her surrogacy contract. While Parvati earned many times the income of Kapil, she affirmed that women simply “can’t survive without their husbands.” Antara, too, worked to increase payments for her surrogates, yet her negotiations of power as an agent/caretaker did not represent interventions against structural processes. Rather, her actions intensified and re-created hierarchies among working class women involved in surrogacy. As Rhacel Parreñas has argued in her discussion of migrant Filipina domestic workers’ resistance to power (Parreñas 2001), this is the “bind of agency” that Judith Butler articulates (Butler 1997). Because the social processes from which agency emerges limit it, resistance, as it recuperates power, does not necessarily challenge structural inequalities. In

the case of transnational surrogacy, the intermediary positions of agent/caretaker further reinforce these inequalities.

This chapter offered a critical examination of transnational surrogacy, with a focus on the views and experiences of the women without whom gestational surrogacy would be impossible, in order to reveal how women express agency in the context of structural constraints and social inequalities. While focusing on the everyday experiences of women involved in surrogacy, I have connected their experiences within the larger global structures that foster reproductive tourism. The narratives of Antara, Nishi, and Parvati illustrate the unique contours of stratified reproduction in the context of transnational surrogacy, while simultaneously challenging popular portrayals of surrogates as powerless victims. While the system treats surrogates as though they are no more than wombs-for-rent, their voices and hopes reveal complex histories of women and families struggling to get into a global market on the best terms they can muster.

CHAPTER SIX

Defining Parents, Making Citizens:

Nationality and Citizenship in Transnational Surrogacy

In July 2010, consuls general of eight European countries sent letters to over ten Mumbai surrogacy clinics, demanding the clinics' cooperation in ceasing to cater to their citizens. The letter, endorsed by the consuls general of Belgium, France, Germany, Italy, the Netherlands, Poland, Spain, and the Czech Republic, emphasized the importance of directing nationals from their countries to their respective consulates before beginning the surrogacy process. Moreover, the consuls general asked that clinics immediately comply with this request to avoid future legal hassles. Each of these countries prohibits surrogacy, and many citizens of these countries have encountered difficulties in applying for citizenship rights for their children born via gestational surrogacy in India.

Many doctors welcomed the letter, asserting that the European consuls' general notification is in line with the Indian Council for Medical Research guidelines, which recommend that prospective surrogacy clients obtain a letter of no-objection from their own consuls general (Roy 2010a). Other doctors, however, took offense at the letter. One Mumbai obstetrician conveyed her deep dismay at the thought that the dictates of foreign consulates might influence her own work as an Indian doctor. When I asked for her thoughts on the recent letter, the doctor replied:

They're trying to use us as bait for their rules and their problems. *That is their* country. They have to sort out their problems. *We're* living within the purview of our laws and regulations. I am ruled by the Indian consul; not by some European consul. I am an Indian citizen so what applies to you may not apply to me. It's simple. The woman I am delivering is an Indian citizen and she has the right to deliver at this hospital. Whose baby

is it? That's your problem. You don't want your people to come here? Then, don't allow them to leave your country. Why hold a gun to my head?

These actions—of consular officials seeking to restrict their citizens' access to surrogacy in India, and of doctors intent on offering surrogacy options to foreign clients—demonstrate the ways in which states and institutions become involved in transnational surrogacy, particularly when incompatible legal frameworks intersect. At the time the letter was circulated, there had been growing concern about how to deal with the legal inconsistencies that permeate the international market for surrogacy. Several high profile cases of parents unable to obtain citizenship for their babies born through surrogacy in India drew attention to the plight of “stateless babies” and to the lack of legal certainty around the connections between transnational surrogacy, nationality, kinship, and citizenship.⁶⁴

At the root of these struggles for citizenship, I argue, are conflicting ideas about kinship and family, which are called into question in the context of the globalization of ARTs. The once taken for granted correspondence between citizenship, nation, and state has been challenged as new forms of citizenship take on an increasingly transnational character. Within this context, contradictory processes of citizenship—and its connections to notions of national belonging and kinship—complicate ideas about who counts as a mother, father, or parent.

This chapter examines notions of citizenship and nationality in the context of transnational surrogacy, and how these notions intersect with ideas of kinship and family. What happens when incompatible national legal frameworks collide in India in the process of requesting citizenship? What unfolds when different systems of kinship classification, policies about surrogacy, and practices of assigning citizenship clash—all on Indian soil? Throughout my interviews with couples and individuals who had traveled to India, I was struck by how widely

⁶⁴ See for example 2009; 2012; Mahapatra 2008; Roy 2010b; Roy 2011.

their experiences varied when it came to the process of leaving India and returning home with their newest family members. I became particularly interested in the myriad ways that parents are defined—by states, institutions, and families—and how this connects with ideas and practices around nationhood and citizenship. Much of the literature on the citizenship and nationality issues entangled in transnational surrogacy takes a policy or legal perspective (Ergas 2013; Points 2009); however, relatively little work engages an ethnographic approach. In what follows, I foreground the narratives of non-Indian parents of children born through surrogacy in India, in order to shed light on their experiences seeking citizenship for their newborns. I focus on the citizenship process in two countries that illustrate the range of approaches to transmission of citizenship: the U.S. and Norway. In particular, I consider how ideas about nationhood, citizenship, family, and motherhood take on new meanings in the global lives of families built through surrogacy in India.

Nationality, Citizenship, Family, and Motherhood

In this section I trace how the domains of nationality and citizenship intersect with ideas about kinship and family; gender and race also inevitably factor into such analyses of kinship and nationality, particularly within kinship models understood as based on blood and sexual reproduction.

Historically, citizenship has been linked with the rights and obligations that individuals have within a nation-state; so, too, is it connected to the overall politics of belonging. As Nira Yuval-Davis et al. demonstrate in their work on the politics of belonging (2006), while certain individuals and projects are seen as “belonging” within the nation-state, simultaneously other individuals and projects are excluded.

However, how do nations determine who does and does not “belong”? Here, mutually reinforcing ideologies of race and nation come into play. Gilroy (1987) has noted that in postwar Britain, ideas of nationality, and threats to that nationality, were strongly linked to discourses that viewed racialized immigrants (but not white immigrants) as problematic. The notion of “Britishness,” then, was defined as white by default (Gilroy 1987). Gailey (1996) has examined the intersections among race and nationality in historical colonial context. Observing how English, French, and Dutch travelers portrayed Pacific Islanders differently at various moments, Gailey illustrates the readiness of European colonizers to make judgments based on skin color. These judgments correlated with the rise of transnational slavery in West Africa and colonization in other regions. Consequently, as colonial relationships develop over the years, colonizers depicted the skin color of Pacific Islanders as noticeably darker.

Balibar (1991), too, traces the entangled ideologies of race and nation to the moment when nation-states envision their “people” as not only political, but also an ethnic and/or racial entity, joined by a common history, origin, and culture. According to Balibar, racism and nationalism each depend on a balance between inclusion of citizens and people who share a common origin, and exclusion of people outside those categories. Racism becomes a “super-nationalism” of ideas about national culture and evokes themes of genealogical roots and purity of blood.

The origins and character of blood, too, have an intimate relationship with nationalism, and scholars have illustrated the gendered dimensions of this relationship. While the reproduction of the nation’s population involves the endless mixing of blood, the character of the individual and his/her body is seen as affected by the essence of what is inherited in the blood. Thus, scholars have elucidated the ways in which ideologies of race, ethnicity, and nation,

historically linked to reproductive sexual relations between men and women, have a powerfully gendered dimension. As Stoler (1995) demonstrates, beliefs in appropriate sexual behavior and morality were central to definitions of “proper” members of the nation and the white racial category. Moreover, “appropriate” conduct was typically different for men and women, with women often tasked with maintaining the purity of the race, nation, or ethnic group (Smith 1997).

These notions of race and nation inevitably intersect with ideas of kinship. A starting point for this chapter is the understanding that many contemporary nation-states organize citizenship and nationality around notions of family membership. Belonging to a nation depends, in part, on one’s belonging to a family, and various authors have linked nationalism and citizenship to ideas of kinship (Alonso 1994; Anderson 1991; Schneider 1969). Schneider, for instance, observed parallels between U.S. kinship and nationalism. Whereas in kinship, one might have relatives by blood (natural connection) and relatives by law (marriage), so, too, will ideologies of nationalism determine the modes of assigning citizenship: by birth or by legal process (often referred to as “naturalization”). Anderson also has argued that nationalism ought to be viewed “as if it belonged with ‘kinship’” (Anderson 1991: 5).

Historically, nations have distinguished between assigning citizenship by *jus soli*, “right of the soil,” or place of birth, and *jus sanguinis*, or “right of blood,” in which citizenship is passed from parent to child. The principle of *jus sanguinis*, in particular, reiterates an unspoken blood relationship and a notion of belonging based on racial and cultural homology. This principle forms the basis of several European countries, including Norway (as will be discussed later in this chapter). These categories, however, are unstable and are historically constructed. In practice, soil and blood are often interlinked through a common origin story (Linke 1999).

Teman (2010) has shown how citizenship and motherhood mutually inform each other, particularly in the context of ARTs. In her study of surrogate motherhood in Israel, Teman examines motherhood and nationality to show how an Israeli surrogate gives birth not only to a new Jewish citizen, but also to a gendered citizenship (that of the Jewish mother). Through this process, surrogacy reaffirms both the goals of nation building, as well as the traditional goals of motherhood. Surrogacy arrangements in Israel, then, are carefully managed to support core categories of motherhood and family while achieving the reproductive goals of the state (Teman 2010).

Finally, while the concept of “citizen” has been classically defined as the legally recognized subject or national of a state, recent anthropological work on citizenship has unpacked this standard definition to examine the nature of citizenship as a mechanism through which people make different kinds of political claims. Aihwa Ong’s (1999) concept of flexible citizenship, for instance, delves into the realm of the transnational, connecting global mobility and flexibility with the logics of displacement. This linkage can be applied to assisted reproduction as well: as reproductive workers such as egg donors and surrogates frequently travel long distances to participate in reproductive tourism, the fact that most of them are nameless, anonymous persons highlights them as disposable bodies and substances—yet valuable in light of their particular biogenetic substances. This overlaps with the concept of biological citizenship, as forwarded by Adriana Petryna (2002) and Nikolas Rose and Carlos Novas (2005), which illustrates how individuals are united and make rights claims on the basis of a shared biological experience. Here, the role of the Internet and social networking sites comes to the fore, as many commissioning parents rely on social media and personal blogs to share and collectivize their efforts involved in the making of families and citizenship. To discuss how

transnational surrogacy complicates understandings of citizenship, nationality, and kinship, I turn now to contrast citizenship policies and practices in India, the U.S., and Norway.

Privileging Biological Ties: U.S. Citizenship and Notions of Parenthood

For foreign parents who pursue surrogacy in India, themes of citizenship and nationality are paramount. Parents often describe the process of obtaining citizenship for their children as stressful, bewildering, and maddening. In many cases, the relative ease (or difficulty) with which parents undergo this process depends largely on their country of origin. Their wide-ranging encounters with state bureaucracies, too, indicate the multiplicity of ways in which states define citizenship and kinship.

In India, citizenship is not immediately assigned to children born in the country; instead, at least one parent must be an Indian citizen in order for their child to be Indian as well. Moreover, individuals born after 2004 are considered Indian citizens only if both parents are citizens, or one parent is a citizen and the other is not an “illegal migrant.” However, in the age of assisted reproduction, questions of who is the “parent” abound. In the context of gestational surrogacy, Indian doctors and policymakers insist that the woman who contributes her own eggs to the creation of embryos (i.e., the genetic mother of the child) and intends to raise the child is the mother of that child. In cases involving egg donation, the commissioning mother is considered the mother. Thus, according to the ICMR guidelines, the Indian surrogate who gestates and gives birth to the child (to whom she has no genetic relationship) holds no rights as a “parent” to this child. Consequently, she has no power to transmit Indian citizenship to the newborn. This definition of “parent,” then, enables the genetic and/or commissioning parents to seek citizenship for their babies from their home countries.

These guidelines largely facilitate the transmission of citizenship for U.S. parents of children born in India. U.S. citizenship is conferred through a mixture of *jus solis* and *jus sanguinis*, in which individuals may acquire citizenship either through birth in the U.S. or through transmission from a U.S. citizen parent to their genetic child. Thus, for children of U.S. parents born in India, the claim to citizenship is based on a genetic connection to the parents, their U.S. citizenship, and various transmission requirements, including the parents' physical presence in the U.S.

The U.S. application for citizenship for children born abroad entails a number of steps. Parents first apply for a Consular Report of Birth Abroad (CRBA), which is the primary evidence of U.S. citizenship to be used throughout the child's life for any event that normally requires a U.S. birth certificate. Along with the CRBA application, parents submit a passport application and photos. Once these applications are approved, parents must then obtain an exit permit for their child from the Foreigners Regional Registration Office (FRRO), an office of India's Bureau of Immigration, in order to leave the country. In general, the CRBA, passport, and exit visa applications are time consuming and document intensive; for straightforward cases, the process can take two to three weeks, while more complicated cases can take months.

With the rise of consumers seeking ART services abroad, the U.S. Department of State sought to clarify practices of transmitting citizenship, and in 2009 the American Citizen Services Unit (ACS) in Mumbai issued a letter detailing the process for CRBA applicants who relied on surrogacy and/or gamete donation in the creation of their children. This letter emphasized the importance of "biological ties," requiring "clear evidence of the child's biological relationship to the transmitting U.S. citizen parent." The Consulate recommended carefully documenting all medical procedures in order to establish the facts of biological parentage, and if they are unable

to clearly establish biological ties, consular officers may request DNA testing as verification of a genetic relationship.

These recommendations, however, left open some room for interpretation. In interviews with ACS staff stationed in Mumbai, officers tasked with evaluating the CRBA applications confirmed that they looked for “clear and convincing evidence” of a genetic relationship between the U.S. parent and the child. But how do officers determine what constitutes “clear and convincing” evidence? When I posed this question, officers explained that the types of documentation they receive have changed over the years. When surrogacy first came to their attention around 2007, documentation of biological ties, such as a letter from the hospital in which the child was born, was considered unreliable, but often accepted. Speaking about the process of evaluating documentation, one officer remarked, “The process is awfully discretionary...but if it feels right, you know.” When asked to expand on how he knows when it “feels right,” he simply replied that the process is about whether “someone coming in off the street can convince you that this is your biological child,” and that in the absence of clear and convincing evidence, they request DNA testing.

As a result, some parents found the process straightforward, while others encountered difficulties along the way. Marlene, first introduced in Chapter 3, is a U.S. mother of a two-year-old son born in India in 2008. Marlene and her husband had recently contracted with a surrogate for a second attempt, hoping to produce a sibling for her son. Now that she was in the midst of another surrogacy process, I asked Marlene what differences she noted between the two experiences thus far. Her main concerns, she replied, dealt with the exit process: “The first time I was worried about how long it would take to leave the country, what the protocol was, how much I was going to have to pay off people to get my son out. Now that I’ve done that already,

I'm not worried. I already know how it's going to go." She went on to describe her experience after the birth of her son:

At the time you had to contact the embassy to get an appointment, and the embassy said they would get us an appointment a couple weeks out. I was like, that's not happening. Number one, I said, I'm Jewish and my son needs to be circumcised. Even though I'm not! So we get there and we get this person who's just hemming and hawing, and I'm like, look, if you think I'm spending one more day here in India, think again, it's not happening. Passport was done that day. I said I want an emergency passport, because he must be circumcised. I got an emergency passport.

While many parents acknowledged the frustrations involved in the bureaucratic processes of applying for citizenship and exit visas, Marlene (who described herself as a "dark, black woman") admitted she was proud of the way she navigated the system to her advantage.

Moreover, as discussed in Chapter 3, Marlene's son was conceived with her husband's sperm and an Indian woman's eggs. Marlene herself had no genetic connection to her son, and she was traveling by herself without her husband, the sole parent who had a genetic relationship to the child. Yet, she reported that the consular officer did not request a DNA test. Somehow, Marlene was able to negotiate U.S. bureaucratic processes in a way that allowed her to leave the country expeditiously and without requiring additional evidence such as DNA testing.

However, even as Marlene received all the necessary documents from the U.S. Consulate and the Indian FRRO, she encountered problems with airline officials at the airport as she tried to leave India:

I didn't even think I was going to leave India. They [airline officials] were acting like I had a stolen baby, even though I had all the paperwork. They harassed me for a good two hours—with an infant! I would never fly that airline again. They claimed that they knew nothing about surrogacy, nothing. How did I get in the country at nine months pregnant and have a baby? I had all the paperwork, but I thought I was stuck.

Clearly, Marlene's experience of obtaining citizenship and exit documents for her son unfolded relatively simply, particularly in comparison with other parents I interviewed in similar situations

who endured long delays and frustrating encounters with bureaucratic officials. Yet, her position as a woman who became a mother through the use of ARTs raised questions among airline officials in India. Here, it is worth recalling that Marlene struggled with issues of race and racism, as Marlene is African-American and her son, conceived with his white father's sperm and a fair-skinned egg donor, had much lighter skin. Paradoxically, while U.S. officials deemed Marlene's son a legitimate U.S. citizen through presumed biological connections, Indian airline officials challenged Marlene's motherhood status to a child of a different skin color than herself.

Other U.S. parents related different stories with respect to the process of leaving India with their newborns. Here I return to the story of Patricia, a U.S. mother of a one-year-old son born via surrogacy in India, whose narrative elucidates distinct challenges and frustrations involved in the citizenship and exit process. In order to facilitate the process and avoid long delays, Patricia studied and researched all the requirements while preparing the necessary documents. Patricia related, "This is one area where I felt like I spent nine months totally trying to get everything perfect, to have all the paperwork printed out, to know exactly which offices to go to and when. I felt like I had researched everything and we were going to just speed through the process." However, on arrival in India, Patricia realized, "Everything was more complicated than we thought." She went on to describe the process of obtaining citizenship for her son, Sam, as a "kind of torture. In retrospect it was only two and a half weeks, but it felt at the time so long, so uncertain, it felt like we were trapped in a 'Waiting for Godot' situation."

Patricia saw her plans unravel at various moments in the process. Sam was born in mid-2009, and at the time, many parents reported that they, like Marlene, had been able to obtain citizenship and travel documents without a DNA test. Patricia also hoped she and her husband might avoid this additional hurdle. However, their adjudicator at the consulate requested

laboratory proof that her husband, Jonas, was the father. Patricia and Jonas assumed that their doctor would be able to provide this evidence:

We called them [the doctors] up and we sat in the U.S. embassy office for literally eight hours waiting for the doctors to fax over proof that Jonas was the sperm donor for our son. And we had numerous conversations with the doctors, back and forth, and what they ended up faxing over was basically a note that they had written that day. It wasn't laboratory proof, basically. So we ended up having the DNA test and we missed our appointment [with the adjudicator to apply for the CRBA].

Patricia went on to explain the communication issues embedded in her interactions with doctors:

It was just a whole series of stressful situations that we didn't really need to go through if we had just gone over to the doctor's office and gotten the DNA test. That was one thing that we subjected ourselves to that we probably should just have not bothered with. There was this total miscommunication. We were speaking the same language as the doctors, but we didn't feel like they understood. That was a common thing with our interactions with them. We were all speaking the same language but not quite understanding each other.

Problems of miscommunication also affected Patricia and Jonas's experience getting the Indian birth certificate, a crucial document in the process of obtaining citizenship and travel documents. The process of transnational surrogacy involves many layers of mid-level brokers, agents, and "fixers" who take care of various tasks. Patricia hired one such agent to help with obtaining the birth certificate, as she had heard that the Indian birth certificate office "was not a place for Westerners to go, because it was not set up to handle Westerners." However, Patricia learned that her doctors at the surrogacy clinic became angry when she hired the agent, unrelated to the clinic, to take care of the birth certificate:

We took this agent with us to the birth certificate office, and that made our doctors very pissed off. Apparently he caused some waves that made them look bad. When we got to the office the birth certificate wasn't ready, so when we got there we were looking around for someone we could bribe to get the certificate. I think after this whole experience the clinic actually started using this guy as the conduit to the birth certificate office, but at the time they were very antagonistic toward us for using him and they were yelling at us. We spent another day just basically sitting in this waiting room not really understanding what was happening or why things were not going as smoothly as we thought they would. We were there around the time when swine flu was getting big news, so we were sitting there

with crowds of Indian people and a week-old baby in our arms, and it was pretty stressful.

The birth certificate itself, however, was also a source of disappointment and stress for Patricia:

When we started this whole process, the clear implication was that my name would be on the birth certificate. And I think at some point, as more people started to use this process [surrogacy], the U.S. embassy became stricter about how that process worked. When we called the embassy to make the appointment for the CRBA, I told them I was the genetic mother. But in between then and the appointment I realized that I have absolutely no proof for that. And I don't want to get caught in a lie with the U.S. government, so we ended up going back and just my husband's name is on the birth certificate. And so the implication of that is that now I have to go through an adoption process with my son.

The process of acquiring a valid birth certificate was central to gaining citizenship rights for many parents. In acquiring this document, however, many parents, like Patricia, observed firsthand the contradictions involved in the process. Indian policies define Patricia, the woman who commissioned the surrogacy process, as Sam's mother. Yet, hoping to avoid any hassles in gaining U.S. citizenship for Sam, Patricia opted to withhold her own name on Sam's birth certificate as his mother. Many parents believed this process was unjust and discriminatory, as commissioning parents then had to go through the process of adopting "their own children." As I will describe in the following section, this process takes on particular gendered dimensions in the context of Norway.

“But You Are Not the Mother”: ARTs and Norwegian Dictates of Motherhood

In the previous section I elaborated U.S. practices that value bio-genetic notions of parenthood in the transmission of citizenship from parent to child, which are in line with Indian policies regarding definitions of parenthood in the context of ARTs. In contrast, Norway defines the mother solely as the woman who gives birth to the child, thus excluding any possibility that

an infertile woman who intends to raise the child (and who may or may not be genetically related to the child) can be the mother without undergoing the process of adoption.

Norway's laws on the use of ARTs shed some light on this policy. Despite its reputation as a liberal, progressive country, Norway passed some of the strictest ART laws in Europe. Commercial surrogacy, egg donation, and anonymous sperm donation are all banned (Howell and Melhuus 2007). As a result, infertile Norwegians frequently travel to other countries such as the United States and India (for surrogacy), Spain (for egg donation), and Denmark (for anonymous sperm donation) (Hammerstad and Haugdal 2010). What is interesting about these laws is the centrality of the role of genes and biology in the making of the Norwegian mother. Because the laws emphasize the importance of knowing one's genetic roots, anonymous sperm donation is prohibited, while known sperm donation is permitted. Yet egg donation is completely banned, in part to ensure that blood and biogenetic relations remain intact, avoiding any uncertainty about who the mother may be (Campbell 2007).

Thus, Norwegian citizenship is attributed to children of a Norwegian birth mother, her husband, or a Norwegian man genetically related to the child. A Norwegian man, then, who uses his own sperm in the production of embryos and commissions a surrogate to gestate the fetus for him can transmit citizenship to his children because the child is considered his genetic offspring. In contrast, a Norwegian woman who uses her own eggs and also commissions a surrogate cannot gain Norwegian citizenship for the child. Nationality is embedded in Norwegian semen, while Norwegian eggs are positioned as "belonging" to the Norwegian birthing mother alone (Kroløkke 2012).

As a result, transnational surrogacy in India has posed particular problems for Norwegians—particularly Norwegian women—seeking to obtain Norwegian citizenship for their

children.⁶⁵ While Indian policies effectively strip the surrogate of any parenthood rights, Norway only recognizes the birth mother—in this case, the Indian surrogate—as the legal mother to the child born via surrogacy arrangements. Consequently, Norwegian parents of children born through surrogacy must obtain a statement from the surrogate mother, stating that the surrogate consents to transferring all parental rights to the commissioning individuals. The Norwegian process of obtaining citizenship was significantly longer for Norwegians than it was for those from the U.S., and I had several opportunities to interview Norwegian parents, such as Paul and Astrid, during their extended stays in Mumbai.

Paul and Astrid were 34 and 36 years old, respectively, when I met them at a restaurant in their hotel. Astrid had attained high school level education, while Paul had completed university. The couple had been together since they were teens, when Astrid was 17 and Paul, 15, and they were married three years prior to our interview. Paul and Astrid knew that when the time came to begin thinking about raising a family together, they would turn to ARTs. As the couple explained, Astrid had received a cancer diagnosis when she was only an infant, which required her to undergo a hysterectomy (though her ovaries functioned normally). When they were ready to raise children, they began exploring their options and considered adoption. As Astrid stated, “I always thought that if I’d have children when I grow up, it would be by adoption.” The couple, however, was quickly discouraged by the low rates of domestic adoption in Norway and the long waiting periods for international adoption.

⁶⁵ One such case involves Kari Ann Volden, a single Norwegian woman who commissioned a surrogate pregnancy in India with eggs from an Indian woman and sperm from a Danish man. The surrogate gave birth to twin boys who were considered “stateless” and unable to leave India for the first fifteen months of their lives, as the Norwegian government did not consider Volden their mother (and consequently the boys could not attain Norwegian citizenship) and the Indian government did not consider them Indian. See Kroløkke (2012) for an extended discussion of this case.

Paul and Astrid then learned about surrogacy. At first, it took some time to get used to the idea. As Astrid remarked, “If it’s possible to give me hormones and take my egg out and then take sperm and put it into a petri dish—,” Paul finished her thought: “It’s like magic!” Surrogacy, however, is not permitted in Norway, so they knew they would need to journey abroad. Eventually, they decided to travel to India, and on their third attempt their surrogate mother became pregnant with twins, conceived with Paul’s sperm and Astrid’s eggs. The newborn twins—one girl and one boy—slept nearby in a bassinet as the couple went on to describe their experience navigating the Norwegian citizenship process.

As Paul explained, the law is somewhat unclear regarding traveling abroad for surrogacy. Until recently, the process was fairly simple and state authorities typically accepted birth certificates without hassles. “When they started, it was not an issue at all. It was—you go here, you get the birth certificate in your names, of course, as you are the biological parents, or simply because you are the intended parents. So, Norway would just accept that birth certificate.” However, with the increase in couples traveling to India from Norway for surrogacy, Paul noted, the process had become much more problematic:

When this became an issue just a few months ago, there were several couples here, and I know it sounds incredible, but someone in government decided that there were these cases where our law needed to be clarified and no guidelines have been made. But, instead of continuing the existing practice until those guidelines existed, he just stopped everything. So, they [the parents] were just stuck here without knowing how, if, or when they were going home. They were stuck here for weeks.

As Paul and Astrid awaited their own children’s travel documents, Paul expected that they would not have to wait as long, given they had what he believed was a straightforward case:

Fortunately, our case is very clear, and it’s one of the cases that is clearly within the guidelines. We had to go to the consulate with the surrogate mother and, since she’s married, she also had to bring her husband because he is assigned fatherhood by default. Because of the “pater est rule,” that’s who the father is. Basically, the woman is married, she has a child, and her husband is, by default, the father. So, he had to agree that I was

the father, and there are then simple forms for us to fill out. So it's just a matter of filling out the forms, reassuring that she agrees and he agrees that I am the father.

Paul and Astrid's case was relatively clear because they were a married couple, and they each had a genetic tie to the children. However, the "pater est rule," as Paul stated, is a Norwegian law based on Roman principles that the woman giving birth is the mother. He continued, "Of course, that principle was intended to protect the biological mother, the genetic mother, so no one could lay claim to her children. But the presumption behind the law is that the woman giving birth is also the genetic mother, which isn't always the case anymore." Thus, according to Norwegian law, Astrid is not considered a mother to her genetic offspring and must adopt the children on her return to Norway.

As part of the process, Paul had to provide DNA evidence of his genetic relationship to the twins, and at the time of our meeting, he had already submitted this test to the administrative office in India that processes the citizenship applications. Yet, information must pass through multiple channels across national borders, and Paul explained that the test results needed to be sent to Norway before they could complete the process. Already on their third week in India, Paul expressed impatience at impending delays:

The papers were filled out more than two weeks ago, but they still haven't left the embassy, actually, because they are extremely inefficient and slow. They insist on sending it [to Norway] by diplomatic mail, which only goes once a week. Of course, I don't know if they actually want to complicate the process, if that's their orders or what, they won't say, but they insist on sending it by diplomatic mail. And it wasn't sent the first week because they were missing an original, and they wanted the original document, not the copy. I don't know if that's really relevant for the rest of the process, but they insisted that they have the original. I don't know if that was just a cover, but they got the original and then it was just too late for it to be sent that week, so it's stuck another week, and they still haven't sent it.

However, as they were completing the paperwork, Paul and Astrid learned that Norwegian officials began enforcing a three-week waiting period for issuance of passports following

approval of the application. Paul interpreted these events as intentional efforts by the Norwegian government to stall the process for parents of children born via surrogacy: “It’s extremely frustrating, to be treated in that way by our own government. When they have the DNA test, they have every reason in the world to give you the passport and just get you home. Still, they resist until the very, very last moment. So we feel that we are not treated very well. They should protect our interests and we don’t feel like they are doing that at all.”

Paul and Astrid’s experience illustrates the challenges parents encounter in the process of gaining citizenship for their children. While the requirements for citizenship may appear clear at the outset, guidelines and protocols are in flux, and many parents endured long waits and unexpected delays. Like Paul and Astrid, another Norwegian couple I met, Marla and Roland, felt frustrated with the uncertainty of the process.

When I first met Marla, a tall, blonde-haired, blue-eyed woman from Norway, she was relaxing poolside in the company of her husband, Roland, and their newborn baby girl, Anna. It was a warm, humid day in 2010 and I visiting their deluxe, five star hotel in the suburbs of Mumbai. Marla and Roland, 32 and 31 years old, respectively, had been trying to have a child for several years before they discovered surrogacy in India. After three failed IVF attempts, they learned that because Marla suffered from a chronic disease that affected her ability to conceive and carry a child, they would have to explore other options for expanding their family. This realization, following her last attempt at IVF, was heartbreaking, as she described: “I was so sad after failing again. Well, not failing, but, you know, not working. First you are told that you can’t carry a pregnancy. Then, your eggs are not working. And all the things that you are supposed to do as a woman in life...you're failing on all of them.”

Because surrogacy is illegal in Norway, Marla and Roland's journey to parenthood led them to India, where they found a surrogacy clinic that was well known for their relationships with international clients. Embryos made from an Eastern European woman's eggs and Roland's sperm were transferred into the womb of a surrogate mother in Mumbai. The resulting child, Anna, was born at a healthy 7.2 lbs. via cesarean section.

As I learned through my interviews with the couple, their long history of medical infertility—as well as restrictive laws that made surrogacy illegal in Norway—led them to pursue surrogacy in India. Yet, their journey was not over, and they were going on their fourth week in the hotel. While they were hopeful they could return home to Norway soon, they knew that realistically they could expect at least several more weeks of legal limbo, while they awaited the documents that would verify their baby's citizenship and allow them to return to Norway.

Marla was clearly relishing her new role as a mother, stopping frequently during our interview to check on Anna. Yet she expressed deep frustrations at the fact that her motherhood role was illegitimate in the eyes of the Norwegian state. She spoke with anger and disbelief at the seemingly endless bureaucracy of paperwork and DNA tests that established a genetic link between father and daughter—the link that mattered, in this case, in the family's quest to return home. As she explained to me the process of gaining Norwegian citizenship and travel documents for her child, she resented the fact that once home, she still would not be considered a mother under Norwegian law:

Once we get all the paperwork we can go home...And then, I will not be considered a mother in Norway because they know that it's a surrogate birth...If you don't give birth to a child yourself – you are not considered a mother. It's also about who is the father, and, you know, anyone can become a father if the mother of the child wants them to be. She can just point to whoever she wants to point to, and if she's married, the husband has just to sign a paper saying, "No, I'm not the father; he is." That's how you become a father. It's discriminating.

I asked Marla to expand on how she felt about this, and she replied:

Horrible, horrible. If something happens to her in Norway, she is considered a child with only the father. If he's working, and say, she needs to go to the hospital, if they really want to be assholes at the hospital, they can say, "But you are not the mother. So, we are not allowed to give you any information about her health."

Assisted reproduction allowed Marla to move from a space in which she felt failure—as a woman who desperately wanted to become a mother—to another space, located in India, in which she finally became one. However, though she, like Astrid, is considered the mother according to Indian policies, Norwegian law dictates that she is not the legal mother of her child. While Astrid held a genetic connection to her child and Marla did not, neither woman enjoyed any legal motherhood rights, and would have to undergo the process of adoption on their return to Norway.

In this chapter, I have examined particular ways in which assisted reproduction in India challenges notions of kinship and citizenship. Transnational movements of reproductive tissues and bodies clearly call into question understandings of citizenship and motherhood. As families like those discussed in this chapter take issue with their countries' definition of mother and family, nations must decide how to respond to citizenship disputes in the context of transnational reproduction. Yet while such movements may expand conventional understandings of kinship and family, they also renaturalize state definitions of citizenship and motherhood. In the case of the U.S., genes are framed as powerful entities that shape human relationships and confer citizenship rights and responsibilities. In Norwegian law, the same holds true, with the exception that genetics and gestation are intertwined in the definition of motherhood. A Norwegian woman who does not give birth to a child, even if she is genetically related to that child, has no rights as a mother and no power to confer Norwegian citizenship to the child. These cases illustrate the

evolving ways in which ARTs challenge notions of the reproductive body, citizenship, motherhood, and nation.

CONCLUSION

For would-be parents around the world, Indian commercial surrogacy services offer an appealing package: the chance to have a child through the use of assisted reproductive technology at an attractive price. As many parents and doctors in this study have argued, gestational surrogacy in India offers infertile couples and individuals a remarkable opportunity to have children, as they find the doors to adoption or ART access in their home country closed due to legal barriers or high cost. Media coverage on the subject, and indeed, my own research in India, support this dominant narrative, which focuses on the prospective parents' need for a child. This narrative highlights notions of family, desire, and kinship, and shifts the focus to the couple or individual who will travel, literally, to the ends of the earth to have a child.

At the same time, however, the narrative asserts that reproductive tourism is a “win-win” situation for all actors involved, and surrogacy in India offers an additional perquisite for parents concerned with issues of social welfare. As many parents claimed, their payments to the surrogate “are going to make a real difference in her life,” by providing much-needed income and support. Such “aid,” as it is framed, assumes that fundamental change occurs not by transforming structures of inequality that underlie women's low socioeconomic status, but by providing one-time lump sums of cash.

While this narrative does not mask the commercial aspects embedded in reproductive tourism, it does characterize transnational surrogacy as a fortuitous means of achieving the dream of parenthood. At the same time, it justifies the practice through narratives of rescue, in which commissioning parents “save” or “rescue” poor women. Along the way, however, discrepancies and contradictions emerge that challenge the idea of surrogacy as a process that

equally benefits both surrogates and parents. Though parents, international surrogacy brokers, and doctors frequently cited claims that surrogacy allows poor women to provide for their children's future or to buy a home, in reality this does not always unfold so neatly. As Rajan, whose sister previously worked as a surrogate explained, "Yes, my sister and her family have bought a house—but they needed to take out a loan. The cost of the house was US\$30,000 (including registration costs, etc.), and they paid US\$4,500 of that from surrogacy." Rajan and Karishma, who underwent embryo transfer twice in her attempt to become a surrogate, themselves noted how little they were able to save from the initial payments of US\$220. Similarly, Parvati found she earned just below the amount needed to take out a loan for a house; she had to sell her family jewelry just to meet the minimum payment. Indeed, as I have argued in Chapter 2, declarations of surrogacy as a "win-win" situation effectively render unnecessary any deeper understanding of women's everyday lives and challenges. While many parents felt satisfied with the claim that their payments would help their surrogate buy a house or pay for their children's education, the particular structures of transnational surrogacy in India disallowed the opportunity to actually follow-up and know the impact that surrogacy had on their surrogate's life and family.

One goal of this dissertation has been to refute the "single story" told of surrogacy throughout popular media narratives. This single story is about infertile couples desperate for children, and about women desperate to help their own. However, what are the implications of this narrative for notions of kinship, race, power, and agency? What does this overarching surrogacy narrative naturalize, and what does it obscure? And what do the narratives of surrogates and egg donors, whose voices are so often absent in such debates, reveal?

As I have shown, there is no single story about surrogacy in India. Rather, transnational surrogacy is full of complexities and contradictions that are impossible to capture in a solitary narrative. My focus in this dissertation has been on these complicated and often conflicting stories that reveal and reinforce transnational and local hierarchies. I have sought to elucidate the experiences and concerns of the range of actors involved in reproductive tourism, bringing their experiences into conversation with each other to explore the ways in which these actors construct notions of kinship and family, as well as to address issues of inequality and agency. In doing so, I have argued that actors rely on strategies of concealment or, to return to Bourdieu's term, "misrecognition," to mask the commodification of reproduction. This process, I contend, simultaneously obscures broader patterns of stratification and reinforces hierarchies of class, ethnicity, gender, and nation, albeit in complex and contradictory ways.

I began by situating the emergence of cross-border reproductive migrations to India. In order to answer the question, "Why India?," I traced the history and context of global medical travel for assisted reproduction in India. I examined the history of public health approaches, assisted reproduction, and medical tourism in India to show how the country mobilized domestic resources—at the expense of primary health care services for the poor—to negotiate a prominent position in the global medical tourism industry. I also laid out the practices and practicalities that are central to the experience of reproductive tourism in India, illustrating how the political economy of reproductive tourism produces certain practices that bolster national capacities in a global marketplace, while reinforcing global stratified reproduction. By contextualizing the practice of transnational surrogacy in India, I argued that the industry is not only about creating families for infertile couples and supporting poor, Indian women; it also is about positioning India as a modern, safe space for foreigners seeking ARTs.

Chapter 2 examined transnational surrogacy through the lenses of kinship and rescue. The goals of this chapter were two-fold. First, I explored commissioning parents' narratives about kinship to reveal how parents employ a range of strategies to connect with the surrogate and the children born through surrogacy. I demonstrated that such strategies alternately challenge, transform, or reinforce bio-genetic and social kinship ties. These stories illuminate the work involved in creating kinship (Carsten 2001), whether kinship is based on "biogenetic" or "blood" relations. Indeed, kinship is a complex constellation of relations, and kin relationships formed through transnational surrogacy are processual and fluid, substantiated through everyday actions and experiences (Gailey 2010). Moreover, parents' kinship narratives uncover a disjuncture between policy and the lived experiences of actors involved in surrogacy. Medical and policy discourse in India endeavor to compartmentalize the multiple actors involved in making babies through surrogacy, effectively defining the "commissioning" couple or individual as the parent, and stripping the surrogate of any claim to the child.⁶⁶ However, the couples I interviewed did not view these roles as clear-cut. Indeed, while many parents would not advocate for the legal rights of the surrogate as a mother and do not maintain relationships with the surrogates who gave birth to their children, parents nonetheless take up the work of kinship, in articulating and defining their children's relationship to their surrogate.

Second, I considered how and to what extent these narratives build on and reproduce relations of stratified reproduction. Parents often noted the tensions between commercial aspects

⁶⁶ The California Supreme Court case, *Johnson vs. Calvert*, set the precedent for defining the "commissioning" couple as the legal parent in the context of surrogacy. *Johnson v. Calvert* featured conflicting biological claims to a baby between a woman who provided the ovum and another who carried the baby to term. Faced with these contradictory claims to motherhood, the California Supreme Court shifted from the physical to the mental realm, drawing on a model of intellectual property law: Who had first intended to bring the child into the world? Who was the "originator of the concept" of the child? In contrast to the case of *Whitehead v. Stern*, i.e. *Baby M*, which centered on the legitimacy of the contract, the main issue at stake in *Johnson v. Calvert* was the question of genetics versus gestation. Drawing on the work of Andrea Stumpf (1986), who invoked the intellectual property paradigm to argue that the "originators of the concept of the child" must determine parentage in the context of surrogacy, the court eventually ruled in favor of the intended parents, the Calverts (*Johnson v. Calvert* 5 Cal. 776 [1993]).

of surrogacy and inequalities of class and nation that are inherent in their kinship stories. I found that parents employed various strategies to resolve these tensions; in particular, parents relied on rescue narratives that positioned the Western family as saving or rescuing the Indian surrogate, converting the woman herself into a humanitarian object. Such strategies, I argued, effectively conceal the more complex stories of inequality that mark transnational surrogacy as a form of stratified reproduction.

I continued my exploration of kinship in Chapter 3, focusing on the role of perceptions of race and skin color in the practice of transnational ova donation for parents pursuing gestational surrogacy. In contrast to reports that gestational surrogacy simply offers an opportunity for infertile parents to have genetically related children, I found that for many intended parents, “lineage” did not matter. In these cases, egg donation emerged as a key site in which parents negotiated issues related to kinship, notions of race, and identity, as they navigated the process of selecting an egg donor. As parents pursue surrogacy and egg donation in India, I illustrated how they make reproductive decisions within a framework of transnational inequalities, including along ethnic, national, and class lines. Through this process, I argued that parents’ narratives about egg donation across national/ethnic lines maintained racial and racist structures that rely on essentialized notions of culture and racialized beauty. In doing so, the social constructs of race, skin tone, and nationality become ever more biologized within transnational relations of power.

Here, I analyzed transnational egg donation as an “intimate industry,” extending Hardt and Negri’s concept of “immaterial labor” to include the intimate labor that sustains assisted reproduction. Scholars have recently paid close attention to the commodification of intimacy and intimate labor (Boris and Parreñas 2010; Constable 2009a; Hochschild 2003; Hochschild 2012), while Hochschild explains, “on issue after issue, people sought to protect the personal from the

purchased, the village from the market, the self from a strange new emotional capitalism” (Hochschild 2012: 13). Intimate industries, which commodify intimate matters of care and reproduction, provide a key lens through which to explore the gendered and racialized inequalities that emerge through transnational linkages and technological advances. My particular focus was on the ways in which the intimate matters of assisted reproduction intersect with the construction of race, class, and nation, attending to the multiple and complex ways in which emotional ties and relationships are understood within transnational spaces. In the context of transnational egg donation, I illuminated how parents negotiate the process of egg donation across ethnic, class, and national boundaries. Across these overlapping and fluid lines, parents employ a range of strategies to create intimacy and closeness—with the egg donor and the child conceived through egg donation—even as they acknowledge the commodifying aspects of this particular form of family-making. In confronting the anxieties associated with the intimate industry of egg donation, and evading the marketlike aspects of their family’s origin stories, parents engaged in discursive strategies that inject intimacy, emotion, and affect into a relationship that is otherwise anonymous. These strategies, too, seek to reconcile tensions inherent in the transnational structures of inequality in which egg donation takes place.

In Chapter 4 I turned to examine reproductive tourism through the lens of geography, in order to shed light on how notions of space, place, and mobility are entangled in reproductive tourism. I focused especially on questions about how various reproductive actors negotiate the myriad spaces through which they travel. What are the lived experiences of surrogates and intended parents when refracted through the lens of geography? And what does such an analysis reveal about the intersections among space, stratification, and reproduction? While Massey productively prompts us to ask how “our relative mobility and power over mobility and

communication entrenches the spatial imprisonment of other groups” (Massey 1994: 236), in this chapter I illustrated the subtle registers on which power operates, beyond the act of one group limiting the lives of the less powerful. I argued that power and mobility play out in complex and contradictory ways, wherein both surrogates and commissioning parents experience moments of movement and mobility interrupted by periods of stillness, immobility, and anticipation. In doing so, this chapter elucidated how dichotomous portrayals of parents and surrogates as “exploiters and exploited” or “agents and victims” are facile representations of individuals connected through complex transnational processes of reproduction. Indeed, it reveals why there are no conditions of absolute victimhood, and how stakeholders might remain committed to such structurally uneven and exploitative processes.

In Chapter 5 I focused on the views and experiences of women involved in surrogacy in order to uncover the complexities of agency, constraint, and inequality in women’s everyday lives. In this chapter my goal was to move beyond simplistic stereotypes of the surrogate as “victim,” and to demonstrate how women develop strategies of resistance and agency in their everyday lives. In doing so, I contrasted the experiences of women who work as surrogates with surrogate agents and caretakers, demonstrating how they occupy distinct subject positions, especially with respect to power and agency. By highlighting the diversity of ways that women enact agency, however limited, I reveal how intermediary roles produce intra-class social divisions that engender further levels of stratification among women.

Finally, in Chapter 6, I examined the ways in which transnational reproduction challenges notions of citizenship and kinship. By focusing on two nations—the U.S. and Norway—I demonstrated the ways in which these countries’ citizens navigate distinct practices and policies with respect to transmission of citizenship to their children born in India. The transnational travel

of reproductive tissues and bodies has posed particular challenges to understandings of citizenship, motherhood, and family, as these notions are closely intertwined in the transmission of citizenship from parent to child. Yet, in discussing the experiences of U.S. and Norwegian parents, I illustrated how such cases expand conventional understandings of kinship and family, while also renaturalizing state definitions of citizenship, parenthood, and motherhood.

In sum, the preceding chapters have provided a careful study of transnational surrogacy in India. While Chapters 2 and 3 explored notions of kinship, rescue, race, and relatedness, Chapters 4 and 5 are linked through themes of power, agency, and the need to resist dichotomous frameworks. In Chapter 6 I returned to the concept of kinship in the context of citizenship, in order to interrogate the intersections among notions of citizenship, kinship, and national belonging. I have examined the practice of transnational surrogacy through different theoretical lenses and from the perspectives of the range of actors involved, with the goal of elucidating the contradictions and complexities that encompass reproductive tourism. In this dissertation, I have used transnational surrogacy as a lens to understand changing notions of family and kinship, race and relatedness, movement and mobility, and resistance and agency. At each stage of surrogacy, I also offered examples of how individuals weigh risks and benefits of surrogacy, reminding the reader that none of these individuals exists outside of a complex web of social, political, familial, and other relationships.

This work builds on feminist theoretical analyses of reproductive labor and social stratification, particularly within the landscape of global capitalism in the twenty-first century. While many practices and discourses examined in this dissertation are not new, one of the key contributions of this dissertation is its emphasis on the particular sociocultural, political, and historical contexts that make possible the kinds of transactional relationships I have described in

the preceding chapters. Currently, the global surrogacy industry is in a moment of tremendous flux; my focus, then, has been on the relationships of kinship and inequality that have emerged amid complex histories in a particular time and place. From this perspective, this study presents ethnographic findings that shed light on the messiness of “reproductive entanglements” (Rapp 2011) in the present moment, contributing to a growing literature on surrogacy in India and around the world. With the ever-increasing global market for reproductive and affective services, this dissertation also has important implications for scholars who examine inequalities that emerge from transnational linkages, technological advances, and service work. While I have focused on the specific case of transnational surrogacy, the findings of this research can shed light on power and social relationships formed through other “intimate industries” (Parreñas, et al. 2013) such as medical tourism, international adoption, international marriage brokerages, call centers, and sex, domestic, and care work. This dissertation also extends anthropological work exploring the impact of assisted reproduction on notions of kinship, space, mobility, and agency. More broadly, it contributes to analyses of inequality and globalization, revealing the nuanced ways in which transnational surrogacy broadens our understanding of stratified reproduction.

Directions for Future Research

This dissertation raises several questions for future research. First, what lessons can be learned from feminist organizing around ARTs and surrogacy in India? In 2011 and 2012 I attended the Tarrytown Meetings organized by the Center for Genetics and Society; one of the main goals of these meetings was to convene a multi-disciplinary group of activists and academics concerned with the social justice implications of human biotechnologies. Throughout these enriching meetings, I found there was great concern among feminist organizations in the

U.S. about the lack of response, particularly with respect to the social impact of ARTs and surrogacy. Here, I believe that many lessons can be learned from Indian feminist organizations that have researched and organized coherent responses to the expansion of ARTs in India. Organizations such as Sama-Resource Group for Women and Health quickly organized critical responses to the Draft ART Bills, highlighting areas of concern for surrogates' rights and health. Their efforts could serve as a model for feminists concerned with the impact of surrogacy in other contexts. Such research would also add to the literature on the ethics of and feminist responses to commercial surrogacy.

Second, during the course of my fieldwork between 2008 and 2010, there were ongoing debates around policy and how to regulate ARTs and surrogacy. As I complete this dissertation, the Draft Bill remains pending, but the Indian government has taken its first step toward regulating surrogacy by requiring surrogacy visas of all intended parents who travel to India. These surrogacy visas, however, will be made available only to heterosexual married couples who have been married at least two years. If carried out, this restriction will profoundly affect the surrogacy industry in India, which emerged as a key destination for gay couples and single intended parents. It also raises questions about the priorities and desired impacts of regulation. As women continue to face physical risks in the treatments associated with surrogacy, why is the government focused on policing the sexuality of parents who travel to India? Future research is needed on the impact of reforms in law, and the effectiveness of its implementation. As reproductive tourism emerges in different sites around the world, in different legal systems and historical contexts, such research will complement and enhance studies of ART law and policy in other parts of the world.

There is also much work to be done with respect to the collection of public health data in the context of gestational surrogacy in India. Throughout my research I was struck by the extraordinarily high rates of cesarean sections, induced labors, and other medical interventions, as well as the high prevalence of multiple pregnancies and pre-term birth. Doctors openly told me that they performed cesareans “at the slightest risk” of something going wrong (with either the fetus or surrogate), or that surrogates’ labors were induced to accommodate parents who were traveling internationally and were “waiting around” for their child to be born. Yet, research reveals that there are significant risks associated with the over-reliance on medical interventions, particularly when not medically indicated. More research is needed on the prevalence and impact of these interventions on women’s and children’s health.

Concluding Thoughts

With the increasing global demand and travel for ARTs, there have been accompanying calls to criminalize, outlaw, or de-commercialize surrogacy.⁶⁷ Yet, doing so could only drive the practice underground where it becomes even more dangerously unregulated.⁶⁸ Instead, I suggest that in the short term the focus should shift to ensuring greater transparency within surrogacy arrangements, where medical standards are ensured and enforced, culturally appropriate procedures of informed consent are followed, and long-term follow-up care is required of surrogates and egg donors.

Further, in the long term, more attention must be paid to the contexts that compel women to become surrogates in the first place. Surrogates are not the “poorest of the poor” as commonly described in the media, yet they are indeed struggling mothers and wives, seeking income to

⁶⁷ See for example Gupta (2012).

⁶⁸ See for example Thompson (2007) for a discussion of why egg donors for stem cell research should be compensated.

alleviate the financial burdens that come with raising a family, sending children to school, and securing permanent housing in Mumbai where housing is scarce and expensive. We cannot understand why they seek to become surrogates unless we consider the structural contexts that have shaped their lives. Many opponents of surrogacy take issue with the practice because of its implications for the commercialization of reproduction and exploitation of women, among other bioethical implications. These are important issues to consider, however, I would add that debates should also focus on easing the structural and gender inequalities that limit women's choices and make surrogacy their most appealing work option.

Similarly, intended parents pursuing surrogacy in India must navigate difficult ethical questions themselves, and most of the parents in this study pursued surrogacy only as a last recourse to parenthood. Thus, it is important, too, to address laws and regulations that make domestic and international adoption difficult or impossible for infertile and gay couples who desire children.

Finally, this dissertation holds important implications for studies in bioethics and policy-making in the fields of human biotechnology. As surrogacy remains a controversial practice and the Indian government remains undecided about how to regulate it, I have argued that society must not only focus on the process or act of surrogacy, but the causes and motivations of people who pursue surrogacy as a path to parenthood, or, alternatively, an avenue to financial security. Thus, I argue for a more political economic orientation of bioethics, or a “practice-oriented approach,”⁶⁹ that takes into account the social, political, and economic contexts of the actors involved in surrogacy.

⁶⁹ See Hamdy (2012) for a discussion of practice-oriented approaches to bioethics in the context of organ transplantation in Egypt.

This project has engaged with the practice of reproductive tourism through an analysis of power in various contexts and through distinct theoretical lenses. In today's globalized world, neoliberalism has permeated every area of thought, including in the realm of family and reproduction. Reactions to the field of assisted reproduction reflect this, as clients and doctors, among others, argue that consumers have a "choice" to access ARTs through whatever means necessary to have babies and create a family. Indeed, an underlying thread in many conversations with intended parents revealed their strong belief that with enough passion and persistence, anyone should be able to have children using ARTs. As one parent proclaimed, "Only those people who give up, won't get babies." Yet, an approach that focuses on "choice" reflects primarily the priorities of institutions, states, and corporations, and has limited potential to address deep structures of inequality, structures that make possible this particular form of family-making in the 21st century. Clearly, new reproductive practices reproduce and enhance existing unequal relations that reflect the contours of stratified reproduction. While more research is needed in mapping the operation of this power in the context of surrogacy and reproductive tourism, such a mapping can serve as an important beginning to demystifying and challenging prevailing structures of power.

APPENDIX 1. Characteristics of commissioning parents who used surrogacy with or without egg donation, 2008-2010

Pseudonym	Age	Ethnicity	Nationality	Education	Employment	Relationship status	Sexual orientation	Number of surrogacy attempts	Children born through surrogacy	Used donor eggs
Aaron	38	White	Israel	Bachelor's	Computer science	Live-in (w/Ben)	Gay	5+	2	Y
Adam	47	White	USA	Bachelor's	Media	Married (to Nadine)	Straight	1	1	Y
Ahmet	Mid-40s	White	Turkey	Bachelor's	n.a.	Married (to Sharon)	Straight	1	0	Y
Alain	30	White	France	Bachelor's	Software programmer	Live-in (w/Gaspar)	Gay	1	1	Y
Alberto	34	Asian	USA	Post-graduate	Law	Married (to Jocelyn)	Straight	1	1	N
Ana	31	Latina	USA	Post-graduate	Pharmacist	Married (to Morgan)	Straight	1	1	N
Andrew	Late 30s	White	USA	Post-graduate	Business	Single	Gay	1	2	Y
Anthony	38	Asian	USA	Bachelor's	Consulting	Live-in (w/Matthew)	Gay	2	3	Y
Astrid	36	White	Norway	High school	Teacher	Married (to Paul)	Straight	1	2	N
Ben	37	White	Israel	Post-graduate	Law	Live-in (w/Aaron)	Gay	5+	2	Y
Carol	37	Mixed (WH/AA)	USA	Bachelor's	Teacher	Married	Straight	1	0	N
Carson	28	White	USA	Bachelor's	Paralegal	Live-in	Gay	1	1	Y
Diana	Early 40s	White	USA	Post-graduate	Media	Married	Straight	3	0	N
Fred	44	White	USA	Post-graduate	Public relations	Single	Gay	1	0	Y
Gaspar	30	White	France	Bachelor's	Pharmacist	Live-in (w/Alain)	Gay	1	1	Y
James	41	White	Australia	High school	Massage therapist	Live-in (w/Lucas)	Gay	2	3	Y
Jan	43	White	Australia	Bachelor's	Media	Married	Straight	5+	3	Y

Pseudonym	Age	Ethnicity	Nationality	Education	Employment	Relationship status	Sexual orientation	Number of surrogacy attempts	Children born through surrogacy	Used donor eggs
Jason	Mid-40s	White	USA	Bachelor's	Finance	Live-in (w/William)	Gay	1	2	Y
Jocelyn	35	Asian	USA	Post-graduate	Medicine	Married (to Alberto)	Straight	1	1	N
Juan	46	Latino	Australia	Bachelor's	Engineer	Live-in (w/Tristan)	Gay	1	n.a.	Y
Karen	41	White	Australia	Some college	Accounting	Married	Straight	3	2	N
Lionel	31	White	Italy	Bachelor's	Architecture	Live-in (w/Mark)	Gay	1	1	Y
Liz	54	White	USA	Some college	Unemployed	Married	Straight	1	2	Y
Lucas	41	White	Australia	Post-graduate	Business	Live-in (w/James)	Gay	2	3	Y
Lucy	36	White	Australia	Post-graduate	Social sciences	Married	Straight	3	3	N
Mark	33	White	Australia	Bachelor's	Media	Live-in (w/Lionel)	Gay	1	1	Y
Marla	32	White	Norway	Bachelor's	Designer	Married (to Roland)	Straight	3	2	Y
Marlene	48	AA	USA	Bachelor's	Law	Married	Straight	3	3	Y
Martin	42	White	USA	Bachelor's	Retail	Live-in	Gay	1	2	Y
Matthew	36	White	USA	Bachelor's	Business	Live-in (w/Anthony)	Gay	2	3	Y
Morgan	32	White	USA	Post-graduate	Pharmacist	Married (to Ana)	Straight	1	1	N
Nadine	43	White	USA	Post-graduate	Medicine	Married (to Adam)	Straight	1	1	Y
Patricia	44	White	USA	Post-graduate	Insurance	Married	Straight	1	1	Y
Paul	34	White	Norway	Bachelor's	Software development	Married (to Astrid)	Straight	1	2	N
Roland	31	White	Norway	Bachelor's	n.a.	Married (to Marla)	Straight	3	2	Y

Pseudonym	Age	Ethnicity	Nationality	Education	Employment	Relationship status	Sexual orientation	Number of surrogacy attempts	Children born through surrogacy	Used donor eggs
Sharon	Mid-40s	White	Canada	Bachelor's	n.a.	Married (to Ahmet)	Straight	1	0	Y
Simon	29	White	UK	Some college	Flight attendant	Live-in	Gay	1	2	Y
Tristan	56	White	Australia	Bachelor's	Flight attendant	Live-in (w/Juan)	Gay	1	n.a.	Y
William	Mid-40s	White	USA	Bachelor's	Finance	Live-in (w/Jason)	Gay	1	2	Y

Abbreviations:

Ethnicity: AA=African-American; WH=white

n.a.=not available

APPENDIX 2. Characteristics of surrogates and egg donors in Mumbai, 2008-2010

Pseudonym	Age	Marital status	Age at marriage	Children	Religion	Education (grade completed)	Work	Husband's work	Household monthly income (US\$)	Roles
Aditi	25	Married	15	1	Buddhist	5 th	Housewife	Social worker	n.a.	SM, ED
Anjali	24	Married	18	2	Buddhist	10 th	Housewife	Contractor	200	SM
Antara	36	Married		4	Buddhist	12 th	Housewife	Construction	130	SM, AG
Anusha	24	Married	18	2	Buddhist	10 th	Beautician	Insurance agent	200	ED, AG
Asha	28	Married	16	3	Buddhist	7 th	Housewife	Housepainter	130	SM
Ashima	25	Married	12	2	Christian	Illiterate	Housewife	Housepainter	90	SM
Avani	25	Married	15	2	Hindu	2 nd	Housewife	Security guard	45	SM
Dipti	28	Married	18	1	Hindu	10 th	Housewife	Tailor	175	SM
Divya	26	Married	21	1	Hindu	n.a.	Pharmacy assistant	Taxi driver	n.a.	SM
Gauri	28	Widow	20	2	Hindu	3 rd	Housecleaner	n.a.	45	SM
Geeta	27	Married	17	1	Hindu	7 th	Housewife	Mechanic	175	SM, ED
Hena	29	Widow	15	2	Hindu	Illiterate	Housecleaner	n.a.	n.a.	SM
Hetal	23	Married	17	2	Hindu	9 th	Housewife	Tailor	n.a.	SM
Jyoti	39	Married	18	3	Hindu	12 th	Housewife	Rickshaw driver	165	ED, AG
Karishma	29	Married	20	2	Hindu	12 th	Housewife	Hospitality, consulting	650	SM, ED
Kavita	30	Married	17	3	Hindu	Illiterate	Housecleaner	Painter	90	SM
Lalita	25	Married	15	3	Buddhist	Illiterate	Housewife	n.a.	n.a.	SM
Mandira	27	Married	16	2	Hindu	10 th	Housecleaner	Security guard	130	SM
Mansi	23	Married	17	2	Hindu	10 th	Housewife	Office worker	n.a.	SM
Meera	25	Married	13	5	Christian	7 th	Factory	Manual worker	65	SM
Naseem	30	Married	14	2	Muslim	Illiterate	Housecleaner	Mechanic	80	SM
Nishi	27	Divorced	19	2	Buddhist	7 th	Telecom	Telecom	200	SM, ED
Parvati	30	Married	14	2	Hindu	4 th	Housewife	Rickshaw driver	140	SM
Puja	25	Married	22	1	Hindu	15 th	Housewife/Manual labor	Security guard	145	SM
Rina	22	Married	18	2	Buddhist	4 th	Housewife	n.a.	n.a.	SM
Rishima	21	Married	15	1	Hindu	Illiterate	None	Manual laborer	65	SM
Sandhya	25	Married	15	3	Hindu	Illiterate	Catering	n.a.	150	ED
Shanti	22	Married	17	1	Buddhist	10 th	Packing company	n.a.	55	SM, AG, ED
Sumita	27	Widow	12	2	Buddhist	2 nd	Housecleaner	n.a.	25	SM, AG

Pseudonym	Age	Marital status	Age at marriage	Children	Religion	Education (grade completed)	Work	Husband's work	Household monthly income (US\$)	Roles
Tarani	22	Single	n.a.	0	Hindu	4 th	None	n.a.	220 (father's income)	SM
Tejal	32	Married	26	1	Hindu	12 th	Tailoring at home	Office worker	400	SM, AG
Urvashi	24	Married	15	3	Hindu	8 th	Housecleaner	Security guard	175	SM
Usha	30	Married	19	1	Muslim	9 th	Housewife	Tailor	190	SM
Varsha	30	Married	11	3	Hindu	Illiterate	Housewife/M annual labor	Security guard	175	ED
Yamini	23	Separated	18	1	Hindu	10 th	Factory work	n.a.	Na.	SM, AG

Abbreviations:

Roles: SM=surrogate; ED=egg donor; AG=agent/caretaker

n.a.=not available

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