

Surrogate Motherhood- Ethical or Commercial



CSR



Centre for Social Research (CSR)

2, Nelson Mandela Marg, Vasant Kunj – 110070

Tel: 91+11+26899998/26125583, Fax: 91+11+26137823

Email: info@csrindia.org, csr@vsnl.com

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Chapter I

Introduction

Nature has bestowed women with the unique ability to procreate a life. However in some cases, women or couples are unable to/decide not to conceive due to social, physiological or some other reasons. The desire for a baby leads them to search for alternative solutions, and surrogacy presents itself as the most viable alternative.

Advances in assisted reproductive techniques such as donor insemination and, embryo transfer methods, have revolutionized the reproductive environment, resulting in ‘surrogacy’, as the most desirable option. The system of surrogacy has given hope to many infertile couples, who long to have a child of their own. Taking advantage of the advanced medical facilities, they seek alternative solutions like Artificial Reproductive Technology (ART), In-Vitro Fertilization (IVF) and, Intra-Uterine Injections (IUI), in the hope of having a child of their own.

The very word ‘surrogate’ means ‘substitute’¹. That means a surrogate mother is the substitute for the genetic-biological mother. In common language, a surrogate mother is the person who is hired to bear a child, which she hands over to her employer at birth.

According to the Artificial Reproductive Technique (ART) Guidelines,

surrogacy is an “arrangement in which a woman agrees to a pregnancy, achieved through assisted reproductive technology, in which neither of the gametes belong to her or her husband, with the intention of carrying it to term and handing over the child to the person or persons for whom she is acting as surrogate; and a ‘surrogate mother’ is a woman who agrees to have an embryo generated from the sperm of a man who is not her husband, and the oocyte for another woman implanted in her to carry the pregnancy to full term and deliver the child to its biological parents(s)”.²

In the past, surrogacy arrangements were generally confined to kith and kin of close relatives, family, or friends, usually as an altruistic deed. But, with the introduction of financial arrangements in the process, surrogacy has extended its network beyond family, community, state, and even across the country. The concept of surrogacy has turned a normal biological function of a woman’s

¹ ‘Surrogacy from a feminist perspective’ by Malini Karkal, published in Indian Journal of Medical Science (IJME), Oct.- Dec. 1997 – 5(4), link; <http://www.Issuesinmedicalethics.org/054mi15.html>. Also in *Nelson Hilde Lindemann, Nelson James Lindemann: Cutting motherhood in two : some suspicions concerning surrogacy. In: Holmes Helen Bequaert, Purdy Laura (Eds.): Feminist perspectives in medical ethics. New York: Hypatia Inc., 1992.*

² The Assisted Reproductive Technologies (Regulation) Bill-2010, Indian Council of Medical Research (ICMR), Ministry of Health & Family Welfare, Govt. of India, pg. 4 (aa).

body into a commercial contract. Surrogate services are advertised. Surrogates are recruited, and operating agencies make huge profits. The commercialization of surrogacy has raised fears of a black market and of baby selling and breeding farms; turning impoverished women into baby producers and the possibility of selective breeding at a price. Surrogacy degrades a pregnancy to a service and a baby to a product. Experience shows that as with any other commercial dealing, the 'customer' lays down his/ her conditions before purchasing the goods.

Slowly but steadily India is emerging as a popular destination for surrogacy arrangements for many rich foreigners'. Cheap medical facilities, advanced reproductive technological know-how, coupled with poor socio-economic conditions, and a lack of regulatory laws in India, in this regard combined to make India an attractive option.

Nevertheless, reasons for foreigners coming to India in search of surrogate mothers vary. Women from lower socio-economic backgrounds readily agree to become a surrogate mother in India in return for payment, as hiring a surrogate in the western countries³ is not only difficult, but, the treatment is also immensely costly. The legal prohibition of surrogacy in some countries also leads people to come to India. For example, a 37-year-old Russian came to Bhopal as the expense for surrogacy is prohibitive in her country - between Rs. 15, 00,000 and 20, 00,000 - as compared to the Rs. 200,000 cost in Bhopal. The issue of legal acceptance/non-acceptance of surrogacy arrangements in different countries of the world will be discussed at length in the next chapter of this report.

Women, who undertake these assignments in India, usually come from lower class to lower middle class backgrounds, are married, and are often in need of money. Their need for money is so acute that more than often, childless couples can negotiate a better price as a result of competition. The amount of money given to a surrogate mother in India may appear very miniscule from any reasonable perspective, however, the amount may serve as the economic lifeblood for the families, and will be spent on the needs of the family (a house, education of the children, medical treatment). These are basic needs and may seem trivial from a notably rich westerners' perspective, but they become mega needs in a country like India, which lack social safety nets, and where the governance structure is attuned only to the needs of the rich and powerful sectors of the society.

³'Surrogacy Boom', article by Shuriah Niazi, October 14, 2007, by arrangement with WFS, Source: <http://www.boloji.com/wfs6/wfs1027.htm>

Most women who become surrogates insist on anonymity for fear of social stigma. Some men, particularly the husbands of surrogate mothers, react badly to this 'encroachment' on their rights. Women who participate in surrogacy programmes report that their partners, initially agreeable to their undertaking the responsibility, often change their attitude after they take on their new role. One American woman told of being left by her fiancée for another woman. The husband of another surrogate mother would not look at her after she was inseminated.

Even as an increasing number of childless couples from overseas come to India, legal experts express their reservations. Many foresee hurdles after the child is born and caution that surrogacy should be carefully considered. As there are several clinics now that perform such services - gauged by the number of advertisements in the local media as well as on the Internet - it is easy to select a clinic. However, the real problem arises after the birth of the baby. In India, in the absence of clear laws on the issue, foreigners are unable to get legal assistance when it comes to taking their child back to their home country.

However, with the entry of financial arrangements in exchange of the surrogate child, surrogate motherhood has raised difficult ethical, philosophical, and social questions. Surrogacy arrangements have made child a 'saleable commodity', and complications have arisen regarding the rights of the surrogate mother, the child, and the commissioning parents. As there is no legal provision to safeguard the interests of the surrogate mother, the child, or the commissioning parents in India, looking at such an issue from commercial or business point of view has complicated the matter further. For example, the surrogate may be forced to terminate the pregnancy if desired by the contracting couple and she will not be able to terminate it if it is against the desire of the couple. She has no right whether to abort the baby or keep it and continue with the pregnancy even if it her womb which is carrying the baby. There have been instances where the contracting individual has specified the sex of the baby as well and even refused to take the baby if it was born with birth defects and filed a suit against the surrogate saying she had broken the contract.

In surrogacy, the rights of the child are rarely considered. Early handover of the child hampers breastfeeding. Transferring the duties of parenthood from the birthing mother to a contracting couple is denying the child its claim to both the mother and the father. It could affect the psycho-social well-being of children who are born as a result of a surrogate motherhood arrangement. A shocking case of surrogacy was recently unearthed in the Bombay International Airport, where a foreigner couple came for surrogacy arrangements in India in order to get an organ transplant to their sick child in their country. This revelation further highlights the need for studies on surrogacy

to provide a foundation for the formulation of laws and regulations in surrogacy arrangements. Therefore, there is a clear need to protect the interests of both the surrogate mothers and the children produced out of such arrangements.

The practice of renting a womb and getting a child is similar to outsourcing pregnancy. The volume of this trade is estimated to be around \$ 500 million and the numbers of cases of surrogacy are increasing rapidly. The exact extent of this practice in India is not known, but inquiries have revealed that this practice has doubled in the last few years. There is a growing demand for fair-skinned, educated young women to become surrogate mothers for foreign couples. Often, couples have to wait for as long as eight months to a year for their turn. Normally women from small towns are selected for outsourcing pregnancy⁴. In places like Anand, Surat, Jamnagar, Bhopal, Indore, a large number of couples from both within India and abroad travel to fulfill their desire for a child. Several American, Russian and British women are duly registered with the Akankshya Clinic of Anand and the Bhopal Test Tube Baby Centre for the procedure.

1.1 Government initiatives

To address such issues and to regulate surrogacy arrangements, the Government of India has taken certain steps including the introduction and implementation of National Guidelines for Accreditation, Supervision, and Regulation of Assisted Reproductive Technology (ART) Clinics in 2006, and guidelines have been issued by the Indian Council of Medical Research (ICMR) under the Ministry of Health and Family Welfare, Government of India⁵.

However, till now there is no legal provision dealing directly with surrogacy laws to protect the rights and interests of the surrogate mother, the child, or the commissioning parents. Nonetheless, Assisted Reproductive Technology (ART) Regulation Bill, 2010⁶ lays down few guidelines which are discussed as follows:

⁴ 'Surrogate mothers: Outsourcing pregnancy in India' article by Joseph Gothia, 26th June 2008, link: http://india.merineews.com/cat_Full.jsp?articleID=136421

⁵ 'National Guidelines for Assisted Reproductive Technology: Ethical issues in Surrogacy' - Paper presented by Dr. R.S. Sharma, DDG (SG), Division of RHN, Indian Council of Medical research, New Delhi at the meeting-cum-workshop organized by the Ministry of Women and Child Development, Govt. of India on 25th June 2008 at India Islamic Centre, New Delhi.

⁶ ART (Regulation) Bill 2010, n. 2, Chapter V, pg. 20-35

Rights and duties in relation to surrogacy:

- (1) Both the couple or individual seeking surrogacy through the use of assisted reproductive technology, and the surrogate mother, shall enter into a surrogacy agreement which shall be legally enforceable.
- (2) All expenses, including those related to insurance if available, of the surrogate related to a pregnancy achieved in furtherance of assisted reproductive technology shall, during the period of pregnancy and after delivery as per medical advice, and till the child is ready to be delivered as per medical advice, to the biological parent or parents, shall be borne by the couple or individual seeking surrogacy.
- (3) Notwithstanding anything contained in sub-section (2) of this section and subject to the surrogacy agreement, the surrogate mother may also receive monetary compensation from the couple or individual, as the case may be, for agreeing to act as such surrogate.
- (4) A surrogate mother shall relinquish all parental rights over the child.
- (5) No woman less than twenty one years of age and over thirty five years of age shall be eligible to act as a surrogate mother under this Act, provided that no woman shall act as a surrogate for more than five successful live births in her life, including her own children.
- (6) Any woman seeking or agreeing to act as a surrogate mother shall be medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the child, and must declare in writing that she has not received a blood transfusion or a blood product in the last six months.
- (7) Individuals or couples may obtain the service of a surrogate through an ART bank, which may advertise to seek surrogacy provided that no such advertisement shall contain any details relating to the caste, ethnic identity or descent of any of the parties involved in such surrogacy. No assisted reproductive technology clinic shall advertise to seek surrogacy for its clients.
- (8) A surrogate mother shall, in respect of all medical treatments or procedures in relation to the concerned child, register at the hospital or such medical facility in her own name, clearly declare herself to be a surrogate mother, and provide the name or names and addresses of the person or persons, as the case may be, for whom she is acting as a surrogate, along with a copy of the certificate mentioned in clause 17 below.
- (9) If the first embryo transfer has failed in a surrogate mother, she may, if she wishes, decide to accept on mutually agreed financial terms, at most two more successful embryo transfers for the same couple that had engaged her services in the first instance. No surrogate mother shall undergo embryo transfer more than three times for the same couple.
- (10) The birth certificate issued in respect of a baby born through surrogacy shall bear the name(s) of individual / individuals who commissioned the surrogacy, as parents.
- (11) The person or persons who have availed of the services of a surrogate mother shall be legally bound to accept the custody of the child / children irrespective of any abnormality that the child / children may have, and the refusal to do so shall constitute an offence under this Act.
- (12) Subject to the provisions of this Act, all information about the surrogate shall be kept confidential and information about the surrogacy shall not be disclosed to anyone other than the central database of the Department of Health Research, except by an order of a court of competent jurisdiction.
- (13) A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy.
- (14) No assisted reproductive technology clinic shall provide information on or about surrogate mothers or potential surrogate mothers to any person.
- (15) Any assisted reproductive technology clinic acting in contravention of sub-section 14 of this section shall be deemed to have committed an offence under this Act.
- (16) In the event that the woman intending to be a surrogate is married, the consent of her spouse shall be required before she may act as such surrogate.
- (17) A surrogate mother shall be given a certificate by the person or persons who have availed of her services, stating unambiguously that she has acted as a surrogate for them.
- (18) A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple/ individual. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.
- (19) A foreigner or foreign couple not resident in India, or a non-resident Indian individual or couple, seeking surrogacy in India shall appoint a local guardian who will be legally responsible for taking care of the surrogate during and after the pregnancy as per clause 34.2, till the child / children are delivered to the foreigner or foreign couple or the local guardian. Further, the party seeking the surrogacy must ensure and establish to the assisted reproductive technology clinic through proper documentation (a letter from either the embassy of the Country in India or from the foreign ministry of the Country, clearly and unambiguously stating that (a) the country permits surrogacy, and (b) the child born through surrogacy in India, will be permitted entry in the Country as a biological child of the commissioning couple/individual) that the party would be able to take the child / children born through surrogacy, including where the embryo was a consequence of donation of an oocyte or sperm, outside of India to the country of the party's origin or residence as the case may be. If the foreign party seeking surrogacy fails to take delivery of the child born to the surrogate mother commissioned by the foreign party, the local guardian shall be legally obliged to take delivery of the child and be free to hand the child over to an adoption agency, if the commissioned party or their legal representative

fails to claim the child within one month of the birth of the child. During the transition period, the local guardian shall be responsible for the well-being of the child. In case of adoption or the legal guardian having to bring up the child, the child will be given Indian citizenship.

(20) A couple or an individual shall not have the service of more than one surrogate at any given time.

(21) A couple shall not have simultaneous transfer of embryos in the woman and in a surrogate.

(22) Only Indian citizens shall have a right to act as a surrogate, and no ART bank/ART clinics shall receive or send an Indian for surrogacy abroad.

(23) Any woman agreeing to act as a surrogate shall be duty-bound not to engage in any act that would harm the foetus during pregnancy and the child after birth, until the time the child is handed over to the designated person(s).

(24) The commissioning parent(s) shall ensure that the surrogate mother and the child she deliver are appropriately insured until the time the child is handed over to the commissioning parent(s) or any other person as per the agreement and till the surrogate mother is free of all health complications arising out of surrogacy.

Determination of status of the child:

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

(2) A child born to an unmarried couple through the use of assisted reproductive technology, with the consent of both the parties, shall be the legitimate child of both parties.

(3) In the case of a single woman the child will be the legitimate child of the woman, and in the case of a single man the child will be the legitimate child of the man.

(4) In case a married or unmarried couple separates or gets divorced, as the case may be, after both parties consented to the assisted reproductive technology treatment but before the child is born, the child shall be the legitimate child of the couple.

(5) A child born to a woman artificially inseminated with the stored sperm of her dead husband shall be considered as the legitimate child of the couple.

(6) If a donated ovum contains ooplasm from another donor ovum, both the donors shall be medically tested for such diseases, sexually transmitted or otherwise, as may be prescribed, and all other communicable diseases which may endanger the health of the child, and the donor of both the ooplasm and the ovum shall relinquish all parental rights in relation to such child.

(7) The birth certificate of a child born through the use of assisted reproductive technology shall contain the name or names of the parent or parents, as the case may be, who sought such use.

(8) If a foreigner or a foreign couple seeks sperm or egg donation, or surrogacy, in India, and a child is born as a consequence, the child, even though born in India, shall not be an Indian citizen.

Right of the child to information about donors or surrogates:

(1) A child may, upon reaching the age of 18, ask for any information, excluding personal identification, relating to the donor or surrogate mother.

(2) The legal guardian of a minor child may apply for any information, excluding personal identification, about his / her genetic parent or parents or surrogate mother when required, and to the extent necessary, for the welfare of the child.

(3) Personal identification of the genetic parent or parents or surrogate mother may be released only in cases of life threatening medical conditions which require physical testing or samples of the genetic parent or parents or surrogate mother, provided that such personal identification will not be released without the prior informed consent of the genetic parent or parents or surrogate mother.

***Extracted from the ART (Regulation) Bill, 2010*

The ART guidelines and other legal issues are analysed under the sections 2.4 and 2.5 of the next chapter.

1.2 Need of the study

The lack of research on surrogacy also poses a problem for Government agencies when it comes to initiating legal provisions and taking substantive action against those found guilty. A number of surrogacy related questions remains unanswered, including: is it legal to become surrogate mother in India? Will the child born to an Indian surrogate mother be a citizen of this country? Who

arranges the birth certificate and passport required by the foreign couple at the time of immigration? Whose name will appear on the birth certificate? How will the commissioning parents claim parenthood? What happens if the surrogate mother changes her mind and refuses to hand over the baby or blackmails for custody? Who will take the responsibility of the child if the commissioning parents refuse to take the child? What would happen if the child is born disabled? What would happen if the sex of the child is not to the liking of the commissioning parents? Such questions need thorough analysis before any policy relating to surrogacy is designed and legal provisions are made. According to senior advocate Kirti Gupta, "At present, it is not difficult to have a baby through surrogacy in India because there is no law to control or regulate it. The technique is cheap, when compared to other countries, and surrogate mothers here charge comparatively less for the services"⁷.

Therefore, the risks and the disadvantages involved in the surrogacy arrangements often prove detrimental to the interests of the surrogate mother, and the child. At times the commissioning parents also face legal hassles, which was demonstrated in the case of a Japanese couple and the child born to them, which brought out many issues related to surrogacy arrangements⁸. In light of this case and several other issues arising out of the misuse of surrogacy arrangements, the Ministry of Women and Child Development, Government of India called a meeting-cum-workshop of Government agencies, NGOs, Doctors, and concerned Ministry personnel on the 25th June 2008, to discuss various aspects of this issue. A particular aspect was given to its effects on the welfare of women and children born out of this arrangement, and to draft a legal procedure to address these issues.

The supposed benefits of surrogacy are created by a capitalist patriarchal society. It is assumed that there is an equal exchange - money paid for the service rendered. In reality the contract between the parties to surrogacy would not exist if the parties were equal. The woman must give more than her egg in order to gestate a child - an important gender difference. Within this framework the contract is always biased in favour of the financially secure male. The freedom of the surrogate mother is an illusion. The arbitration of rights hides central social and class issues which make surrogacy contracts possible⁹. In addition, bio-ethicists are concerned that Indian surrogates are being badly paid and working as surrogates in a country with a comparatively high maternal mortality rate.

⁷ Ibid.

⁸ Hindustan Times, dated 7th August 2008, Nation Page, pg. 13, column 2.

⁹ Malini Karkal, ref. no. 1

To address these issues relating to surrogacy, Centre for Social Research (CSR) conducted an exploratory study on surrogacy in three of the high prevalence areas: Anand, Surat and Jamnagar of Gujarat state.

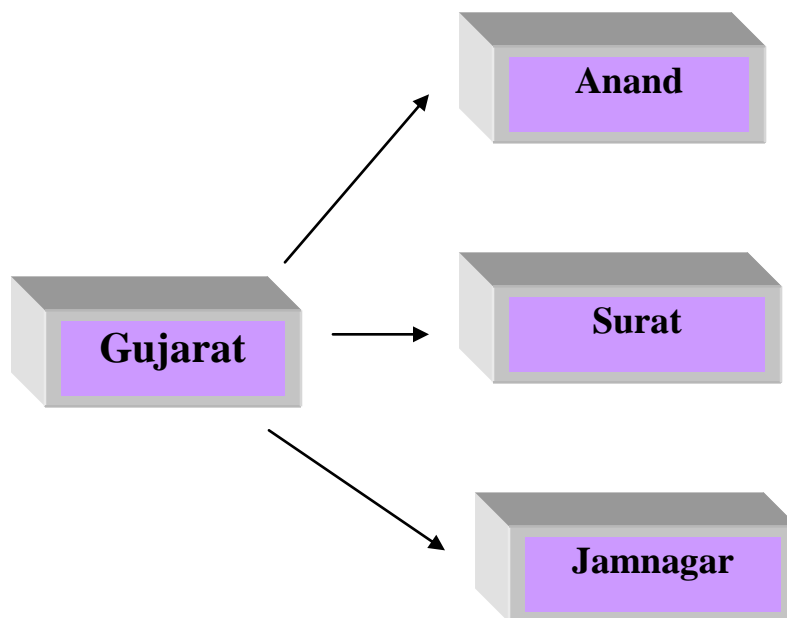
1.3 Objectives

The objectives of the study were to:

- ◆ conduct a situational analysis of surrogacy cases in the three study areas and the issues involved
- ◆ examine the existing social and health protection rights ensured to the surrogate mother
- ◆ analyse the rights of the child in surrogacy arrangements
- ◆ study the rights and issues pertaining to commissioning parents
- ◆ suggest policy recommendations for protection of rights through legal provisions of surrogate mother, child and the commissioning parents based on the study

1.4 Methodology

The methodology adopted for the study was exploratory research of situational analysis study through the means of a survey. It was carried out in the three prominent areas of Gujarat state where well-known ART clinics such as Akankshya are operating and a high incidence of surrogacy is reported. Anand in Gujarat is quoted as the ‘cradle of the world’. Similar technology is also available in Surat and Jamnagar. Due to the high demand in the Anand clinics, couples who do not want wait for long head to the other two cities.



The sample size consisted of one hundred surrogate mothers and fifty commissioning parents and their families in three cities of Gujarat. Both primary and secondary data was collected and

analyzed. The final report aims to highlight the major findings and suggests recommendations for future policy implications. The tools included structured questionnaires with 75% close ended and 25% open ended questions. The gender aspect has been kept in focus as personal observation and interviews included the husbands of surrogate mothers and the male counterpart of the commissioning parents wherever possible. The questionnaires were field-tested prior and then modified. Interview schedules were developed and administered to the stakeholders. The stakeholders included: the ART clinics, the doctors and the nurses carrying out the procedure, the immediate society and community members, family members, agents including travel agents who arrange for commissioning parents arrival, stay, passport and departure with the child and guest house/hotel owners where foreign couples stay during the whole procedure and the maternity homes/shelter homes where surrogate mothers sometimes stay to ensure secrecy. Focus Group Discussions (FGDs) were conducted with surrogate mothers, stakeholders and community members.

The universe of the study were surrogate mothers, their families, commissioning parents, the clinics conducting surrogacy, families where such cases happened within those cities, agents who facilitate such procedures including travel agents who arrange for passports and other documents, other stakeholders like the community members, owners/care takers of shelter homes/ guest houses, etc. Since, no research study has been done previously addressing issues pertaining to surrogacy so far, a first-hand study has found out the field-level realities, which will be dealt in detail in the subsequent chapters.

This report on Surrogate “Motherhood: Ethical or Commercial” has six chapters including an introduction, a Literature Review and the Conclusion. Chapter II discusses the literature available on surrogacy both national and international documents and also analyses surrogacy arrangements across the globe, the legal issues so far, etc. at length. Chapter III chronicles the profile and plight of the surrogate mother before and after surrogacy and aims at analysing her status during the entire process taking into consideration each and every aspect of the surrogacy arrangement. Chapter IV looks at the Commissioning Parents and aims to give an overview of the profile of the commissioning parents, their perspectives and views regarding surrogacy arrangement in India and a detailed analysis of different factors in surrogacy. This chapter also deals with the surrogacy clinics, primarily falling back on the detailed observations of the researchers during field visits as the medical practitioners concerned were unwilling to divulge information about their modus operandi. The last chapter consists of a conclusion on the existing situation of surrogate motherhood in India and recommendations for the formulation of a strong legal framework to address the issue of surrogacy in India.

Chapter II

Literature review

Worldwide, approximately 259,200 children are born every day. That is almost 3 children each second. The birth of a newborn child is often a very special and fascinating event for all the people involved. Some couples, due to certain physiological conditions (or for some other reasons), cannot give birth to their own offspring.

Infertility affects about 1 out of every 6 couples. This includes not just those unable to conceive after 12 months of trying, but also those that cannot carry a pregnancy to term. Since the 1970s, the number of infertile couples has increased (Winston & Bane, 1993). Some might argue that the reason for this is that this number only includes couples who seek clinical assistance for infertility. Over the years the social attitudes towards medical interventions like IVF have changed. As a result infertile couples have become less reluctant to seek help, which is reflected in the percentage of infertile couples registered by the clinics. Others do not fully share this opinion. Medical experts believe that nowadays, contraception and career prospects lead to postponement of childbearing. Consequently, women are older once they start trying to conceive a baby. Older women are generally less fertile because of age-related biological factors. Due to several reasons, such as the changing sexual practices, the use of intrauterine devices, more and more women suffer from pelvic inflammatory disease, which is a leading cause of female infertility (Winston & Bane).

For many infertile men and women, being unable to bear and raise children has severe emotional and psychological consequences. They often feel guilty, and experience a loss of self-worth and confidence. To many infertile people, their condition affects their most fundamental feelings about who they are and what their role in the family is. It influences one's personal identity and the extent of fulfilment. For that reason, infertility is regarded a major health problem. Also, it makes it clear why people who cannot have children the natural way look for other ways in order to become a parent.

In the past, couples unable to conceive were expected to turn to adoption to achieve their parenthood dreams. Nowadays there are many options for infertile couples, as well as singles and homosexuals who want children. The urge of parenthood leads them to seek alternative solutions including Artificial Reproductive Technology (ART), In-Vitro Fertilisation (IVF) and Intra-Uterine Injections (IUI).

Advances in medical sciences and technology, particularly in assisted reproductive techniques, with techniques like donor insemination and embryo transfer methods have revolutionized the reproductive environment and have led to an increase in popularity of surrogacy. With the introduction of financial agreements in exchange for the surrogate child, the child becomes a 'saleable commodity'. As a result, complications arise and questions must be raised regarding the rights of the surrogate mother, the child and the commissioning parents.

2.1 Theoretical background

Surrogacy is a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party. The word 'surrogate' means 'substitute'.¹ Surrogacy arrangements do not only take place within the family, but also within the community, the state, the country and presently even the world.

When it comes to surrogacy, there are two types currently used: "traditional" and "gestational". Traditional surrogacy is done via artificial insemination, with the surrogate using her own egg and another man's sperm. Gestational surrogacy is done via In Vitro Fertilization (IVF), where fertilized eggs from another woman are implanted into the surrogate's uterus. Choosing which route to take is one of the most important and earliest decisions a surrogate and the intended parents will have to make.

Antagonists of traditional surrogacy often have a problem with the genetic link between the surrogate and the baby she carries. Most gestational surrogates believe that they would never be able to relinquish a child that they are genetically related to. Another reason to opt for gestational surrogacy instead is that some people might feel comfortable with their children having half siblings out and about in the world (Weller, 2001).

Proponents of traditional surrogacy often argue that although there is a genetic link, this link is not as important as the link between the commissioning parents and their child to be. Those who do choose traditional surrogacy most commonly describe their feelings on the matter as being similar to egg donation: there is a genetic link, but that link is less important than the link between the intended parents and their child to be. Some intended parents worry about the legal ramifications of traditional surrogacy; but in reality this has never proven to be a problem (Weller, 2001). IARC (2010) does not fully agree. They state that judges are, to some extent, more likely to rule in favour

of the traditional surrogate if conflicts arise. Since the surrogate is genetically related to the child, the intended mother will typically need to adopt the baby through a stepparent adoption process.

Traditional surrogacy was previously the only way to conceive a child via a surrogate mother. Since artificial insemination is easy, not painful, and importantly, significantly less expensive than IVF, traditional surrogacy continues to be used by many people (Pande, 2009). Another argument for traditional surrogacy is the high success rate when the surrogate mother has proven to be fertile. Also, in general, traditional surrogates do not have to be on any special medication. Keeping track of their menstrual cycle and timing the inseminations around when they naturally ovulate will usually suffice. However, in order to increase the chances for twins or to fine-tune the timing of ovulation, some surrogates do take some mild fertility drugs (Weller, 2001).

Gestational surrogacy on the other hand is a more complex and more expensive process. Nevertheless, the reason that an increasing number of intended parents settle on gestational surrogacy is because that procedure can offer one thing that traditional surrogacy cannot: the chance to raise a child that is genetically completely their own. Surrogates can carry embryos that have been created from the commissioning mother's eggs and the commissioning father's sperm. The eggs are retrieved from the intended mother and fertilized with the sperm, allowed to grow, then transferred, via IVF, into the surrogate's uterus. In some situations the intended parents cannot produce the necessary sperm and/or eggs. If that is the case a donor may also be used.

Although this procedure may seem to be surprisingly straightforward, the transfer of the embryos requires heavy medical intervention and weeks of preparation. In the United States surrogates usually receive daily injections for weeks. Firstly the surrogate own ovulatory cycle has to be suppressed. This is done by taking birth control pills and hormone shots. This procedure will be followed by oestrogen shots to build her uterine lining. Once she is impregnated the surrogate must take daily injections of progesterone until her body realizes it is pregnant so it can sustain pregnancy on its own (Beski et al. 2000). These medications often have significant side effects the surrogate must live with. Examples are mood swings, headaches, hot flashes and drowsiness.

As previously outlined, gestational surrogacy is an expensive process. Each IVF cycle can easily cost thousands of dollars. In addition, there is a higher rate of miscarriage among pregnancies achieved this way than through traditional means. In the case of a failed transfer there is often a wait of several months before one can attempt another transfer.

The increased legal benefits of gestational surrogacy and existence of a genetic bond, however, are often strong selling points for the intended parents and surrogates who choose this route. However, given the costs of surrogacy in western countries like the United States and the United Kingdom, intended parents are coming more and more often to developing countries, like India, to find a surrogate mother. The fee the couples have to pay the surrogate mother – about a quarter of what mothers in Europe and North-America charge – is not the only reason for them to come to a country like India. Other reasons are India's cheap medical facilities and advanced reproductive technological knowledge. Hence, India is fast emerging as a popular destination for childless couples to seek help.

Apparently people are ready to travel halfway across the world and hire a surrogate to fulfil their desire to share a genetic tie with their children (Beski et al. 2000). Clearly the genetic tie remains a powerful and enduring basis of human attachment. Authors like Roberts (1995) and Field (1992) acknowledge that through this form of relationship surrogates form kinship ties that disturb the sanctity of biology and genes within a system that might well be the pinnacle of the commoditisation of the genetic tie. They argue that with the entry of financial arrangements in exchange of the surrogate child, the child becomes a 'saleable commodity' and surrogacy commercialized. Hiring couples no longer have to cross borders: the child born would carry its parents' genes and subsequently their race, caste and religion. More on the commercialization and its consequences will be outlined in the section below.

2.2 Commercialisation

As discussed briefly in the Introduction, originally surrogacy happened within families and friends. Known surrogates would give birth for infertile family members or friends. This was an altruistic deed as these surrogates were generally not paid for it. Over the last few decades however, there is a noticeable trend of the commercialization of surrogacy.

Some say that this is an undesirable development as giving birth to a child should not be regarded the production of a commercial product. They feel that surrogacy is similar to baby selling and that a law comparable to the one prohibiting the sale of human organs should apply to the sale of childbearing.

Others argue that surrogacy arrangements are a win-win situation. On the one hand, the intended parents benefit from finally having what they have desired for so long. At the same time, surrogate

mothers profit from the agreement through the opportunity to increase their economic solvency and are thus able to take better care of their families. Therefore the needs of two desperate women are both met in a surrogacy transaction.

Most people agree the important aspects of who we are, what we know, believe or feel and how we function in our societies, is not decided by genetics. It is even less likely that the uterine environment in which we grew as embryos and foetus determines these aspects. The general perception is the way we are raised, the care and guidance we received and the experiences we encountered during this period are far more important for determining what kind of human being we turn into. This perception leaves little doubt of the prime value of parental nurturing. Bromham (1995) states this issue was stressed many years before the issue arose with gestational surrogacy, for instance when men became fathers following donor insemination.

Although society appreciates the importance of parenting and raising a child well, very few individuals question the position of surrogates for parental functions, such as nannies, wet-nurses and boarding schools, even though it seems reasonable to say that these functions are far more valuable to the development of the child than the initial uterine or even genetic origins (Bromham, 1995). Then why are so many people opposed to surrogacy? The reasons for this, as well as motives to advocate for surrogacy will be discussed below. The focus in this will lie on surrogate mothers from developing countries.

2.2.1 Arguments for surrogacy

Advocates of surrogacy argue that the surrogacy agreements are beneficial for all parties involved as the respective needs of two women in difficult circumstances, are met. It is often said that in the surrogacy arrangement *'the barren gets a baby, the broke gets a bonus'*. The surrogate mothers often really utilize the money they earn.

Others claim that the right to procreate is an important right. For example, in the United States this right is protected by the Constitution (Field, 1990). The couple may exercise this right in the most practical way available to them given their infertility. However, Cline (2008) states this right is not literally spelled out in the constitution. Margaret Jane Radin (1988) argues that if men are to donate sperm and receive money for that transaction, then surrogacy should also be allowed as an analogous transaction for women. This constitutional argument can also be used as an argument against surrogacy. Due to the substantive due process privacy right the birth mother has a right to companionship of her children which cannot be overridden by contract.

The liberal argument for surrogacy is autonomy and free choice. As long as one does not harm others, one has a wide sphere for doing what one wants. This relates to the intended parents as well as the surrogate mothers. Practice often tends to be slightly different though, because duress and coercion affect the extent to which someone has free choice.

An economic argument, expressed by Judge Posner (1987), is that efficiency will improve with free trade. This will happen when there are parents who are eager for children and women - anxious to be surrogates. However, once this trade of parental rights is prohibited, black markets will come into existence. Posner (1987) states that due to the complicated adoption regulations in many countries, people go to other countries to evade the regulations creating a vast black market. As a result, it is better to acknowledge the existence of such a market in order to better control it and make it more efficient.

Interestingly, there are very committed feminists on both sides of this issue. According to Radin, feminists who do want to fully legalize surrogacy follow the reasoning that the world is non-ideal. Women and men are not equal and for years women have been relegated to a separate sphere at home, away from the marketplace. This has made women powerless, because the place of power is the marketplace, which is dominated by men. This power has meant the liberation of men. Women want to achieve this as well. They do not want men to tell them what sell and what not to. Whether or not it is morally wrong to engage in child selling and surrogacy should be decided by the women themselves. Many feminists use this reasoning as an argument for why surrogacy should be legal.

Other feminists however agree that women have been kept out of the market for a long time, but historically women also have been seen (in their separate sphere at home) and treated like baby producing machines. Allowing baby selling and surrogacy would mean that women remain being treated as anonymous interchangeable breeders and reinforces the objectification and subordination of women. Entering the market in this context is therefore far from liberating, but rather degrading.

2.2.2 Arguments against surrogacy

According to Kembrell (1988) the practice of surrogacy exploits women economically, emotionally and physically. An important factor is that most women who get involved as surrogates do so because they are in desperate need of the money to maintain their family. In addition, agents are often involved and arrange contracts of questionable legality. Those contracts require the women to undergo all the rigors of childbearing, and eventually they have to give the child away (Kembrell, 1988). The surrogate mothers are often unaware of their legal rights and due to their financial situation they cannot afford the services of attorneys. Once the surrogate mother has signed the

contract, it is impossible for them to escape. Kembrell (1988) goes even further saying: “the practice of surrogacy represents a new and unique form of slavery of women”. This a view supported by Davis (1993). During times of slavery, slave women were often used as birth or genetic mothers and as surrogate mothers nowadays, who possessed no legal rights as mothers. In light of the commoditisation of the children, and actually also of themselves, they have the same status as surrogate mothers have in contemporary times. Another similarity is that slave mothers could not speak freely about their pregnancy and the children they carried; an aspect that is also present in surrogacy as a result of social stigma. Davis is worried that, given this history, poor women may be transformed into a special caste of hired pregnancy carriers (1993). She believes that with the commoditisation of labour services of pregnant surrogate mothers, money is being made, which implies that someone is being exploited. Davis continues by saying that surrogacy appears as a procedure generative of life, what is really generated seems to be sexism and profits.

Horsburgh (1993) is opposed to women because he believes surrogates are physically exploited once they have signed contracts agreeing to give birth to babies for clients. If there is a reason to abort the foetus, because of medical reasons or client’s demands, the surrogate mother must comply. To make matters worse, if the pregnancy is indeed aborted, the surrogates often receive just a fraction of the original payment (Horsburgh, 1993). The contracts can also place liability on the mother for risks including pregnancy-induced diseases, death and post-partum complications (Kembrell, 1988).

Foster (1987) states that many surrogate mothers face emotional problems after having to relinquish the child. She recalls a women who said that she started praying not to go in labour so that she and her child could stay together. However, other authors disagree with Foster. A study by Jadva, Murray, Lycett, MacCallum and Golombok (2003) showed that surrogate mothers do not appear to experience psychological problems as a result of the surrogacy arrangements. Although they do acknowledge that some women do experience emotional problems in handing over the baby or as a result of the reactions around them, these feelings appeared to lessen during the weeks following the birth.

Other authors take a different stance. Radin (1996) raises the issue of surrogacy in fact being baby selling. She states: “if it were okay to think of children as property, then it would be okay to buy and sell them; and if it is not done to buy and sell them, then maybe its not done to think of children as property”. A New Hampshire judge ruled the following in a custody case: “At birth the father does not purchase the child. It is his own biological genetically related child. He cannot purchase what is already his (1987).” Radin (1996), however, believes that even if there is a genetic

relationship between the adopters and the child this does not necessarily make it a non-sale. If some (surrogate) children are conceived as market commodities because there is a practice of paying money for relinquishing parental rights, then every child can be considered a commodity. As a matter of fact, we all are commodities, because we used to be children ourselves. If children are viewed as exchangeable market commodities, it might make the self-conception of those children as persons impossible. Therefore, if conceiving children as commodities has a negative effect on personhood, it means that baby selling, and surrogacy for that reason, is wrong (Radin, 1996).

Others might reason that commissioned adoption, in which someone pays a woman to conceive, gestate, give birth and subsequently relinquish the parental rights to this person, is illegal. The idea is that surrogacy, legal in some countries, is just commissioned adoption under certain special – a contribution of genetic material – circumstances. As a consequence: to permit surrogacy would be an irrational exception to the baby selling laws if that distinction is based on genetic relationship does not hold good. If legislation is passed which enables legal surrogacy arrangement, then the laws against baby selling in general should also be reconsidered.

2.2.3 Discussion

While opponents of surrogacy would like to ban surrogacy completely, some supporters would like countries to declare surrogacy fully legal. Neutrals, which seem to have the upper hand, feel surrogacy is a controversial subject and also acknowledge that the present situation, in which laws are non-existent or poorly enforced, is unfavourable. Field (1990) agrees with Posner and she is very articulate about it. She is worried that if surrogacy was made illegal, surrogacy altogether would not disappear, but instead surrogacy would be driven underground, which would cause more harm than good. Like Behm (1999), Field (1990) believes that surrogate mothers should always have the option to withdraw from the contract, up until they voluntarily give the baby to the intended parents.

2.3 Incidents related to surrogacy

Baby M

A couple decided due to the wife's illness not to have children. Instead of conceiving children the natural way, the husband entered a surrogacy agreement with another woman. He donated his sperm and asked her to deliver the child. However, the deal broke down and the surrogate mother wanted to keep the child. Eventually the case went to the New Jersey Supreme Court. The court ruled that

the surrogacy contract was invalid because, among other things, it violated the New Jersey law against exchange relating to obtaining a child.

Baby Manji

Baby Manji is a child born to an Indian surrogate. Her commissioning parents were a couple from Japan, who filled for divorce shortly before the child was born. The father, still wanting to take care of the child, faced severe legal issues as the Indian law prohibits single men to adopt. Neither the intended mother nor the surrogated mother wanted to take custody of baby Manji. The baby was eventually permitted to leave for Japan after the Japanese government issued a one-year visa to her on humanitarian grounds. However her grandmother needed to accompany her, because she was temporarily given custody over the baby. As a result of this case the debate within India about surrogacy has intensified. In the controversy that followed, several infirmities in the arrangement came to light including the absence of a legal contract between the parties, a fact that many saw as a worrying reminder of the potential for exploitation of native surrogates.

These problems exist because surrogacy contracts are often not clear and hold no legal value. Furthermore, some countries lack specific surrogacy legislation. Those that do have these laws often fail to implement or enforce them. An explanation for this lies probably in the assumption that up until now, medical technology, especially reproductive technology, needed no justification. Its 'benevolent' nature was taken for granted. However with the commercialization of surrogacy, social, demographic, ethical, legal and philosophical issues have been raised. As the debates have shown, these developments have the ability to alter not only the face, but the very soul of human civilization. It might bring about the restructuring of society on lines of a 'reproductive brothel model' in which 'women can sell reproductive capacities the same way old time prostitutes sold sexual ones' (Ravindra, 1992). Currently, in the US, due to the fact that few states have developed legislation, disputes over surrogate parenting often go to court (Markens, 2007). Therefore, clear and enforceable laws should be implemented.

2.4 Legal issues

Nowadays, a parent's surrender of a child for a fee, known as baby selling, is a crime all over the world. In addition, many countries have regulations limiting or prohibiting compensation of intermediaries related to the transfer of a child (Field, 1990). Although gestational surrogacy is (partially) legal in several countries around the globe, in most jurisdictions it is not.

Going to another country to avoid local prohibitions is not always an option. Sometimes the nation's provisions apply only to that country's residents. People who want to take advantage of the laws in that particular country must therefore first establish residency there. The surrogacy map of the world is enclosed here to give a better understanding of the legal provisions across the globe. The countries marked in red shows nations that (partially) allow surrogacy agreements. The different (sub) continents are discussed below.

❖ **North America**

An estimated 25,000 surrogate babies were born in the US from 1976 to 2007.

A typical payment for a surrogate ranges from between US\$ 20,000 and US\$25,000.

States that allow but regulate surrogacy are: California, Arkansas, Florida, Illinois, Nevada, New Hampshire, Texas, Utah and Virginia. Commercial surrogacy in Canada has been illegal since 2004, although altruistic surrogacy is allowed.

❖ **Western Europe**

Although surrogacy is legal in the United Kingdom, no commercial arrangements are allowed and the surrogate mother can only receive expenses – in thousands of pounds through the Surrogacy Arrangement Act – for medical and pregnancy related expenses.

Most women become surrogate mothers for altruistic reasons. Only married couples can participate in a surrogacy agreement. Countries in the European Union who have banned all forms of surrogacy include Germany, Sweden, Norway and Italy.

❖ **South Asia**

When the Indian parliament passes the Assisted Reproductive Technology (Regulation) Bill & Rules, 2008, surrogate mothers may receive money for carrying the child and as well as all their expenses paid during the pregnancy. This will be outlined further in chapter III.

❖ **South East Asia**

Unclear laws regulating assisted reproductive services make Thailand, Malaysia and Philippines an ideal option for foreigners seeking surrogacy services in this part of the world. However, all forms of surrogacy are banned in Singapore.

❖ **East Asia**

In Japan, there is no law to regulate surrogate births. Medical councils, including the Japan Society of Obstetrics and Gynaecology as well as the Science council of Japan have called for surrogacy to

be banned. In 2008, it is reported that more than 100 Japanese couples have used surrogates to have children in the United States. Meanwhile, a law to regulate surrogacy is being studied. Last year, media reported on a 61-year-old Japanese woman who became a surrogate mother to her own grandchild – possibly the oldest surrogate mother in Japan. Gestational surrogacy is banned in China.

❖ **Oceania**

In Australia, the state of Queensland bans all forms of surrogacy. In the other Australian states such as Victoria, the Australian Capital Territory, Tasmania, and South Australia commercial surrogacy is prohibited, except altruistic surrogacy. Commercial surrogacy is banned in New Zealand.

❖ **Eastern Europe**

Russia and Ukraine are the only European countries where surrogacy is fully legalised. Foreign couples are allowed to pursue surrogacy arrangements in both countries.

2.5 Landscapes of surrogacy in India

In 1984 the world saw the first successful birth through gestational surrogacy. Ten years later, in Chennai, this happened for the first time in India. Three years after that, in 1997, an Indian acted as a gestational carrier, and got paid for it, in order to obtain medical treatment for her paralyzed husband. In the past couple of years, the number of births through surrogacy doubled with estimates ranging from 200 up to 350 in 2008 alone (Lal, 2008).

As briefly addressed before, India is rapidly becoming the most popular country for ‘fertility tourists’, which is due to a number of interrelated factors (Smerdon, 2008).

In 2002, the Confederation of Indian Industry (CII) published a study on the potential India has to develop a medical tourism sector. This was picked up on by the then Finance Minister of India who wanted India to become a global health destination. In order to stimulate this development he came up with measures to facilitate a medical tourism industry, including infrastructural improvements (Chinai & Goswami, 2007). Also, hospitals that treat foreign patients were to receive financial incentives including low interest rates on loans and low import duties on medical equipment. In addition, the Ministry of External Affairs introduced a medical visa, which allowed patients and their family members to stay in India for a maximum of 12 months. The tourism departments

teamed up with hospitals to attract foreign patients, and not without success: the number of medical tourists increased from 150,000 in 2005 to 450,000 in 2008 (Chinai & Goswami, 2008).

During these years, fertility tourism has also increased in popularity. The reproductive segment of the Indian medical tourism market is valued at more than \$450 million a year (Ramesh, 2006). These fertility tourists do not all come from Western countries; India is also a popular destination for medical tourists from Sri Lanka, Pakistan, Bangladesh, Thailand and Singapore. At the moment there are over 600 fertility clinics established in both rural and urban areas in almost all states of India. However, it appears that the state of Gujarat is particularly popular, especially among westerners.

It is not only the efforts of India causing the increase in number of surrogacy births on the South Asian subcontinent. As previously stated, many countries around the world prohibit commercial surrogacy contracts and in other countries the enforcement of surrogacy contracts is significantly limited. Due to the restrictiveness of their own countries, desperate couples cross borders into surrogacy-friendly countries, like India, to engage in a surrogacy contract arrangement here.

While commercial surrogacy is also developing in other countries, another contributing factor to the rise in popularity of surrogacy in India is that the patients find it easy to communicate with the English-speaking doctors. This also enables these doctors to promote surrogacy in the press (Ramachandran, 2006). As a result, the press only runs glorifying success stories and fails to pay attention to all the failed attempts. Clinics also sometimes use the media, particularly the Internet to deceive potential clients. Their websites often contain facts and fiction, as part of the marketing strategy (Mulay & Gibson, 2006) and it is not uncommon for them to encourage couple to ignore the implemented laws regarding surrogacy in their home country.

The strongest incentive for foreigners to travel to India is most likely to be the relatively low costs involved in the process. The fees for surrogates are reported to range from \$2,500 to \$7,000. The total costs can be anything between \$10,000 and \$35,000. This is a lot less than what intended parents pay in the United States, where rates fluctuate between \$59,000 and \$80,000 (Sharma, 2008). On average, most Indian surrogate mothers are paid in instalments over a period of 9 months. If they are unable to conceive they are often not paid at all and sometimes they must forfeit a portion of their fee if they miscarry (Insight, 2006).

As an increasing number of childless couples from overseas come to India, legal experts express their reservations. Many foresee hurdles after the child is born because there is no law to control or regulate it. The real problem arises after the birth of the baby since foreigners are unable to get legal assistance when it comes to taking their child back to their home country, which has caused problems in the past. There have also been problems with claiming parenthood. In rare cases the surrogate mother has refused to relinquish the child. In order to deal with these problems the ICMR guidelines have been designed the extracts of which have been cited below. However, these guidelines do not hold any legal validity.

2.5.1 Jurisdiction in India

ICMR guidelines

In 2006, the Indian Council of Medical Research (ICMR) published guidelines for accreditation, supervision and regulation of ART clinics in India. Below are the main points from these guidelines:

- ✚ DNA tests are compulsory to determine that the intended parents are indeed the genetic parents. If this is not the case the child must be adopted instead.
- ✚ Surrogacy should normally only be an option for patients for whom it would be physically or medically *impossible/ undesirable* to carry a baby to term.
- ✚ The payments received by the surrogate mothers should be documented and cover all genuine expenses associated with the pregnancy.
- ✚ The responsibility of finding a surrogate mother should rest with the couple, or a semen bank, not the clinic.
- ✚ A surrogate mother should not be over 45 years of age. The ART clinic should ensure possible surrogate woman satisfies all the testable criteria to go through a successful full-term pregnancy.
- ✚ No woman may act as a surrogate more than three times in her lifetime.
- ✚ The surrogate mother must declare that she will not use drugs intravenously, and not undergo blood transfusion excepting of blood obtained through a certified blood bank.
- ✚ A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple.

The draft ART (Assisted Reproductive Technology) Bill

A new bill is in the works to regulate the practice of surrogacy aiming to avoid some of the pitfalls of the ICMR guidelines discussed above. In the previous chapter were given extracts from the draft

ART bill particularly concerning the surrogacy arrangement, rights of the surrogate mother, the child, etc.

The bill empowers a National Advisory Board to act as the regulatory body laying down policies and regulations. It also seeks to set up State Advisory Boards that are, in addition to advising state governments, charged with monitoring the implementation of the provisions of the Act, particularly with respect to the functioning of the ART clinics, semen banks and research organizations.

The **Artificial Reproductive Technology (Regulation) Bill** defines surrogacy as an “arrangement in which a woman agrees to a pregnancy, achieved through assisted reproductive technology, in which neither of the gametes belong to her or her husband, with the intention of carrying it to term and handing over the child to the person or persons for whom she is acting as surrogate; and a ‘surrogate mother’ is a woman who agrees to have an embryo generated from the sperm of a man who is not her husband, and the oocyte for another woman implanted in her to carry the pregnancy to full term and deliver the child to its biological parents(s)”.

By this definition, all surrogacy arrangements that involve the woman bearing a child using her own egg (oocyte) and the commissioning man’s sperm are illegal. Also, by this definition, fertile surrogate mothers will necessarily have to use technology meant for treatment of infertility. Surrogates will now be forced to use only in-vitro technologies even though they can get pregnant with methods like artificial insemination which are much safer for them.

Further, in light of the Artificial Reproductive Technology (ART) practiced today, it reflects that there is no standardization of the drugs used, no proper documentation of the procedure, insufficient information for patients about the side-effects of the drugs used, and no limit to the number of times a woman may be asked to go through the procedure. They do not disclose the fact that a ‘successful cycle’ need not lead to a baby being born. Further, the clinics do not give exact information on the procedures and their possible side-effects.

A noticeable trend is that the ART clinics are becoming the central hub of all surrogacy-related activities. Some of the duties of the clinics involve selecting the surrogate mothers – the bill lays down conditions that the surrogate mothers have to meet – and obtaining relevant information, informing all parties involved about their rights and obligations. The bill specifies what is and is not allowed regarding these topics. ART clinics are also required to treat all the information they obtain with utmost confidentiality. In practice this entails that ART clinics are not allowed to provide any

information about surrogate mothers or potential surrogate mothers to any person. This creates a problem for intended parents since they have to turn to a middleman in order to find a surrogate mother. This is rather controversial, not just because of the involvement of agents, but also because it seems unfair that the intended parents, who are about to make a significant investment, have little control over the selection process. A better option could be to release personal information at the discretion of the surrogate.

Since several parties with dissimilar interests are involved in the surrogacy arrangement, controversy about someone's role can arise. The bill draws clear lines to avoid these problems:

- ✚ The donors should relinquish parental rights at the time of donation, and the surrogate mother, shortly after birth.
- ✚ Traditional surrogacy is no longer allowed. The reason for this is that when the surrogate is also the genetic mother the risk of legal complications increases.
- ✚ NRIs and foreign couples are required to assign a local resident who is in charge of the surrogate's welfare until the act of relinquishment
- ✚ For the same group, it is also mandatory to be able to document their ability to take the newborn back to their home country with them (in response to the Manji incident).
- ✚ Interestingly, the bill allows unmarried couples and individuals to engage in surrogacy. However, the bill states that conception by surrogacy is not allowed when the intended parent(s) is able to conceive the natural way. Consequently, an issue arises when it comes to individuals: women have to prove that they are not capable of bearing a child, but on the other hand, men are not required to prove this.
- ✚ The surrogate baby will be recognised as the legitimate child of the commissioning couple even if they divorce or become separated, with the child's birth certificate carrying both genetic parents' names.
- ✚ The surrogate mother may receive monetary compensation from the couple or individual for agreeing to act as a surrogate mother.

Next, the Rules of the Bill assume that ART is being used only by heterosexual infertile couples. So they specify indications for various techniques based on the nature of infertility. The side effects are underplayed as 'ART procedures carry a small risk both to the mother and offspring'. Evidently, the 'risk' is small in comparison to the pain and trauma of infertility. In any case, the issue of fertile women's bodies for egg retrieval or for surrogacy does not figure in the discussion on risk.

The ART Bill has provided for many informed consent forms to be filled and records to be kept. But it does not require that adequate information be given to the surrogate mother about the possible side-effects.

Registration of surrogates with a 'sperm bank' further underlines the fact that the surrogate is seen as just another component of the technology – a womb. This ignores the fact that while donated egg or zygote gets separated from the woman's body, the womb continues to stay inside her and thus has to be looked at differently.

Thus, a Bill that is meant to safeguard the provider and to commissioning couples does not seem to protect the rights of the surrogate. She is the most marginalized and vulnerable one in this triad.

Therefore, surrogacy is both a threat and an opportunity. On the one hand it gives infertile couples and surrogate mothers the possibility to fulfil their desires: a child and the opportunity to take better care of their family respectively. On the other hand there is a risk that with the commodification of children and parenthood, women are exploited and turned into baby producers. Several reasons for and against surrogacy have been given and one cannot easily decide what is morally right and what is wrong. However, both opponents and supporters of surrogacy agree that surrogacy poses a series of social, ethical and legal issues.

Although there are now some rules and regulations in place, not enough is done at a national level to protect the interests of Indian women who serve as surrogate mothers, the children they bear, or those intended parents who travel considerable distances to commission pregnancies. These issues will be addressed in this study. The results will unveil the situation the mothers, parents and children are in and as well as serving as a basis for policy recommendations.

Chapter III

Surrogate Mothers

As surrogate motherhood in technical terms has been defined in many ways, before proceeding to the analysis of data collected from the three areas of study in Gujarat, it is important to outline exactly what the term ‘surrogate mother’ means and how it has been defined in different contexts. Surrogate mother, as defined by the Collins English dictionary is, “*a woman who bears a child on behalf of a couple unable to have a child, either by artificial insemination from the man or implantation of an embryo from the woman*”¹⁰ The Oxford dictionary defines surrogate mother as, “*a woman who bears a child on behalf of another woman, either from her own egg fertilized by the other woman's partner, or from the implantation in her womb of a fertilized egg from the other woman.*”¹¹ The ART Regulation Bill, 2010 defines the “*surrogate mother*” as,

a woman who is a citizen of India and is resident in India, who agrees to have an embryo generated from the sperm of a man who is not her husband and the oocyte of another woman, implanted in her to carry the pregnancy to viability and deliver the child to the couple/individual that had asked for surrogacy.

3.1 Profile of Surrogate Mothers

The women who engage in surrogacy are usually poor. They agree to conceive on behalf of another couple in return for a sum of money that would otherwise take many years to make. It is important to understand that these women generally do not have many career prospects as they are predominately uneducated, often engaged in casual work, sometimes migrants in search of better job opportunities and living in slum areas with inadequate housing facilities. They come from lower middle class backgrounds, are married, and are in need of quick money in order to, among other purposes, maintain their families, buy a house or pay for the children’s higher education or to settle up a business for her unemployed, drunkard husband. The need for money is often felt so deeply that childless couples often negotiate a better price as a result of the competition. There is a growing demand for fair-skinned, educated young women to become surrogate mothers for foreign couples. According to the Economist, fertility clinics pay surrogate mothers between \$4,500 and \$5,000 for

¹⁰ Collins English Dictionary – Complete and Unabridged © HarperCollins Publishers 1991, 1994, 1998, 2000, 2003, <http://www.thefreedictionary.com/surrogate+mother>

¹¹ http://www.oxforddictionaries.com/view/entry/m_en_gb0832950#m_en_gb0832950

carrying a pregnancy, and charge their clients - many of whom come from outside the country - about twice that. The need to protect the interest of the surrogate mother is evident in this situation.

Most women who go for surrogacy insist on anonymity as a result of the social stigma that surrounds surrogacy. Some men, particularly the husbands of surrogate mothers, react to 'encroachment' on their rights. The husbands of surrogates sometimes have problems with their wives' 'occupation'. They feel like their rights are being violated and although initially agreeing to the responsibility, they often change their attitude after they take on their new role. In one particular case the surrogate mother's fiancée left her for another woman, because the husband would not lay eyes on her anymore after she was inseminated. If one digs deeper the surrogates begin to reveal the trauma and turmoil they experienced before plunging into what some of them call the "last decent resort" to earn money. Even doctors in India are divided on this issue. There are those who feel that adoption is the best option for couples unable to conceive. However, most IVF doctors recommend surrogacy with stringent guidelines.

Surrogacy turns the biological ability of a woman's body to reproduce, into a commercial business. Surrogate services are advertised, surrogates are recruited and operating agencies make large profits. The commercialization of surrogacy raises fears of a black market and baby-selling, breeding farms, turning impoverished women into baby producers and the possibility of selective breeding at a price. Surrogacy degrades a pregnancy to a service and a baby to a product. Experience shows that like any other commercial dealing the 'customer' lays down his/her conditions before purchasing the goods.

The surrogate may be forced to terminate the pregnancy if so desired by the contracting couple and she will not be able to terminate it if it is against the desire of the couple. She has difficulty in keeping her own baby. There have been instances where the contracting individual has specified the sex of the baby as well, refused to take the baby if it is not normal, and filed a suite against the surrogate saying she had broken the contract.

The supposed benefits of surrogacy are created by a capitalist patriarchal society. It is assumed that there is an equal exchange – money paid for the service rendered. In reality the contract between the parties to surrogacy would not exist if the parties were equal. The woman must give more than an egg to gestate a child – an important gender difference. Within this framework the contract is always biased in favour of the financially secure male. Therefore, the freedom of the surrogate mother is an illusion. The arbitration of rights hides central social and class issues, which makes surrogacy contracts possible. In addition, bio-ethicists are concerned that Indian surrogates are

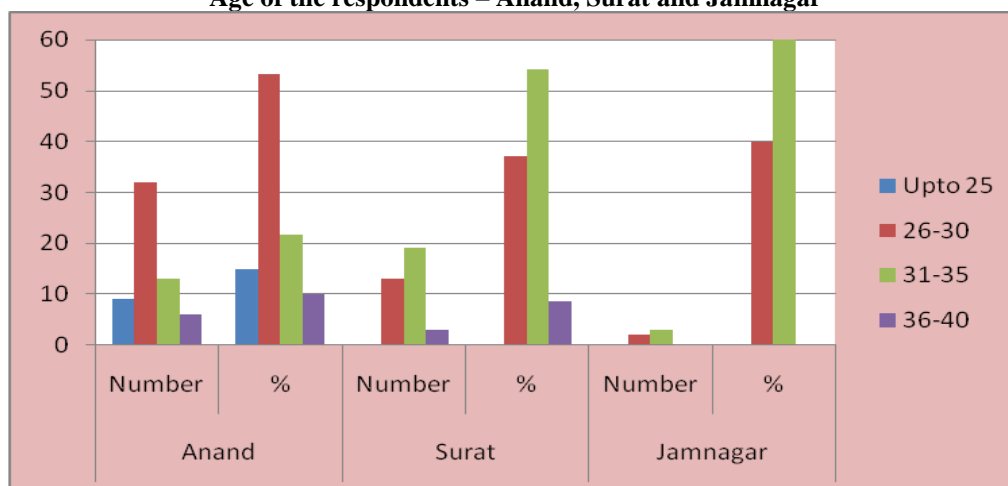
badly paid, and working as surrogates in a country with a comparatively high maternal mortality rate.

Most of the surrogate mothers we interviewed were not willing to answer questions on how they felt after relinquishing the child; however field level observation notes that the surrogate mothers would feel attached to the babies even though they were not biologically their own children.

3.2 Demographic and socio-economic background

The present section deals with the age, religion, educational status, employment scenario, etc. of the surrogate mother to depict a clear picture of the socio-economic background of the study participants.

Figure 3.1
Age of the respondents – Anand, Surat and Jamnagar



From the figure above, it could be ascertained that majority of the surrogate mothers were between the age of 26 and 35. In Anand, 53.33% of the surrogate mothers fell in the 25-30 years age-group categories and 37.14% of them came from 31-35 years age group categories. In Surat, 21.67% of the women belonged to the 25-30 years age group and 54.29% of them came from 31-35 years age group; however in Jamnagar the ratio was 40-60.

Almost all the surrogate women belonged to Hindu religion (86.7% in Anand, 85.7% in Surat and 100% in Jamnagar). Only 5% in Anand and 8.6% in Surat were affiliated to Islam; and 8.3% in Anand and 5.7% in Surat belong to Christianity. Next, most of the surrogate mothers were married; only 3.3% in Anand and 2.9% in Surat were single.

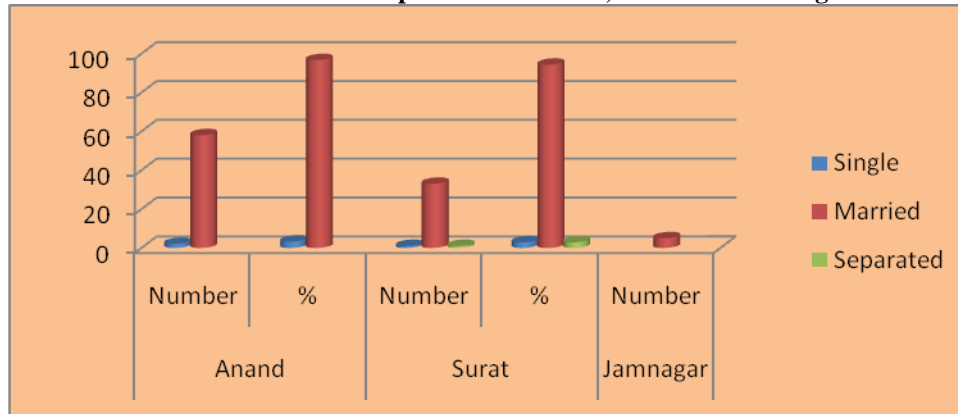
Table 3.1
Religion of the respondents – Anand, Surat and Jamnagar

Sl. No.	Religion	Anand		Surat		Jamnagar	
		Number	%	Number	%	Number	%
1	Hindu	52	86.70	30	85.70	5	100

2	Muslim	3	5	3	8.60	-	-
3	Christian	5	8.30	2	5.70	-	-
	Total	60	100	35	100	5	100

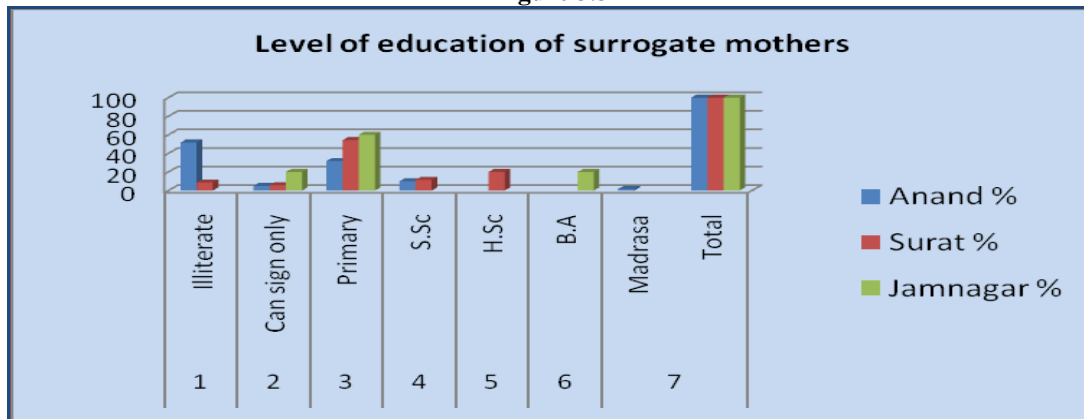
Respondents included widows, persons abandoned by their husbands with children to look after and some who are undergoing mid-wife training while working as nurses in the same hospitals where the surrogacy procedures are carried out.

Figure 3.2
Marital status of the respondents – Anand, Surat and Jamnagar



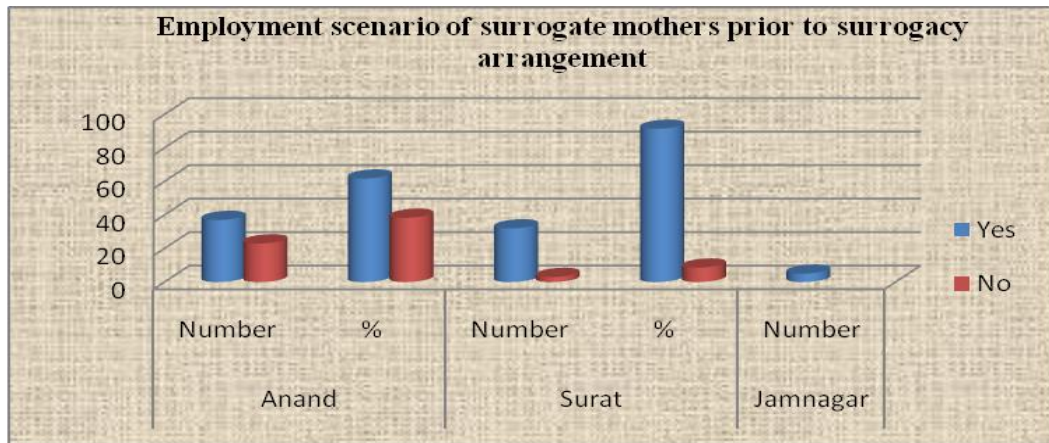
Very few i.e. 2.9% only in Surat are separated from their husbands. On the other hand, 96.7% in Anand, 94.3% in Surat and all the respondents in Jamnagar are married and stay with their husbands.

Figure 3.3



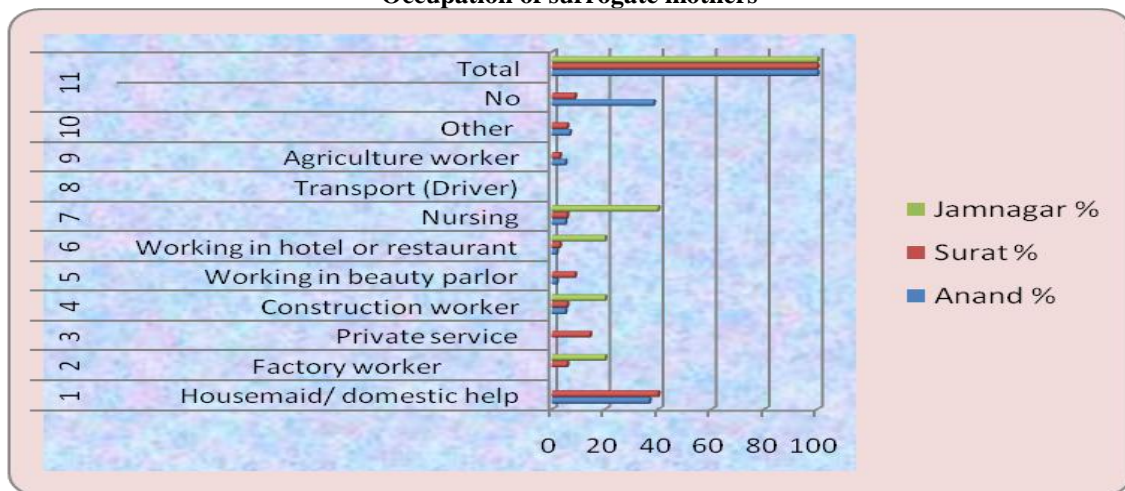
Almost half of the respondents were educated to primary level (31.7% in Anand, 54.3% in Surat and 60% in Jamnagar). However, in Anand around 51.7% of the surrogate mothers are illiterate, which is an important observation as it affects their ability to be involved in gainful employment either in the public or private sector. The majority of the surrogate mothers were employed prior to being a surrogate mother. 61.7% in Anand and 91.4% in Surat were employed. However, 38.3% of them in Anand were unemployed.

Figure 3.4



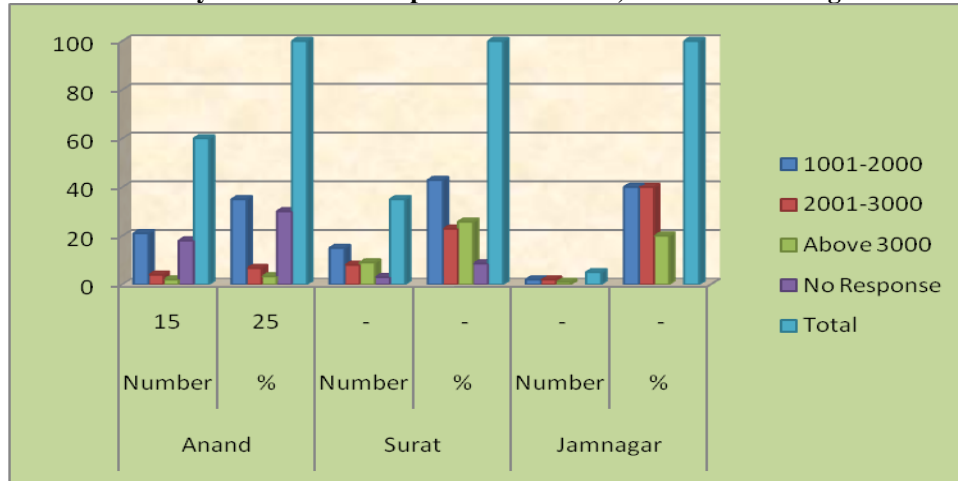
Many of the respondents, who were employed work as housemaids or domestic help in both Anand and Surat (36.7% and 40% respectively). In contrast, 20% of them in Jamnagar were construction workers, another 20% were working in hotels or restaurants and the rest of the 40% were working as nurses or have assisted in the clinic/hospital work as mid wives or casual workers.

Figure 3.5
Occupation of surrogate mothers



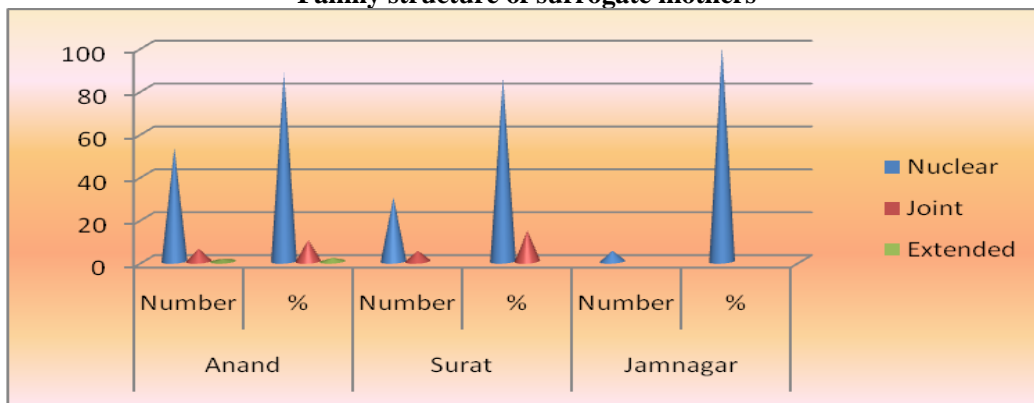
The previous chart shows that in addition to their household chores the majority of the surrogate mothers also contributed economically to their household prior to the surrogacy arrangements. Most of them have a poor economic background and in order to share the burden of the household expenditure both the husband and wife have to work. In some cases, the woman is the sole bread-earner as the husband is an alcoholic or is jobless. However, there is often a desire to earn some money through surrogacy arrangements to pay off debt, buy a house, fund higher education of their children or build up their husband’s business, which prompts them to become surrogate mothers.

Figure 3.6
Monthly income of the respondents – Anand, Surat and Jamnagar



The majority (38%) of the respondents in Anand, Surat and Jamnagar earn within the Rs. 1,000-2,000 category per month. Around 6.67% in Anand and 22.86% in Surat fall under the category of Rs. 2001-3000. However, the overall financial condition of the surrogate mothers in Surat seem better than in another two places; 25.71% of the respondents in Surat earn more than Rs. 3,000 per month whereas this figure goes down to 3.3% in Anand. It should be outlined that as Surat is a textile business centre of Gujarat with proximity to Mumbai and has large migratory population, there are more employment avenues and per capita income is also higher compared to Anand and Jamnagar.

Figure 3.7
Family structure of surrogate mothers

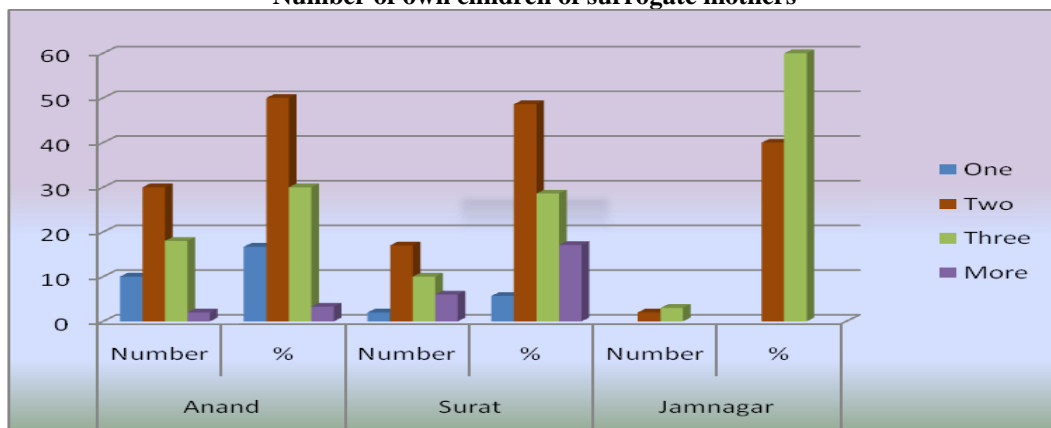


88% of the respondents-surrogate mothers come from nuclear family structure (88.3% in Anand, 85.7% in Surat and all the respondents in Jamnagar). However, 10% of the respondents in Anand and 14.3% of them in Surat are from the joint family structure, and only 1.7% in Anand belongs to an extended family structure. The nuclear family set up allows the couple to take independent decision to be engaged in surrogacy arrangement and the choice to reveal or hide their involvement in surrogacy arrangement from their own family members including their elders. In addition it was also observed that couples in order to tackle immediate financial crisis in the family take this

decision without consulting or seeking the approval of their elders in family who often live either in rural areas or in other states.

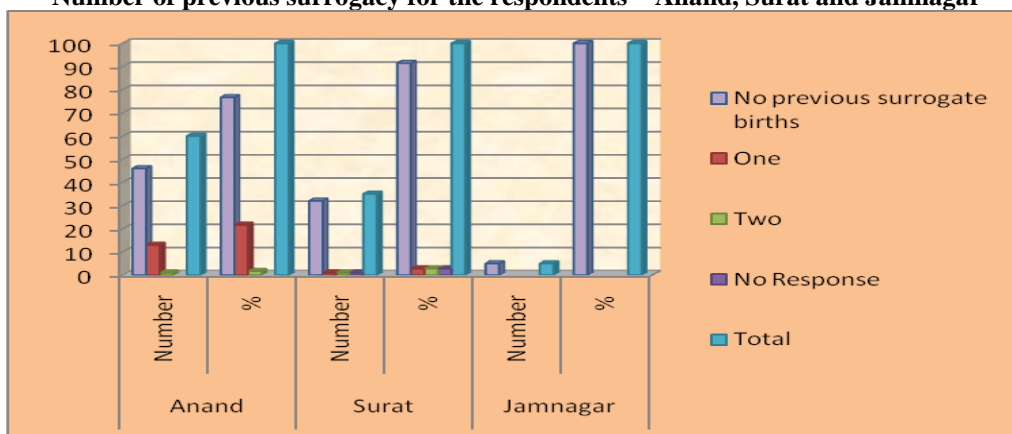
All the surrogate mothers belonged to male- headed household. This fact to a great extent reveals that woman becomes a surrogate mother with her husband’s approval in order to support the family income. Due to the nuclear family structure, majority of the households are comprised of few family members (63.4% in Anand, 42.86% in Surat and 40% in Jamnagar). However, 33.3% of the families in Anand, 54.29% in Surat and 60% in Jamnagar are comprised of 5-8 members.

Figure 3.8
Number of own children of surrogate mothers



It should be noticed that all of the surrogate mothers already have children of their own. The majority of the respondents have two children. For instance, in Anand, 50% of them have two children each while in Surat it is 48.6% and in Jamnagar 60% of the surrogate mothers have two children. While 30% of the respondents in Anand, 28.6% of them in Surat and 60% of them in Jamnagar have three children and 17.1% of the respondents in Surat have more than three children.

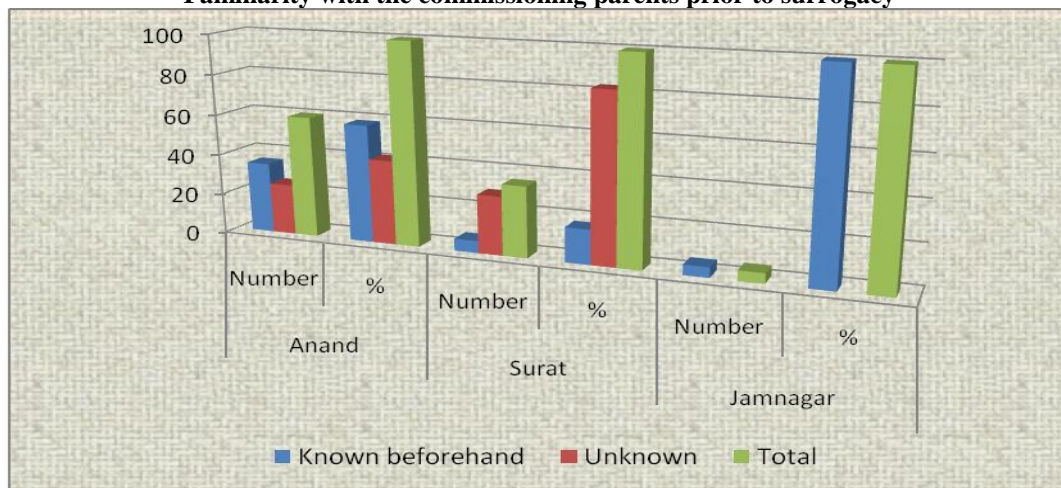
Table 3.9
Number of previous surrogacy for the respondents – Anand, Surat and Jamnagar



As it is depicted in the graph above, the majority of the respondents are experiencing surrogacy for the first time (76.67% in Anand, 91.43% in Surat and 100% in Jamnagar). However, 21.67% in Anand and 2.86% in Surat have already been surrogate mothers. It was also found out that all of the respondents are planning to undergo gestational surrogacy.

The research depicts that 46% of the surrogate mothers knew the commissioning parents before, while 54% of them did not know the intended parents prior to surrogacy arrangements. 58.3% of the surrogate mothers in Anand said that they already knew the commissioning parents before, whereas 17.14% in Surat and all the respondents in Jamnagar replied in the negative. However, 41.7% in Anand and 82.86% in Surat replied that they did not know the commissioning parents before.

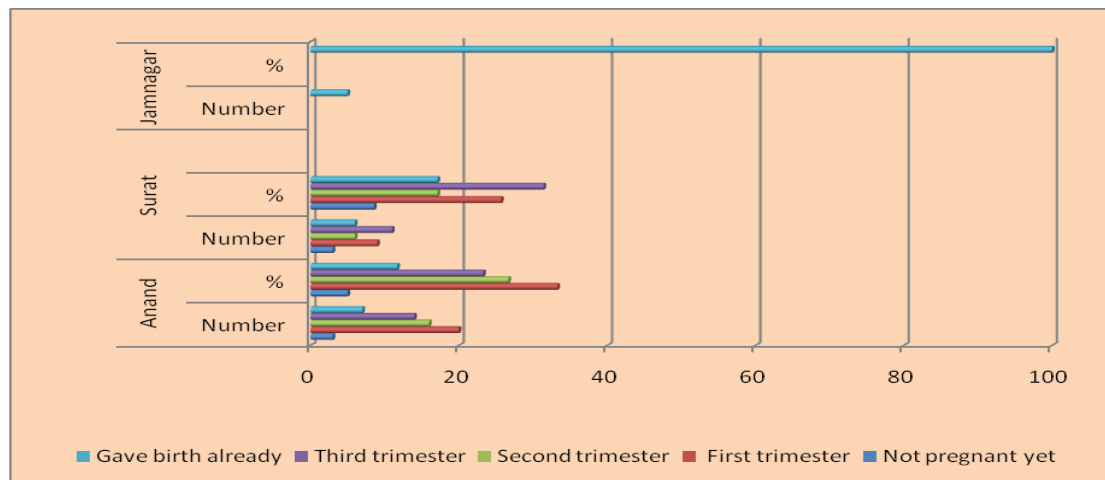
Figure 3.10
Familiarity with the commissioning parents prior to surrogacy



It should be noticed that *'knowing'* the commissioning parents does not mean having familiarity or sharing friendship, etc. but it implies just knowing them by face and name, as far as language is also a barrier for communication between the surrogate mothers and the commissioning parents. In addition, the doctors or their subordinates were always around who seemed to be a barrier for one-to-one communication between the two parties in the surrogacy arrangements. Another crucial factor is that since no one knows which fertilized egg is going to match with which of the supposed-to-be surrogate mothers womb till the end of first two months when the pregnancy is confirmed and the commissioning parents are asked to come to India to sign the contract, it is difficult for the surrogate mothers to meet or know the intended parents before. In fact, during the field visits and after speaking to both the surrogate mothers and the commissioning parents it was found out that in majority of cases, both the parties, get to know each other during the signing of contract.

Most of the interviewed surrogate mothers (76%) were already pregnant at the time of the interview. (All of the respondents in Jamnagar, 11.7% in Anand and 17.14% in Surat have already given birth, 33.3% in Anand and 25.71% in Surat are in their first trimester, 26.7% in Anand and 17.14% in Surat are in their second trimester and 23.3% in Anand and 31.43% in Surat are in their third trimester).

Figure 3.11
Stage of pregnancy



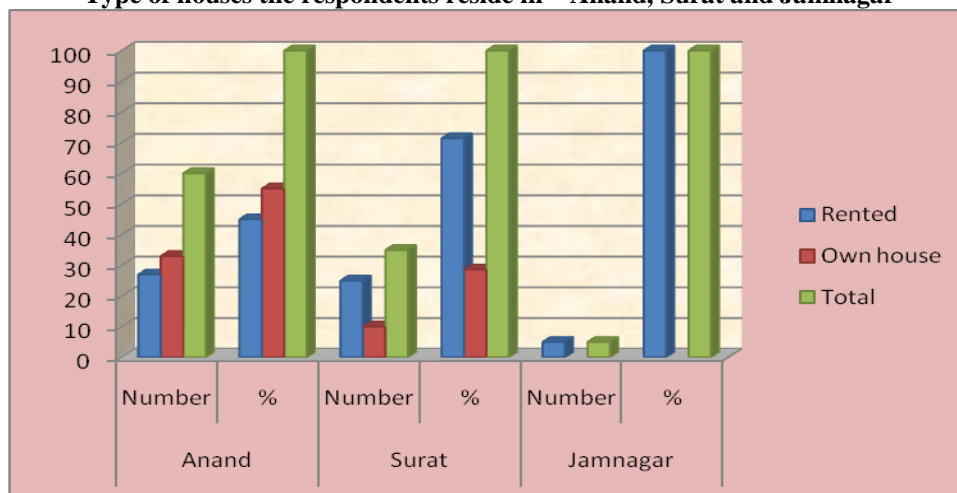
We also interviewed 3-5 of the supposed surrogate mothers, who were undergoing IVF sessions. We asked them similar questions pertaining to decision-making regarding surrogacy, factors responsible for this decision, their psycho-social condition and their preparedness to live in shelter homes during the pregnancy. The responses we received depicted that they had been through the IVF sessions 10 to 20 times till they get pregnant and the survival chances of the foetus they carry is ensured by the doctor/s of the clinic. It is worth to notice that although, the doctors and the hospital staff told us that the women who come for IVF sessions under the surrogacy arrangements are provided with transportation, shelter and food for them and their family members accompanying them when they are required to come and stay in the hospital, our research team did not witness any of these arrangements for these supposed surrogate mothers in the hospital. Moreover, many of them shared with us that they had to come to the hospital in the early morning by bus with their husbands, who are often daily wage earners and lose that day's wages. They also mentioned their concerns of leaving their children either at school or back at home, where the children wait for their parents to come back with some food. The respondents shared that the IVF procedure very often left the women exhausted. It was difficult for the respondents even to sit on the plastic chairs of the hospital after the IVF procedure as it was very painful. Moreover, is it in coherence with the MTP Act of 1961?

3.2.1 Housing and other facilities

To understand the socio-economic profile of the surrogate mothers and to locate one of the triggering factors, which compelled them to undergo surrogacy arrangements, we administered a set of questions in three cities under our current study. Majority of the surrogate mothers (57%) stayed in rented houses and 43% stayed in their own houses. 45% in Anand, 71.4% in Surat and all the respondents in Jamnagar stayed in rented houses. However, 55% of respondents in Anand and 28.6% respondents in Surat stayed in their own houses, while 28% of the respondents stayed in

kutchha houses, 40% stayed in semi-*pucca* houses and 31% stayed in *pucca* houses in all of the three cities under the study.

Figure 3.12
Type of houses the respondents reside in – Anand, Surat and Jamnagar



In Anand, 33.3% of the surrogate mothers stayed in *kutchha* houses, 41.7% stayed in semi-*pucca* houses and 23.3% of the respondents stayed in *pucca* houses. In Surat, 17.1% stayed in *kutchha* houses, 40% of them stayed in semi-*pucca* houses and 42.9% of them stayed in *pucca* houses. In Jamnagar, 40% of them stayed in *kutchha* houses, only 20% of the respondents stayed in *pucca* houses and the rest of the 40% stayed in semi-*pucca* houses. Majority of the respondents in Anand (55%) and Jamnagar (60%) had *kutchha* latrine facility in their houses. However, 26.67% of the respondents in Anand, 68.57% of the respondents in Surat and 40% of the respondents in Jamnagar had sanitary latrines.

The majority of the surrogate mothers fetch drinking water from the tube well (76.7% in Anand, 80% in Surat and all the respondents in Jamnagar); only 23.3% of the respondents in Anand and 20% of them in Surat have access to the supply water. Almost all the respondents replied that they have access to electricity (98.3% in Anand, and all the respondents in each of Surat and Jamnagar).

3.3 The surrogacy decision

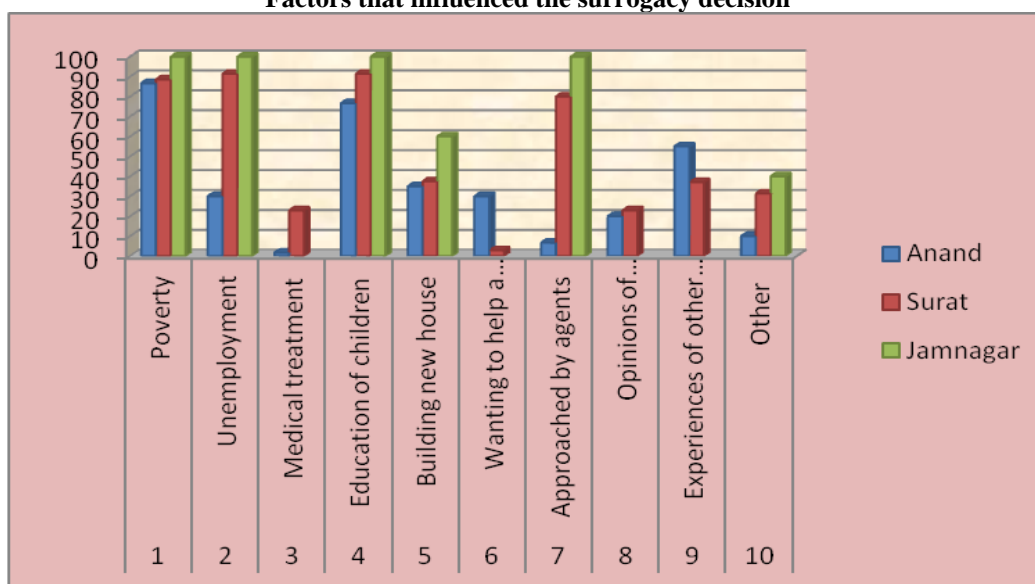
This section is outlining the surrogacy decision-making process. It should be mentioned that surrogacy is looked upon as a stigma and a taboo, hence, to make life-changing decision to go for surrogacy is quite difficult. There are some triggering factors including, poverty, unemployment and education of the children, which compel them to become the surrogate mothers. However, the Gujrat Panchayats Act, 1993, envisages the responsibility of health committees to look after the health needs of each panchayat. Are they ensuring informed consents of women in pockets prone to surrogacy arrangements to enter into surrogacy arrangements?

Table 3.2
Factors that influence surrogacy decision

Sl. no	Factors that influence the surrogacy decision	Anand	Surat	Jamnagar
		%	%	%
1	Poverty	86.7	88.6	100
2	Unemployment	30	91.4	100
3	Medical treatment	1.7	22.9	
4	Education of children	76.7	91.4	100
5	Building new house	35	37.5	60
6	Wanting to help a childless couple	30	2.9	
7	Approached by agents	6.7	80	100
8	Opinions of relatives/friends	20	22.9	
9	Experiences of other surrogate mothers	55	37.1	
10	Other	10	31.4	40

The table above depicts that 86.7% of the respondents in Anand and 88.6% of them in Surat stated that it is poverty that has driven them to take the decision. However, 91.4% of the respondents in Surat said that the main reason for them is unemployment. Further, for 76.7% of the surrogate mothers in Anand, 91.4% of them in Surat and all the respondents in Jamnagar, stated that education of their children has been another driving factor to opt for becoming a surrogate mother. Around 55% in Anand and 37.1% in Surat are also influenced by the experience of other surrogate mothers. The majority of the respondents in Surat (80%) and Jamnagar have also been approached by the agencies or clinics to become surrogate mothers.

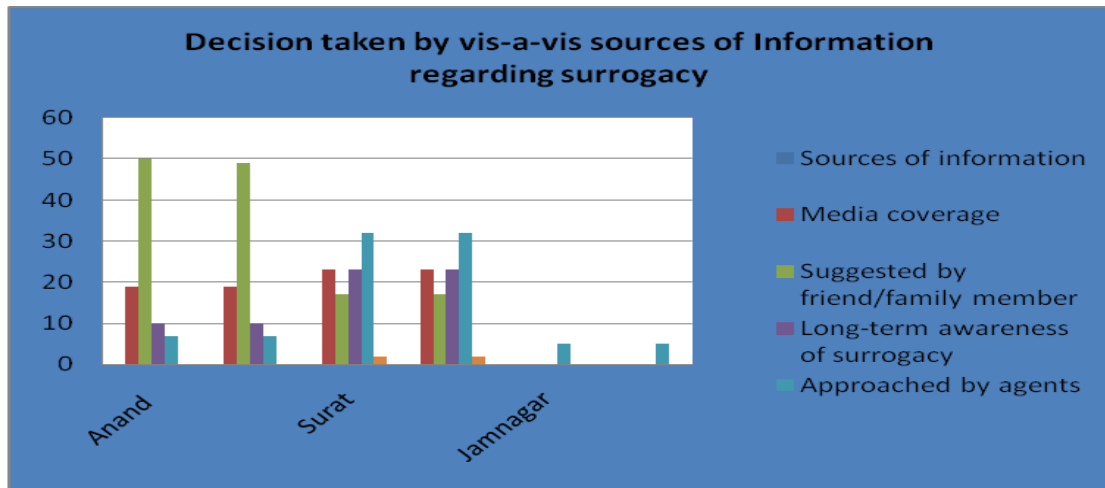
Figure 3.13
Factors that influenced the surrogacy decision



The research study depicts that 31.7% of the surrogate mothers and 65.7% of them in Surat came to know about surrogacy through media coverage. However, in many cases, suggestions from family and friends have also helped to gain more information about surrogacy (86.7% in Anand and 48.6%

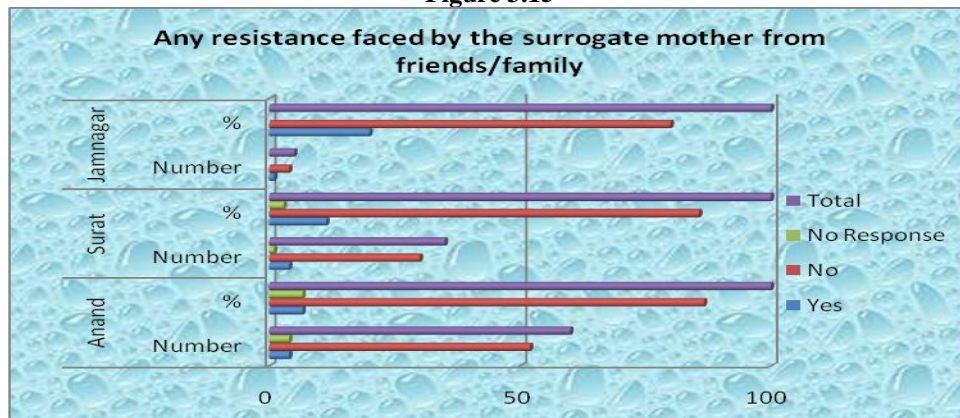
in Surat). All of the respondents in Jamnagar and around 91.4% of them in Surat have been approached by the surrogacy clinics or agencies. In most of the cases the surrogate mothers have taken the decision on their own, but with the support from their respective husbands.

Figure 3.14



If we look at the graph above, we can find that that most of the times the decisions related to surrogacy were suggested and influenced by friends and family members or were approached by the agents. The friends were mostly referred by the respondents as the ones who had been surrogate mothers themselves in the past. Since the matter is looked at as a social stigma it is kept within the four wall of the house and the most often consulted member of the family is the husband. We have already observed in Table 3.4 that the majority of the surrogate mothers come from nuclear families. Hence, there is no need of sharing the decisions related to surrogacy with extended family members. Though the respondents told us that the decision to become a surrogate mother was taken jointly by both the husband and wife, we found that it was the husband who emotionally pressurized the wife to undergo surrogacy in order to buy a house (as most of them live in rented *chawls*) or to set up a garage or to start a business for family maintenance.

Figure 3.15



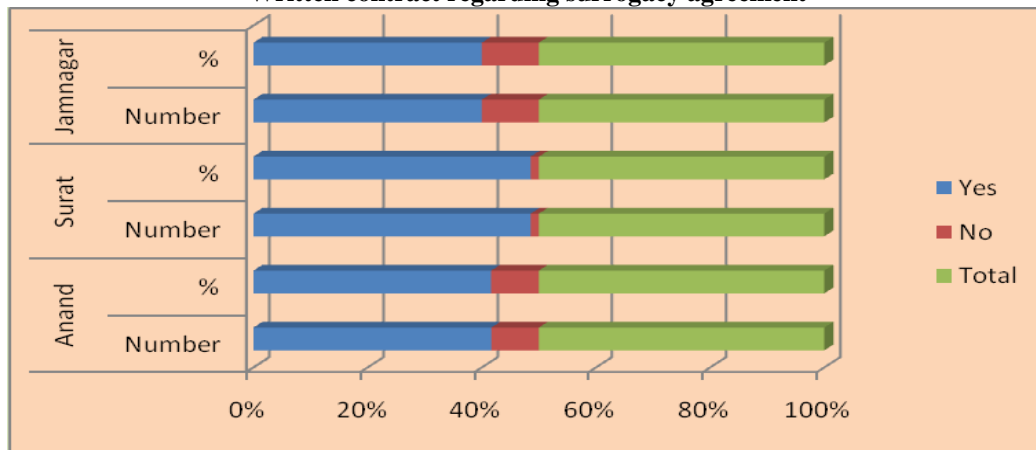
Very few of the surrogate mothers stated that they faced any resistance from family and friends; 86.67% in Anand, 85.7% in Surat and 80% of the respondents in Jamnagar said that they faced no

resistance from their family and friends. For those respondents who said that they faced resistance from family and friends, the resistance was often coming from the husband (6.7% of the respondents in Anand, 5.7% in Surat and 20% in Jamnagar), or from in-laws (8.6% in Surat).

3.4 The surrogacy birthing arrangement

The majority (88%) of the surrogate mothers stated that surrogacy agreement between all the involved parties takes place in the form of a written contract (83.3% in Anand, 97.1% in Surat and 80% in Jamnagar). The remaining respondents were found to be waiting for the contract to be signed by both the parties (the surrogate mother and the commissioning parents) as the clinics normally prefer to prepare and sign the agreement when the pregnancy is confirmed by the end of the first trimester till the middle of the 4th month of pregnancy. Further, they (the clinics and the doctor) prepare the document and inform/request the commissioning parents to come to India to sign the document. 40% of the contracts were found to be signed around the second trimester of the pregnancy as it takes one to two months more for the commissioning parents to arrange their visit to India after being informed about the confirmation of pregnancy of the surrogate mother by the clinic/infertility physician.

Figure 3.16
Written contract regarding surrogacy agreement



However, there are many questions which remained unanswered relating to what if the pregnancy is not continued beyond two months? What if the pregnancy has to be aborted due to the abnormality in the foetus around the end of first trimester when the contract is still not signed by both the parties? When the doctors and respective people in the clinics were asked these questions they responded non-verbally with uncomfortable gestures. The delay in signing the contract puts the surrogate mother at the mercy of the clinic, doctor and the commissioning parents.

The nature of the contract, for most of the surrogate mothers is a bonded paper on which the agreement would take place (86.67% in Anand, 97.1% in Surat and all the respondents in

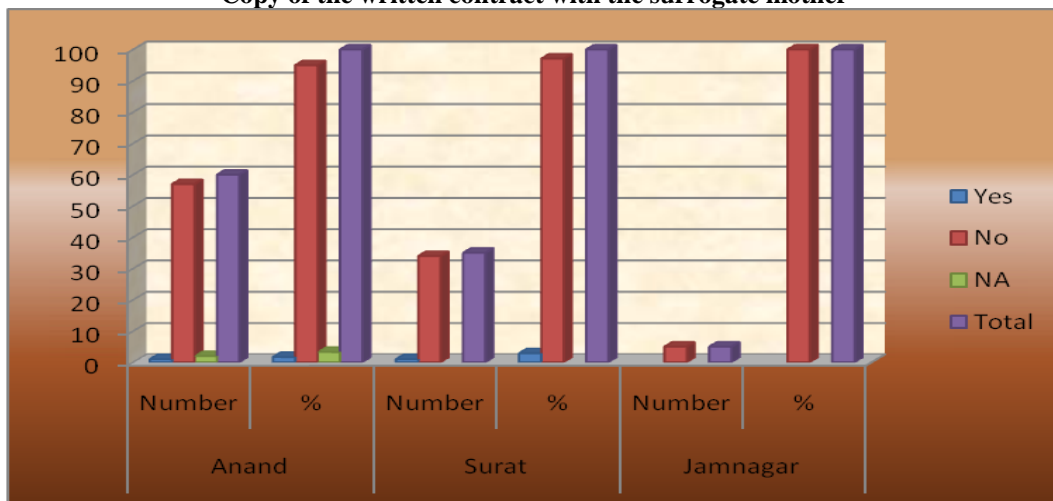
Jamnagar). We gathered evidence of such contracts during our research investigation process. One of the samples can be viewed below.

Figure 3.17
Sample surrogacy agreement/contract paper



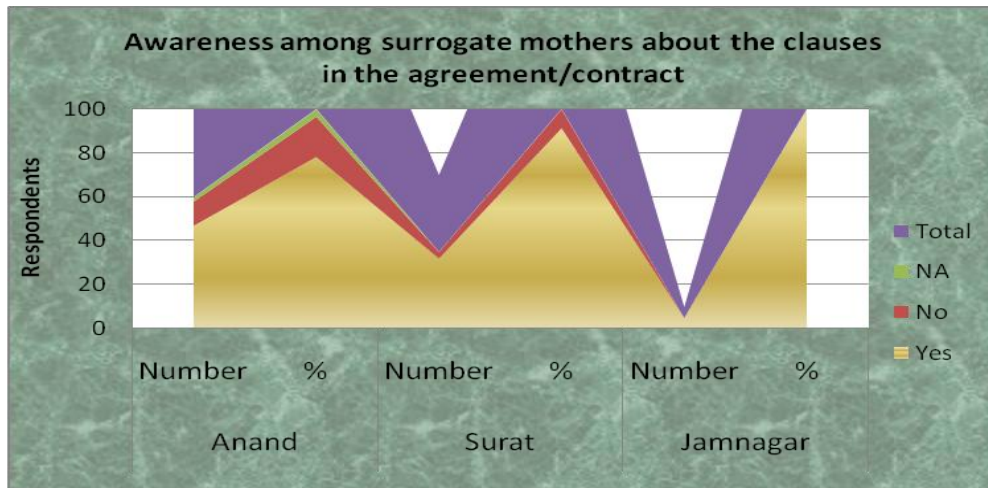
This is a Rs. 50/- bond paper. Often, the surrogate mother is unable to read or write, hence, she and her husband are told about the contract by the hospital/clinic authorities in suitable language and terms, which the surrogate mother cannot verify by any means. She has to sign the agreement as she is already 4 months pregnant and being poor has great financial expectations exaggerated by the hospital/clinic authorities/doctors. The surrogate mothers are completely been ‘brain-washed’ that they would be getting huge sum of money at the end of the road. In such a way, there is a need of legal provisions relating to surrogacy arrangements. It should be mentioned that due to the absence of such a law the surrogate mother suffers most as she is exploited not only physically, but also emotionally.

Table 3.18
Copy of the written contract with the surrogate mother



The research findings revealed that the majority of the surrogate mothers have not received any copy of the contract. Surprisingly, only two surrogate mothers in Anand and Surat respectively stated that they got a copy of the contract.

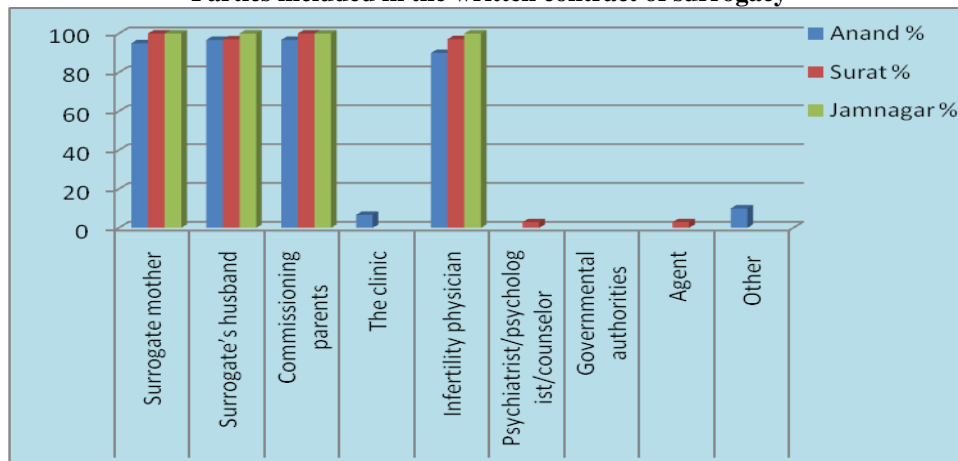
Figure 3.19



Furthermore, the majority of the surrogate mothers said and felt that they were fully aware of all the clauses of the contract (78.33% in Anand, 91.4% in Surat and 100% in Jamnagar). However, when the research team questioned the respondent surrogate mothers about certain clauses of the agreement, they could not answer. On cross reference to this the hospital/clinic authorities, responsible to give the information to the surrogate mothers, stated that the expectant surrogate mothers might have ‘forgotten’ what had been ‘told’ to them during the process of signing the agreement. In addition the fact that in Anand itself around 51.7% of the surrogate mothers are illiterate and 50% of the total respondents had acquired a primary education only, reflects that in most of the cases the hospitals/clinics/doctors were narrating the content of the agreement to the surrogate mother before signing it. First of all, it leaves a wide scope for avoiding any unpleasant thing to be told to the surrogate mother by the hospitals/clinics/doctors which in future could be used against her interest. Secondly, since the surrogate mother is already four months pregnant at the time of contract signing, she has no option left other than sign the contract and agree to what has been ‘explained’ to her by the hospitals/clinics/doctors.

Figure 3.20

Parties included in the written contract of surrogacy



The *Figure 3.20* depicts that the contract almost in all cases includes the surrogate mother (95% in Anand and 100% in each of Surat and Jamnagar), the surrogate’s husband (96.7% in Anand, 97% in Surat and 100% in Jamnagar), the commissioning parents (96.7% in Anand and 100% in each of Surat and Jamnagar) and the fertility physicians (90% in Anand, 97.1% in Surat and 100% in Jamnagar). According to this graph, nowhere any of the government authorities are part of the contract/agreement and in very few cases, clinics or agents are part of the contract. Under the ‘other’ category, we found two witnesses signing the contract. These two witnesses might be the doctor’s spouse who is the co-owner of the clinic/hospital, parents of the doctor who herself is a practicing doctor, mid-wives with prior record of being surrogate mothers themselves, nurses/caretakers, etc. Thus, the surrogate mother, her husband, commissioning parents, the doctor and the witnesses were found to be the main signatory.

As it was discussed earlier, in 50% to 60% of cases the surrogate mothers and their husbands were illiterate or with primary education which leaves no chances for them to understand the medical jargons or complicated procedures that might affect the health and well being of the surrogate mother. The clinics often avoid signing such written agreements/contracts, which can hold them accountable in future. Moreover, the clinics even did not leave a copy of the agreement with the surrogate mother, who is a signing party in the agreement, to have any evidence either of her pregnancy or the surrogacy arrangement.

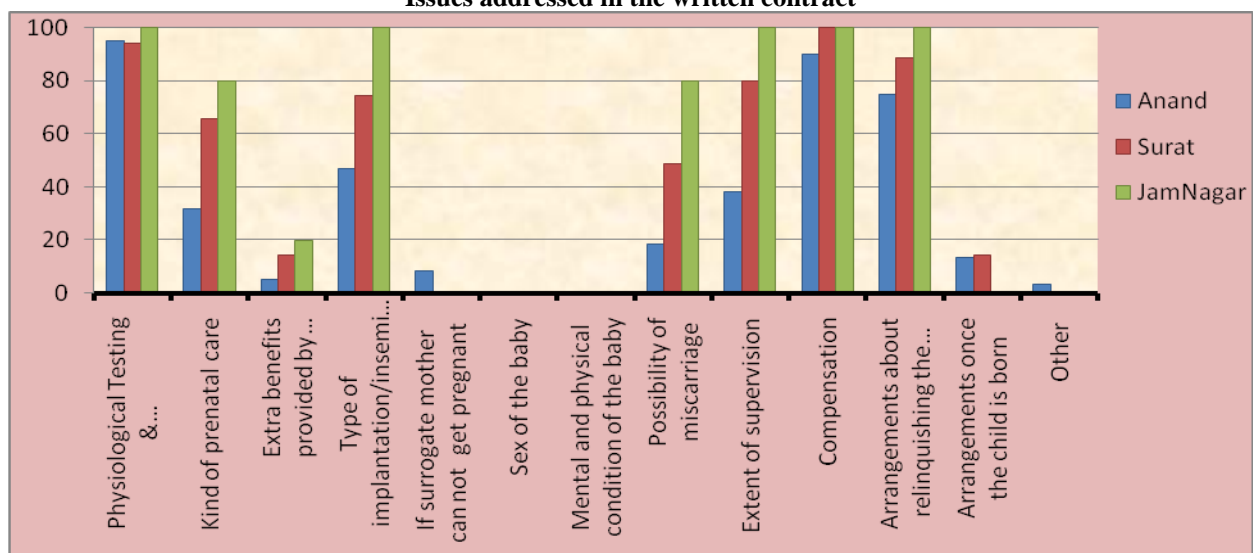
Table 3.3
Issues addressed in the written contract

Sl. no	Addressed issues	Anand	Surat	Jamnagar
		%	%	%
1	Physiological Testing & Psychiatric/ Psychological Evaluation and the release of the results	95	94.3	100
2	Kind of prenatal care	31.7	65.7	80
3	Extra benefits provided by commissioning parents	5	14.3	20
4	Type of implantation/insemination; number of tries	46.7	74.3	100
5	What if surrogacy mother cannot get pregnant	8.3		
6	Sex of the baby			
7	Mental and physical condition of the baby			
8	Possibility of miscarriage	18.3	48.6	80
9	Extent of supervision	38.3	80	100
10	Compensation	90	100	100
11	Arrangements about relinquishing the child	75	88.6	100
12	Arrangements once the child is born	13.3	14.3	
13	Other	3.3		

The priority issues in the contract include the compensation of the surrogate mother (95% of the respondents in Anand and 94.3% respondents in Surat) and the arrangements of relinquishing the

baby after birth (75% of the respondents in Anand, 88.6% respondents in Surat and 100% respondents in Jamnagar). Also, the type of implantation/insemination to be applied to the surrogate (46.7% of the respondents in Anand, 74.3% respondents in Surat), the number of times for which she can be tried for surrogacy and the detail of the physiological tests and psychological evaluation (95% of the respondents in Anand, 94.3% respondents in Surat and 100% respondents in Jamnagar) and their results are also enlisted in such contract. Very few of the contracts mention about the provision of any extra benefit provided by the commissioning parents to the surrogate mother etc. Furthermore, there is no mention about the payment of the surrogate mother in case twins are born which happens in 75% of cases as shared by the surrogate mothers.

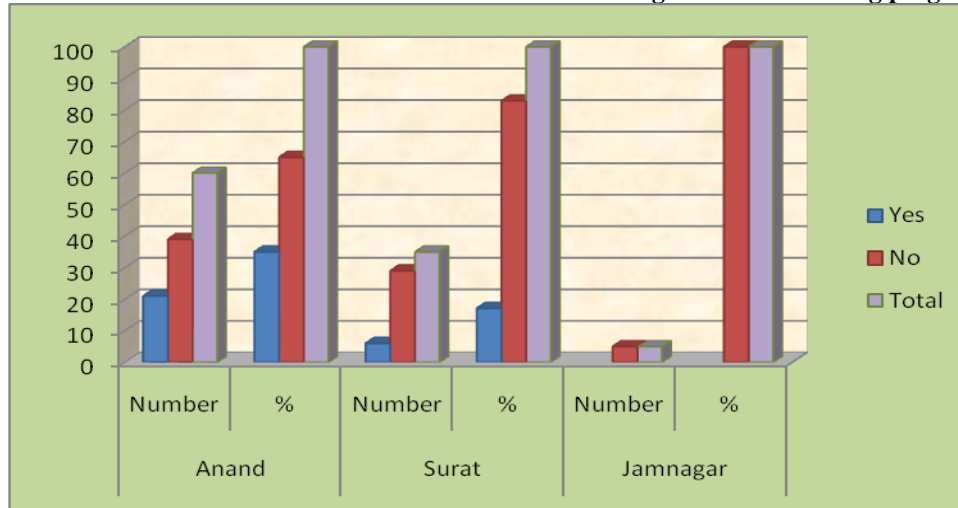
Figure 3. 21
Issues addressed in the written contract



Moreover, though the respondents and the hospital/clinic authorities answered that there was a mention of the number of times the surrogate mother could undergo for the surrogacy arrangement, there was absolutely no mention about how many times she could be injected (IVF sessions). This was discussed under the *Figure 3.11* in the previous section of this report. It has been found that the supposed surrogate mothers undergo 20 to 25 times IVF sessions for being impregnated with a healthy foetus to become surrogate mothers which is also banned under the ART guidelines. The reality does not favour the surrogate mothers who are always at the receiving end for being poor, illiterate/semi-literate and in need of immediate fortune.

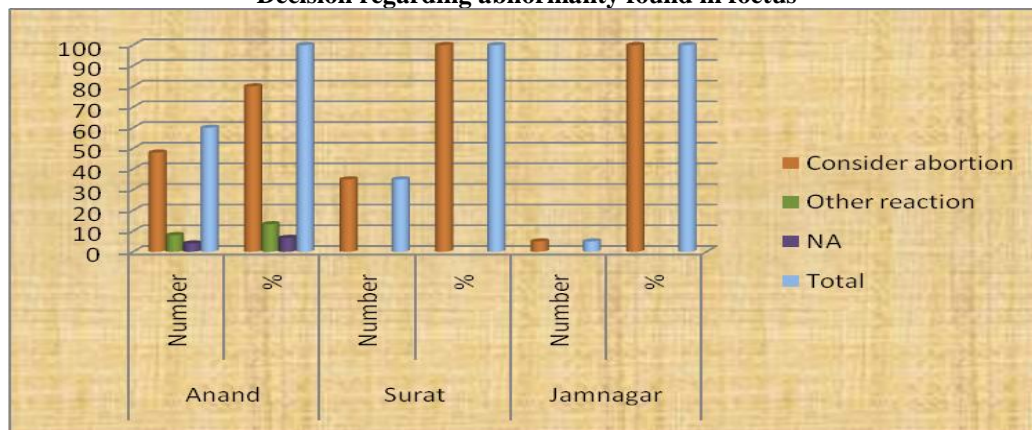
73% of the responding surrogate mothers stated that sex determination tests are not conducted (65% of the respondents in Anand, 82.9% respondents in Surat and all the respondents in Jamnagar) in the surrogacy arrangement. However, the research team found that normally a surrogate was injected with five or more healthy embryos out of which three embryos survive in most of the cases. Out of these three embryos, it is normally found that two are female fetuses and one is a male foetus.

Figure 3. 22
Whether sex determination tests are conducted on the surrogate mothers during pregnancy



Thus, around the fifth month of pregnancy, if the commissioning parents want twins, then the third foetus (in most cases one of the female fetuses) is eliminated through a procedure called Selective Fetal Reduction technology and the surrogate mother is given a stitching. Hence, sex selective preferences are being conducted under the surrogacy arrangements and the surrogate mother may not be aware about it as it is rarely shared with her.

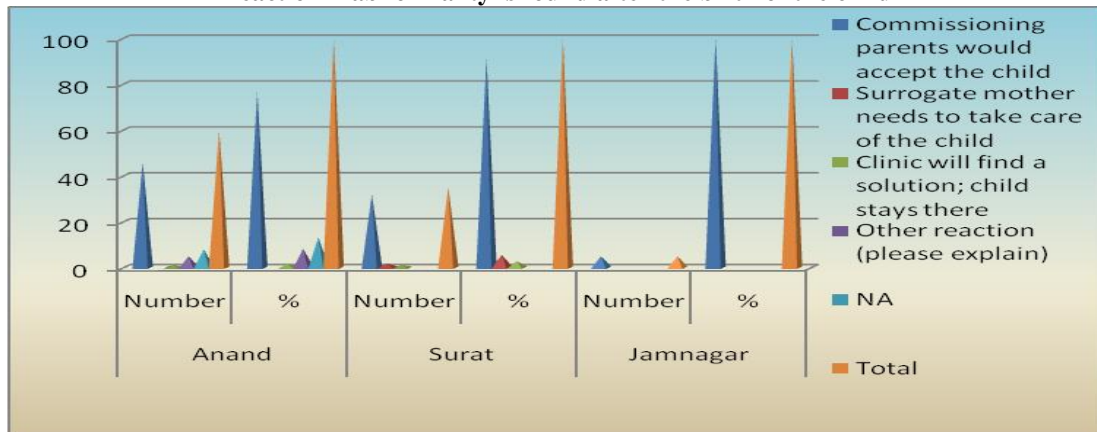
Figure 3.23
Decision regarding abnormality found in foetus



The majority of the respondents (88%) said that in case of undesirable results, such as a foetus with abnormality/Down Syndrome, etc., diagnosed by ultrasound and Colour Doppler tests, they (the surrogate mothers) opt for abortion (80% of the respondents in Anand and all the respondents in each of Surat and Jamnagar). But, if the surrogate mothers get any compensation for that or not is unclear, though the hospital/clinic authorities always claim that they pay the surrogate mothers one third of the total promised amount. Moreover, it has been found during interviews that in case of an abnormality in the foetus the decision regarding the continuation of pregnancy is rarely taken jointly by all the three concerned parties (the surrogate mother, the commissioning parents and the clinics) (5% of the respondents in Anand and 8.6% of the respondents in Surat). In most of the cases, the decision regarding abortion, was taken solely by the commissioning parents (86.7% of the

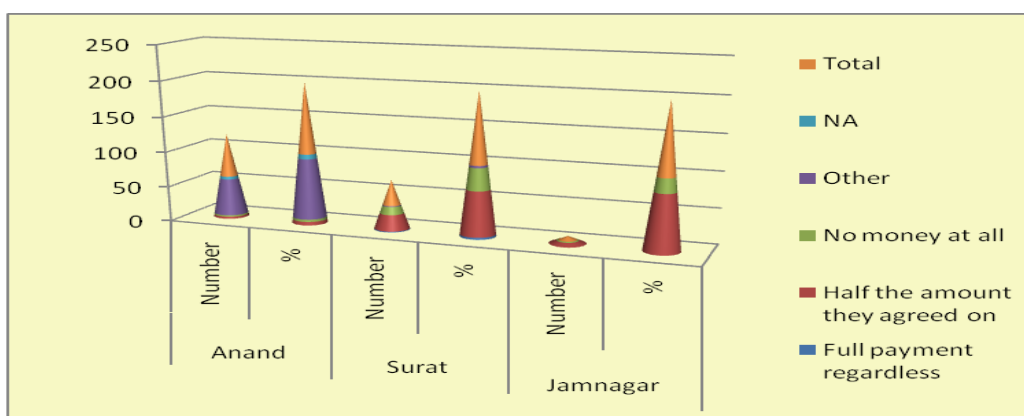
respondents in Anand and 91.4% of the respondents in Surat), or the clinics (36.7% of the respondents in Anand, 82.9% of the respondents in Surat and 80% of the respondents in Jamnagar).

Figure 3.24
Reaction if abnormality is found after the birth of the child



However, regarding the ‘other reactions’ mentioned in the *Figure 3.19*, according to most of the surrogate mothers, the commissioning parents would still accept the child in spite of the abnormalities of the child (76.7% of the respondents in Anand, 91.4% of the respondents in Surat and all the respondents in Jamnagar). Although this expression was completely hypothetical, yet, it reflects the thought of surrogate mothers who realizes the desperation of the Commissioning parents. Even some of the surrogate mothers expressed that they will accept the child if the commissioning parents or the clinics/doctors refuse to take care of the child irrespective of the fact that they have their own children and poverty to fight with. This reflects the emotional bondage between the fetus and the surrogate mother.

Figure 3.25
Financial provision for surrogate mothers if the pregnancy was terminated



The clinic/hospital authorities claim that in case the commissioning parents refuse to accept the child or the pregnancy is aborted due to some reasons, the surrogate mother is often paid half of the amount of what she was supposed to get under normal circumstances (62.86% of the respondents in Surat and 80% of the respondents in Jamnagar). However, in Anand the respondents were not certain about the payment and repeatedly mentioned that the chances of abnormality in the foetus

were ruled out before the first trimester and before the signing any agreement with the Commissioning parents.

Regarding one of the most crucial factors i.e. payment received by the surrogate mothers under the surrogacy agreement/contract, in Anand, majority of the surrogate mothers (91.67%) mentioned that they received between Rs. 3-3.99 lakhs for being a surrogate mother. However, in Surat, around 74.29% said that they received between Rs. 2.1-2.99 lakhs; and in Jamnagar all the respondents said that they received up to Rs. 2 lacs for being surrogate mothers. One lakh is equivalent to US \$1,914.60 approximately.

Table 3.4
Amount of money received by Surrogate mother

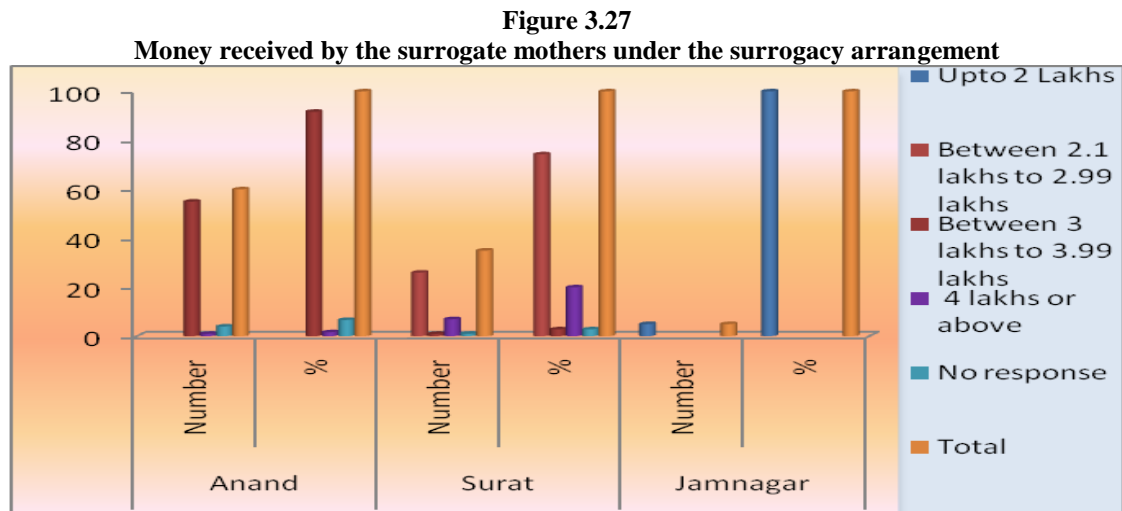
Sl. no	Money received by Surrogate mother	Anand		Surat		Jamnagar	
		Number	%	Number	%	Number	%
1	Upto 2 Lakhs					5	100
2	Between 2.1 lakhs to 2.99 lakhs			26	74.29		
3	Between 3 lakhs to 3.99 lakhs	55	91.67	1	2.86		
4	4 lakhs or above	1	1.67	7	20		
5	No Response	4	6.67	1	2.86		
	Total	60	100	35	100	5	100

It may be cited here that there are certain doubts regarding the payment to the surrogate mothers. The doubts are pertaining to the incoherence found between the amount quoted by the clinic/hospital authorities, the commissioning parents who are actually paying and the surrogate mothers who are at the receiving end. The payments to the surrogate mothers are arbitrarily decided by the infertility physician of the clinic/hospital in all cases. It was found that these clinics/physicians also blame each other for the rise in amount paid to the surrogate mothers.

Similarly, there is no clarity about the payments in case if the surrogate mothers were pregnant with twins. It is a normal practice that when the doctor finds out about twin pregnancy of the surrogate mother, s/he consults the commissioning parents, who in most cases are happy to be parents of twins and want to continue with the pregnancy. The deal is then forwarded to the surrogate mother, during four to five months of pregnancy, when later is not in a favorable situation to bargain with the infertility physician for extra payment for the second child. While logically the payment should be doubled for twin children; in this case, she is been paid just 1 lakh to 1.5 lakh more. Hence, it is not a major gain for the surrogate mother. While commercialisation of surrogacy is encouraged by IVF clinics and doctors associated with it, it is often found that they are the ones who walk out with the maximum benefits in monetary terms rather than the surrogate mother.

All the respondents in Jamnagar and 37.1% of the respondents in Surat said that they would receive the payments after relinquishing the baby; however, 95% of the respondent surrogate mothers in

Anand, the compensation was paid at different points of time (through installments) during their pregnancy.



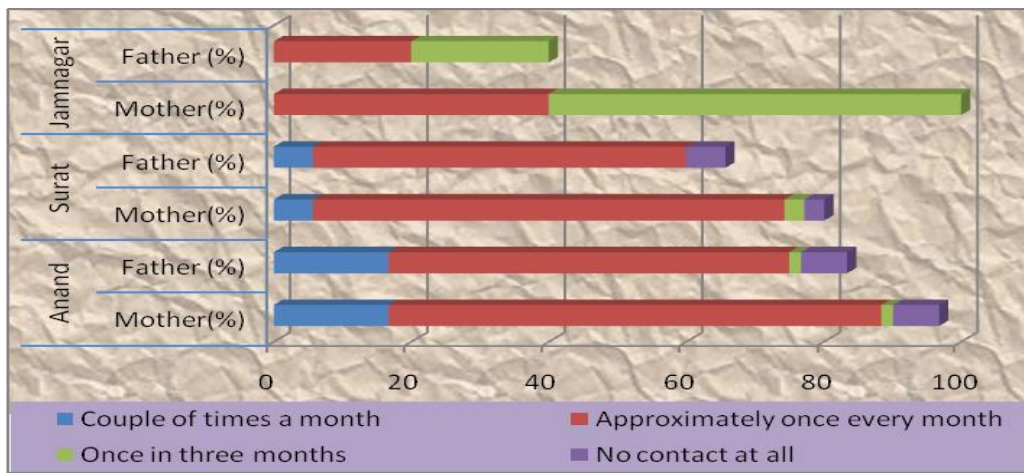
Though the hospital authorities in all study areas claimed that they have significantly changed the life style of the poor surrogate mother by paying her the compensation in terms of buying a new house or paying for her children’s higher education or adding money for their daughter’s marriage, etc. which we have already discussed under the *section 3.3* of Surrogacy decision as which are the driving factors for a woman to become surrogate mother, the research team, in reality, could not find any significant changes in the lives of surrogate mother in any of the study areas. Of course, they are getting little monetary benefit and their children have two square meals with that for some days and they could attach a plastic sheet as the roof to their hatchment, but, that’s all. A single ‘Janta’ house in any of the study area costs more than what the surrogate mother gets as compensation for surrogacy. The entry-level fees to any higher education institution are almost parallel to what the surrogate mother is getting as compensation. Similarly, it is needless to say that the wedding expenses and dowry are costlier than the amount paid to surrogate mothers. Therefore, it is time to rethink if the surrogacy arrangement is really benefiting the surrogate mothers.

Another issue that needs to be highlighted is whether the payment received by the surrogate mother actually improves the socio economic status of her family. It was found out during the study that during the surrogacy process, while the surrogate mothers are in shelter home, the payment made to them either in installments or entire amount, is coaxed by their husbands who spend it on alcohol or use it for setting up business which in most cases does not take up. Thus, when the surrogate mother gets back to her house from the shelter home, after the completion of the surrogacy, she has little money left to take care of her children and herself.

3.5 Experiences before and during pregnancy

A lot of emphasis needs to be given to the experience of the surrogate mothers which depends on a number of factors including their relationship with the Commissioning Parents, their place of stay, relationship with their husbands before and during pregnancy, management of their home and children in their ‘absence’, emotions felt during pregnancy for the baby, etc. So, the present section deals with such critical issues to weigh the pros and cons of surrogacy arrangement.

Figure 3.28
Frequency of contact between the surrogate mother and the commissioning parents during the first trimester



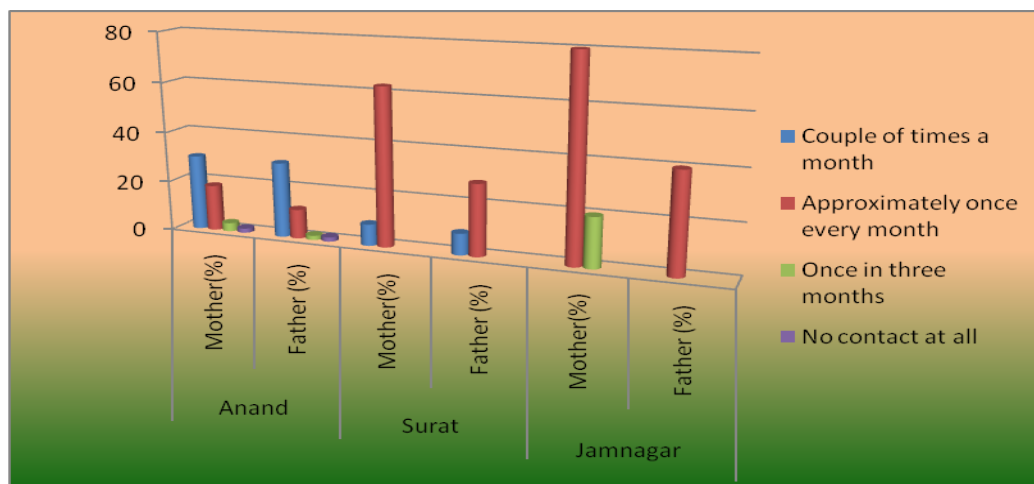
According to most of the respondent surrogate mothers, they shared a harmonious relationship with the commissioning couple before the pregnancy. Majority of the surrogate mothers claimed that they shared a harmonious relationship with the commissioning mothers during the first stage of pregnancy (Anand – 86.7%, Surat – 88.6% and Jamnagar – 100%). During the field visits, the research team observed that the surrogate mothers hardly got a chance to know about the Commissioning parents during the first trimester of the pregnancy as the later are approached once the first trimester is successfully over and the pregnancy is confirmed by the hospital authorities. Thus, by the end of the first trimester the commissioning parents are informed, who then visit India to sign the agreement. In most cases this is the first time the surrogate mother gets to meet the commissioning parents. However, this perception of being in touch with the Commissioning mother comes from the narration of the hospital authorities/doctors who conveys the surrogate mother about the concerns of the Commissioning mother regarding the pregnancy and her well-being.

As the pregnancy period advances to its completion, the relationship between the surrogate mother and the commissioning parents seems to take a downturn; as towards the latter stage of pregnancy only 55% of the surrogate mothers, we interviewed, said that they shared harmonious relationship with the commissioning mothers; and for Surat it is 74.3%. This downturn in relationship can be

attributed to the stress created for the surrogate mother who lives in shelter home away from her children and family. On the other hand, as the pregnancy proceeds, the commissioning parents develop a sense of insecurity and possessiveness for the surrogate child. They time and again express their concerns regarding the well being of the foetus which further puts pressure on surrogate mother. It should not be forgotten here that there is always a communication barrier between the commissioning parents and the surrogate mother in terms of language. The hospital authorities or the doctor is the sole translator and the medium of communication; hence, a lot depends on them as to how they are communicating with both the parties.

Figure 3.29

Frequency of contact between the surrogate mother and the commissioning parents during the last trimester



Most of the surrogate mothers in Anand and Surat stated that they remained in touch with the commissioning parents around once a month during the first stage of their pregnancy (Anand – 71.7% and Surat – 68.6%); however in Jamnagar around 40% of the surrogate mothers said that they had contact with the commissioning parents about once every month and 60% of them said that once in every three months they had contact with the commissioning parents.

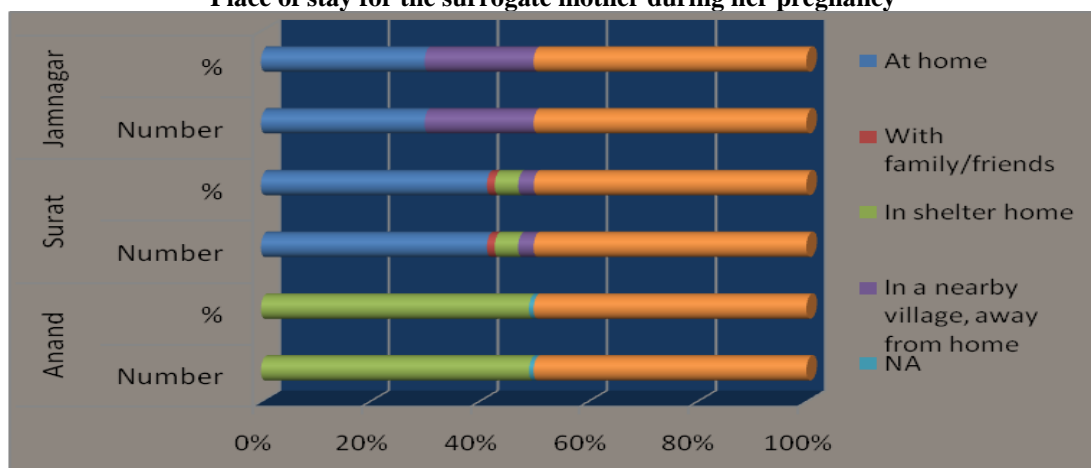
In Anand 30% of the surrogate mothers said that they had contact with the commissioning parents a couple of times every month; in Surat most of the respondents (62.9%) said that they had contact with the commissioning mother once every month, and in Jamnagar 20% of them said that they had contact with the commissioning mother once in three months. In most of the cases the surrogate mother seems to be satisfied with the level of involvement of the commissioning parents. In Anand, only 8.3% answered in negative; and in each of Surat and Jamnagar 2.9% of the surrogate mothers said that they do not feel adequately involved with the commissioning parents in this entire process of pregnancy.

Table 3.5
Relationship of the surrogate mother with her husband at the initial stage of surrogacy

Sl. no	Relationship with the husband initially	Anand		Surat		Jamnagar	
		Number	%	Number	%	Number	%
1	Harmonious	43	71.67	29	82.86	4	80
2	Dissatisfaction/coldness	16	26.67	5	14.29	1	20
3	Major conflict or hostility	1	1.67	1	2.86		
	Total	60	100	35	100	5	100

In majority of the cases the surrogate mothers responded that their relationship with their husbands in the initial stage (after they took the decision of surrogacy) was harmonious (71.67% in Anand, 82.86% in Surat and 80% in Jamnagar). Only 1.67% in Anand and 2.86% in Surat said that they had major conflict or hostility with their husbands during the initial period of surrogacy. Most of the respondents said that they shared a harmonious relationship with their husbands during the first stage of pregnancy (83.3% in Anand, 82.86% in Surat and 100% in Jamnagar). However, 8.3% in Anand and 11.43% in Surat said that their relationship with their husbands during the first stage of pregnancy was dissatisfactory. It is to be noted that majority of respondents in the three selected states reported harmonious relationship with their husbands. The reason for the same may be joint decision of the surrogate mother and her husband to undertake surrogacy or husband’s upper hand in taking the decision. It also seems that the respondents may not be disclosing the bitterness in their marital relationship due to societal pressure. 50% of the surrogate mothers in Anand and 60% of them in Surat said that their relationship with their husbands remained harmonious during the final stage of pregnancy.

Figure 3.30
Place of stay for the surrogate mother during her pregnancy



98.3% of the respondents in Anand said that they had to stay in the shelter homes provided by the surrogacy clinics during their pregnancy period. However, respondents in Surat (82.9%) and Jamnagar (60%) said that they stayed in their respective houses. The rest of the 40% in Jamnagar said that they stayed in nearby villages during the pregnancy period. After much probing the research team found out that the hospitals/clinics mostly prefer the surrogate mothers to stay in their

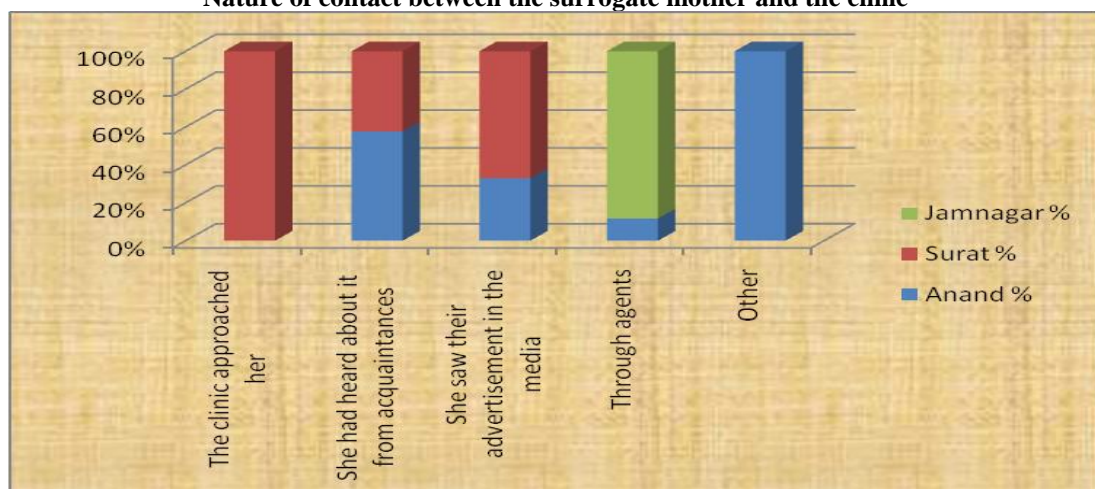
shelter homes in the first hand to ensure that the surrogate mother doesn't come in physical contact with her husband which may can increase the risk of her being infected with STDs or even with HIV/AIDS; and in the second place, the hospitals/clinics earn good money from the Commissioning parents in the name of providing nutritious food and safe environment for the precious pregnancy.

50% of the surrogate mothers in Anand, 74.29% of them in Surat and all the respondents in Jamnagar said that they did not want others to know that they were pregnant through surrogacy, because of the social stigma attached to it; therefore they stayed away from their home during the pregnancy period. However, 48.3% of the respondents in Anand said that the commissioning parents wanted the former to stay in a better condition than their respective houses in the villages can provide (so that good care is taken of the baby in the womb inside).

3.5.1 Role of the Clinic

The role of the clinic and the infertility physician is crucial in the case surrogacy. They can act as the pillar of strength and support both for the Commissioning parents and the surrogate mother. In most of the cases the surrogate mothers are either approached by the agents (Anand – 13.3%, Surat – 97.2% and Jamnagar – 100%), or they had read the advertisements (Anand – 18.3% and Surat – 37.1%) in the media (newspaper, banner etc.) or they had heard about the particular clinics from their acquaintances (93.3% and Surat – 68.6%). As we have already discussed earlier, the agents are prior surrogate mothers themselves and they knew whom to approach for perspective surrogacy and how to approach.

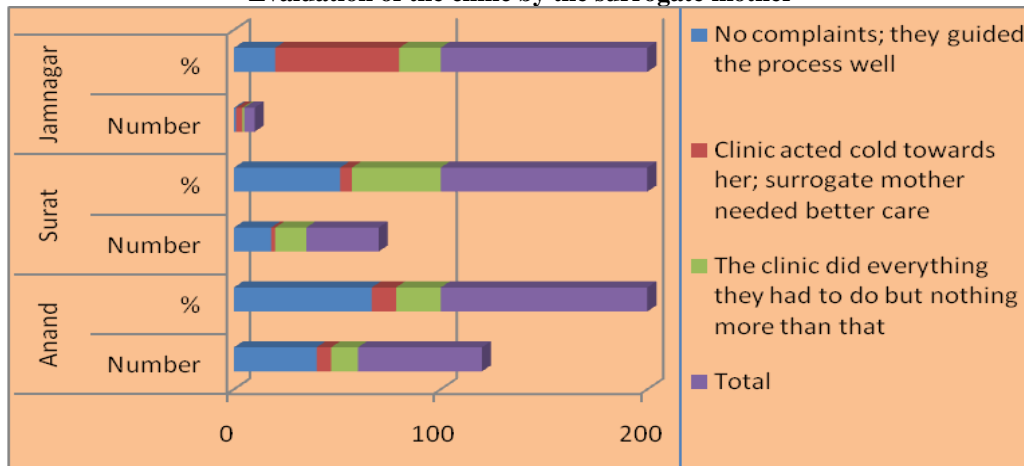
Figure 3.31
Nature of contact between the surrogate mother and the clinic



The majority of the surrogate mothers found the clinic /hospital authorities were friendly when they first approached it. In Anand, 65% of the surrogate mothers, in Surat 77.14% of the respondents and in Jamnagar 20% of them said that they experience cordiality when they first approached the respective clinics. However, 23.3% of the respondents in Surat and 40% of them in Jamnagar said

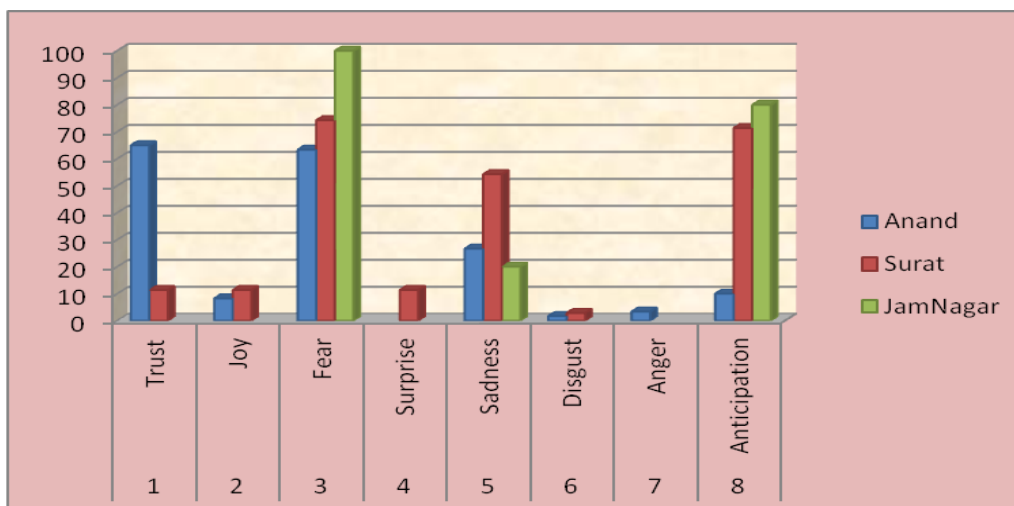
that the clinic /hospital authorities were cold and indifferent, and treated them like objects with specific numbers. The surrogate mothers are merely ‘money banks’ for these hospitals/ clinics/ doctors as they promise huge returns. So, although they care for the well-being of the baby, the emotional care of the surrogate mothers, does not hold any importance for them. Therefore the surrogate mothers remain deprived of the emotional support which is normally provided to an expectant mother by her family.

Figure 3.32
Evaluation of the clinic by the surrogate mother



Most of the surrogate mothers expressed that they were with the role of the clinics in the entire process. 66.7% of the respondents in Anand, 51.4% in Surat and 20% of them in Jamnagar said that they had no complaints against the clinics; as the latter guided the process well. However, 60% of the surrogate mothers in Jamnagar said that the staff of the clinics was rude to them and they expected and needed better care. The respondents who mentioned that the clinics are providing better care may have voiced so because the authorities were around during interviews and did not leave the respondents alone.

Figure 3.32
Types of emotion experienced by the surrogate mother before pregnancy



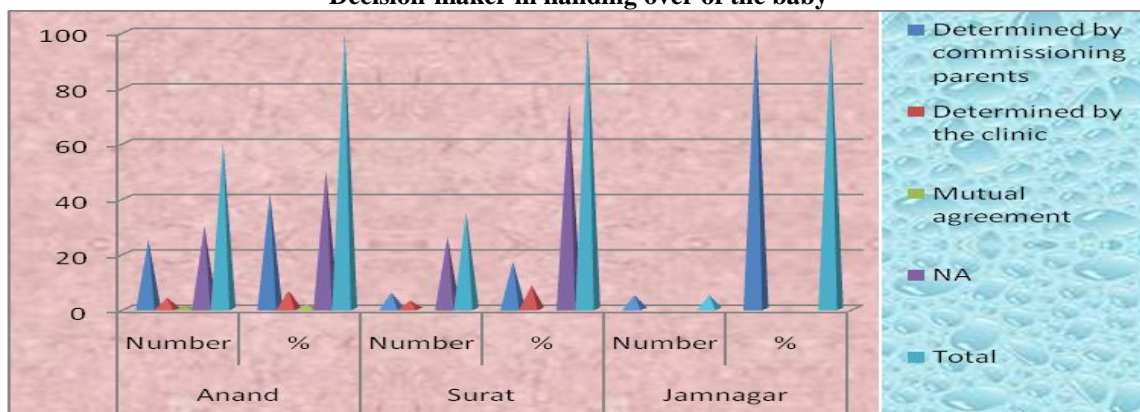
Fear, sadness and anticipation top the list of emotions experienced by surrogate mothers before the pregnancy. In Anand, 65% and in Surat, 11.4% of the respondents felt they needed to have trust on themselves, their family, the clinics and the entire process of surrogacy. Most of the surrogate mothers, however, experienced fear before their pregnancy (Anand – 63.4%, Surat – 74.3% and Jamnagar – 100%). Many of them also experienced sadness (Anand – 26.7%, Surat – 54.3% and Jamnagar – 20%) before their pregnancy in all the three areas. The feeling of sadness and fear in surrogate mothers are due to the fact that they know that they will lose the child after birth. Acceptance by the husband and in laws after the birth of the surrogate child also becomes a factor for creating fear in the supposed surrogate mothers.

It was found out during the field visits that in order to be impregnated successfully the surrogate mothers were tried 20-25 times with IVF sessions, although it is strictly prohibited by ART guidelines. On an average, the surrogate mothers had to wait for 1-3 weeks before they were matched with the commissioning parents by the clinics. In Anand, 45% of the respondents had to wait for 1 week, in Surat 25.71% of the respondents had to wait for two weeks, and in Jamnagar 60% of the respondents had to wait for three weeks and the rest of the 40% had to wait for two weeks.

3.6 After the pregnancy- Relinquishing the child

Relinquishing of the child is the most difficult part in the whole surrogacy arrangement, as in some cases, the surrogate mother becomes emotionally attached to the child but still has to part from him/her. In most of the cases, the decision regarding the handing over of the surrogate baby is made by the commissioning parents. In Anand, 41.67%, in Surat 17.1% and in Jamnagar 100% of the respondents said that it was the commissioning parents’ decision as for when to relinquish the baby after birth. However, few of them in Anand (6.67%) and Surat (8.6%) mentioned that this decision is taken by the concerned surrogacy clinics.

Figure 3.33
Decision-maker in handing over of the baby

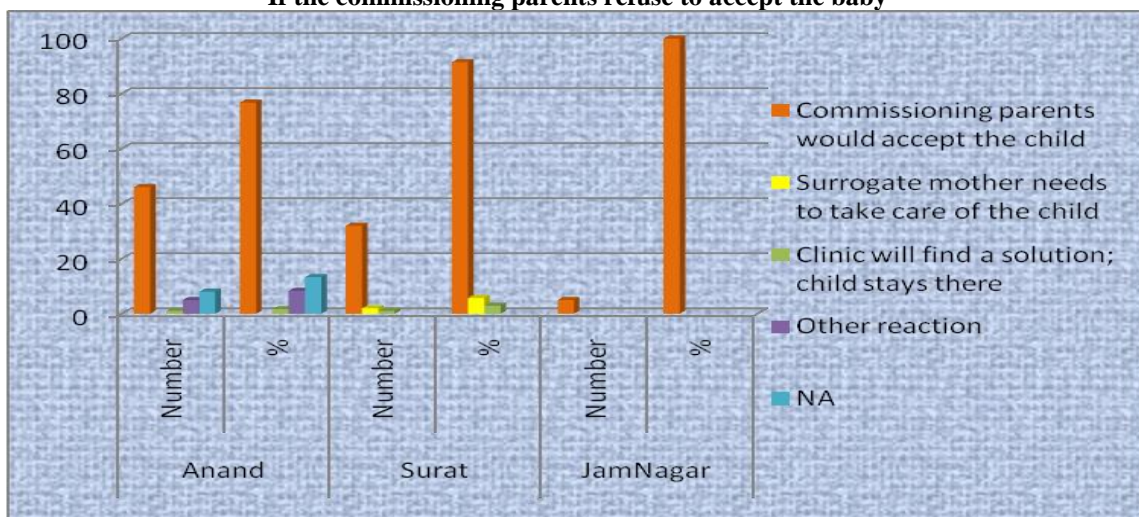


In only 6.7% of the cases in Anand and 2.86% in Jamnagar the surrogate mothers experienced doubts at the handover; the rest of the population in all the three places did not express any such doubts. Even at the stage of post-relinquishment of the child, the surrogate mothers did not have any doubts or difficulties; only 6.7% of the surrogate mothers in Anand and 2.9% of the respondents in Surat complained that they faced difficulties after relinquishing the baby. However, around 40% of the respondents in Jamnagar said that they faced difficulties at this stage. In addition, all the surrogate mothers recalled that though they did not have any doubt yet, they cried a lot at the separation point. It shows the emotional bonding of the mother, though surrogate, with the child.

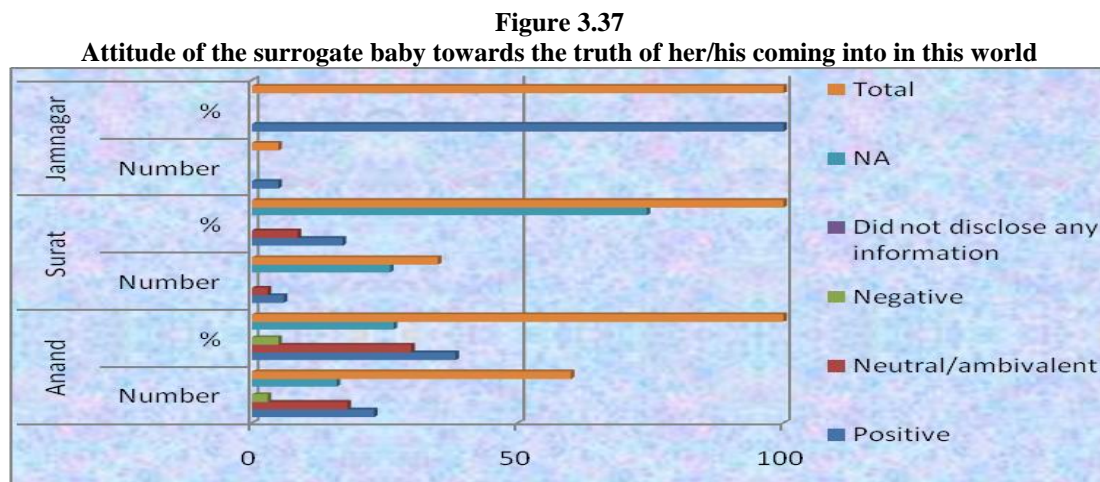
Few of the surrogate mothers did face difficulties from the family and surroundings after the birth of the child, as surrogacy is considered a stigma. Many of them also felt emotionally disturbed after handing over the child as, though not biologically her own, the surrogate mother still would feel attached to the child.

Around 18.3% of the surrogate mothers in Anand and 17.1% in Surat felt joyful after the pregnancy, around 11.40% of the respondents felt anticipation. 26.7% of the surrogate mothers said that the child is kept at the clinic in case the commissioning parents refuse to or are unable to take care of the former. In Jamnagar, 40% of them said that under such circumstance, the surrogate mother willingly keeps the child and the rest of the 60% said that the surrogate mother keeps the child with her for a short period till an alternative is identified. Controversial situations are created when the Commissioning parents refuse to take back the child. There are no clear guidelines to determine the custodians of the child and his/her citizenship.

Figure 3.36
If the commissioning parents refuse to accept the baby



All the surrogate mothers expressed their desire to have information about the child’s growth and whereabouts. However, when we asked the surrogate mothers that if we tell the child that his/her birth is through surrogacy how s/he is going to react to it, majority of them replied that the child will feel positive because of the fact that s/he is so much desired by his/her parents.



In Anand in 38.3% of the cases, and in Jamnagar in all the cases, the attitude of the child towards the truth of his/her coming to this world has been positively accepted. However, in Surat, in 30% of the cases this response remained neutral or ambivalent.

3.7 Consequences of surrogacy for the surrogate mother and her family

In majority of the cases, the attitude of family and friends, especially the husbands of the surrogate mothers remained positive when first told about surrogacy. In very few cases the response has been negative. However, response of the husbands in Anand (25%), Surat (37.1%) and Jamnagar (20%) remained ambivalent in few cases.

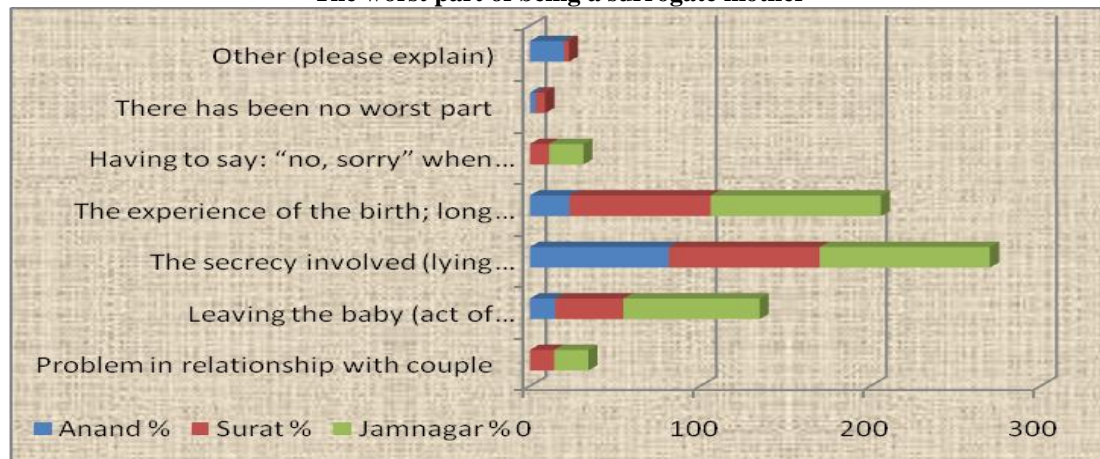
Table 3.6
Attitudes of husband, friends and family of the surrogate mother towards surrogacy initially

Sl. no	Attitudes towards surrogacy when first told	Anand			Surat			Jamnagar		
		Family (%)	Friends (%)	Husband (%)	Family (%)	Friends (%)	Husband (%)	Family (%)	Friends (%)	Husband (%)
1	Positive	27.70	25.00	66.70			57.10			80.00
2	Neutral/ambivalent	10.00	11.70	25.00	8.60	5.70	37.10			20.00
3	Negative	3.30	1.70	3.30	5.70		5.70			
4	Did not disclose any information	60.00	60.00	1.70	85.70	94.30		100	100	

Many of the respondents did not want to disclose much information when asked this question. However, those who need respond, said that in most of the cases the attitude of the families, friends, especially the husbands have largely remained positive after the surrogacy is over.

14.3% in Surat and 20% of the respondents in Jamnagar said that problem in relationship with the husbands was the worst part of the surrogacy process; 15% in Anand , 40% in Surat and 80% of the respondents in Jamnagar said that relinquishing the bay was the worst part of surrogacy; however, a large number of the surrogate mothers in all the three places said that the secrecy involved in the entire process of surrogacy was the worst part (81.7% in Anand, 88.6% in Surat and all the respondents in Jamnagar). Apart from these, other factors include the long and painful period of labour (23.3% in Anand and 82.9% in Surat).

Figure 3.38
The worst part of being a surrogate mother



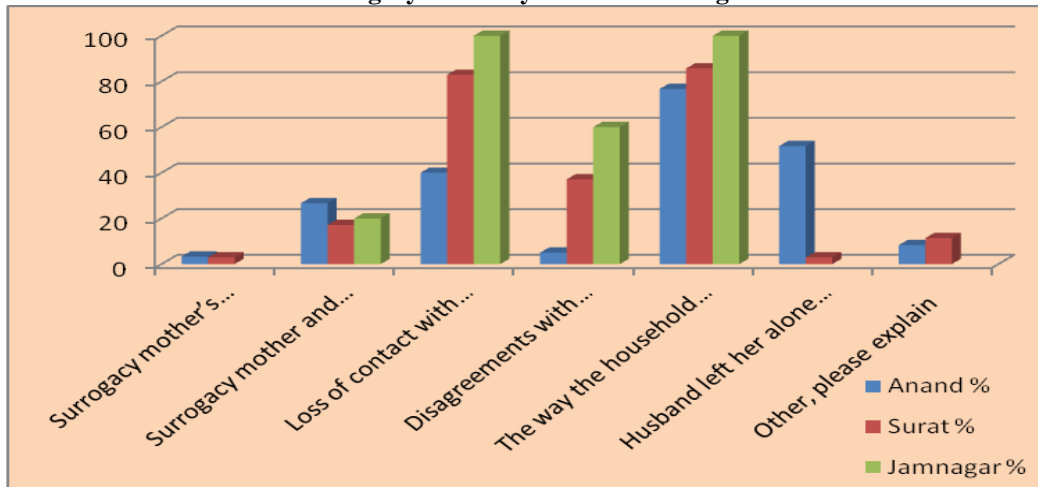
In few of the cases (3.3% in Anand and 2.9% in Surat), the surrogate mothers' children have made themselves distant from the mother. 40% of the surrogate mothers in Anand, 82.9% of the respondents in Surat and all the respondents in Jamnagar said that the surrogacy agreement has led to loss of contact with friends and family members.

Table 3.7
Effect of surrogacy on family life of the surrogate mother

Sl. no	Effect of surrogacy on family life	Anand	Surat	Jamnagar
		%	%	%
1	Surrogacy mother's own children acted distant towards their mother	3.3	2.9	
2	Surrogacy mother and husband became closer	26.7	17.1	20
3	Loss of contact with friends and/or family members	40	82.9	100
4	Disagreements with friends and/or family members	5	37.1	60
5	The way the household is run is affected	76.7	85.7	100
6	Husband left her alone with children	51.7	2.9	
7	Other, please explain	8.3	11.4	

78.3% in Anand, 91.4% in Surat and all the respondents in Jamnagar said that primarily they use the surrogacy money for the education of their children. Next to that, they also use the money for building new houses (28.3% in Anand, 40% in Surat and 60% in Jamnagar).

Figure 3.39
Effect of surrogacy on family life of the surrogate mother

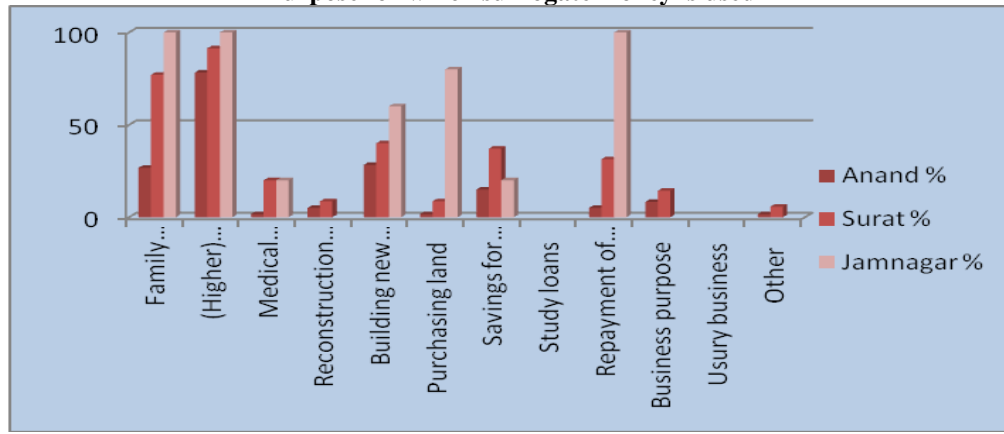


Other areas include saving for daughter's marriage, purchasing land etc. The reason why the money is mainly used for their children's education is that earlier they were not going to school and now with some money to spare for two square meals, they can think of sending their children to school.

Table 3.7
Purpose for which surrogate money is used

Sl. no	Purposes for which "surrogate money" is used	Anand	Surat	Jamnagar
		%	%	%
1	Family maintenance	26.7	77.1	100
2	(Higher) education of children	78.3	91.4	100
3	Medical treatment	1.7	20	20
4	Reconstruction of existing house	5	8.6	
5	Building new house	28.3	40	60
6	Purchasing land	1.7	8.6	80
7	Savings for daughter's marriage	15	37.1	20
8	Study loans			
9	Repayment of loans	5	31.4	100
10	Business purpose	8.3	14.3	
11	Usury business			
12	Other	1.7	5.7	

Figure 3.40
Purpose for which surrogate money is used



However, from the field observation by the research team it was evident that though they have used part of the money either in buying a small hatchment or for the education of their children, its not the complete investment as the payment was small enough to cater to all these. Hence, we have to really think about was the surrogacy arrangement and the physical pain the surrogate mother endure during the process worth the money they earn after relinquishing the baby?

3.8 Conclusion

- ◆ The surrogate mothers generally are from poor families and their average monthly income is not more than Rs. 2,500-3,000.
- ◆ Almost all of the interviewed surrogate mothers have already experienced child-birth before and have two kids of their own. In such a way, this implies that these women are capable of reproduction naturally and are made subjects of reproductive assistance techniques and become surrogate mothers.
- ◆ The majority of them are illiterate, employed as domestic helpers, construction workers or nurses. Thus, they are economically vulnerable and desire for some money. Hence, the need of money is the driving force for them to become surrogate mothers.
- ◆ Most of the surrogate mothers are married and live in nuclear family structure, which makes the surrogacy decision-making easier for the couple.
- ◆ The majority of them spend the money for education of their children, building the house or renovating the old one.

- ◆ Most of them stay in rented houses, which are kutchha or semi-pucca with poor or no latrine facilities. In some cases there was no roof over their houses due to which their children suffered from fever in rainy season.
- ◆ Sometimes though the husbands do not mind the woman to go for surrogacy but after the baby is born and handed over and the woman comes back to her house, the husband and her own children distance themselves from her.
- ◆ Most of the times it is the agent who approaches the particular woman for surrogacy to help her get in touch with the concerned clinic. These agents are often former surrogate mothers who have delivered two surrogate babies in the same clinic.
- ◆ The surrogacy contract is signed between the surrogate mother (including her husband), the commissioning parents and the fertility physicians. In such a way, the clinic authorities evade legal hassles.
- ◆ Almost none of the surrogate mothers have a copy of the written contract of surrogacy arrangement, though they are part of this contract.
- ◆ The surrogacy arrangement contract rarely addresses issues related primarily to the well being and health of the surrogate mother. It is only the health issues related to the fetus when the health of the surrogate mother becomes a prerogative.
- ◆ In case the intended parents do not wish to continue with the pregnancy due to some fetal abnormalities or sex preference, the baby is aborted often without any say of the surrogate mother.
- ◆ There is no fixed rule related to the amount of compensation for the surrogate mother; it is arbitrarily decided upon by the clinics. Convention goes that the surrogate mother is paid 1%-2% of the total amount received by the clinics from the commissioning parents in lieu of the surrogate baby.
- ◆ In most of the cases, relationship between the surrogate mother and the commissioning parents remains as it was described harmonious, but from a distance. It should be taken into account that language remains to be a barrier and the doctor is the sole communicator between them. According to the surrogate mothers, the level of involvement for the commissioning parents with the entire pregnancy experience of the surrogate mother remains restricted to the initial stage of getting introduced to the former and making sure that surrogate mother delivers and relinquishes the baby as it was decided.

- ◆ Most of the surrogate mothers stay in the shelter homes during the pregnancy period. According to them, they do not want to disclose their pregnancy to the neighbours and surroundings due to the social stigma associated with it. In addition, the clinics also prefer them to stay in the homes instead of their respective villages in the interest of the surrogate baby, as the homes are better equipped to take care of the pregnancy-related issues and to prevent the surrogate mother from being infected with STDs or HIV/AIDS due to physical contact with her husband.
- ◆ Very often the surrogate mother remains apprehensive and fearful of the surrogacy process before the pregnancy.
- ◆ In most of the cases the decision to relinquish the baby after birth is jointly taken by the commissioning parents and the clinic, whereas the surrogate mother does not seem to have any right to interfere in the decision-making process.
- ◆ Few of the surrogate mothers faced difficulties from the family and surroundings after the birth of the child due to surrogacy being considered a stigma. Many of them also felt emotionally disturbed after handing over the child, though not biologically her own, the surrogate mother still felt to be attached to the child.
- ◆ The surrogate mothers assume that the child will positively accept the fact that s/he has been born through surrogacy.
- ◆ The surrogate mothers stated that relinquishing the baby was the worst part of surrogacy. However, they added that the secrecy involve in this issue and the long and painful period of labour when they have to live separately from their family members were other worst parts in the surrogacy arrangement.
- ◆ According to surrogate mothers the surrogacy arrangement distanced them from their friends and family members.

Chapter IV

Commissioning Parents

The Commissioning Parents, sometimes also called the intended parents, are the couples, who are unable to have children naturally or with medical help and decide to acquire a child through a surrogacy arrangement. The intended parents opting for surrogacy can be Indians, Non-Resident Indians (NRIs) or Foreigners.

In India, surrogacy is increasingly becoming a popular and well-accepted practice amongst childless couples; most of such Commissioning Parents hail from the creamy layer of the society who can bear the huge cost of surrogacy. India is emerging as a leader in international surrogacy and a destination in surrogacy-related fertility tourism. Indian surrogates have been increasingly popular with fertile couples in industrialized nations because of the relatively low cost. Indian clinics are also becoming more competitive, not just in the pricing, but in the hiring and retention of Indian females as surrogates. Clinics charge exorbitant amount for the complete package, including fertilization, the surrogate's fee, and delivery of the baby at a hospital, including the costs of flight tickets, medical procedures and hotels.

The field study conducted in three of the high-prevalence areas in the state of Gujarat – in Anand, Surat and Jamnagar, have helped CSR come up with extremely interesting findings. The amount of data collected has been categorized by the extent to which the clinics allowed the researcher to observe and the level of information the former divulged. Thus, depending upon the aforementioned factors, CSR could collect maximum data from Anand (30 respondents); Surat could provide us 18 respondents and the least data was gathered from Jamnagar (2 respondents)¹².

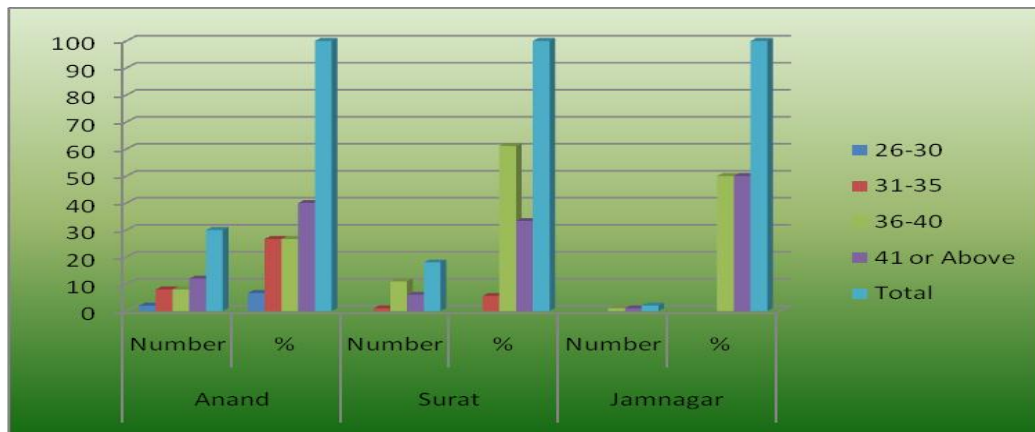
4.1 Demographic and socio-economic background

The table below depicts that the majority of the commissioning mothers were more than 35 years old, indicating towards the fact that most of them have opted for surrogacy after having made several attempts of natural motherhood. It should be mentioned that very few of the surrogate mothers (6.67% of the respondents) in Anand belonged to the 26-30 year age-group.

¹² Total Number of respondents including Anand, Surat and Jamnagar is 50

Figure 4.1

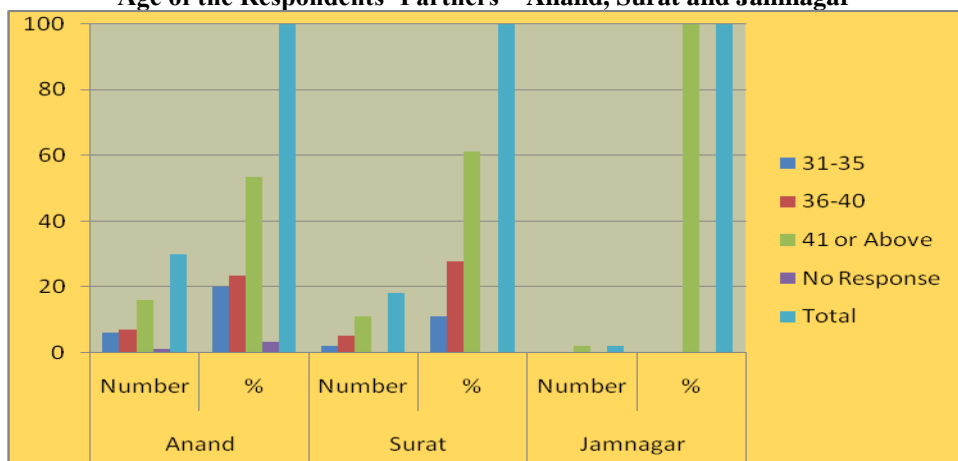
Age of respondent commissioning parents



Similarly, their partners (husbands) in most of the cases were above 40 years (53.40% and 61.11% in Anand and Surat respectively). None of them belong to the 26-30 years age-group category; only 19.90% in Anand and 11.11% in Surat belong to the 31-35 years age group.

Figure 4.2

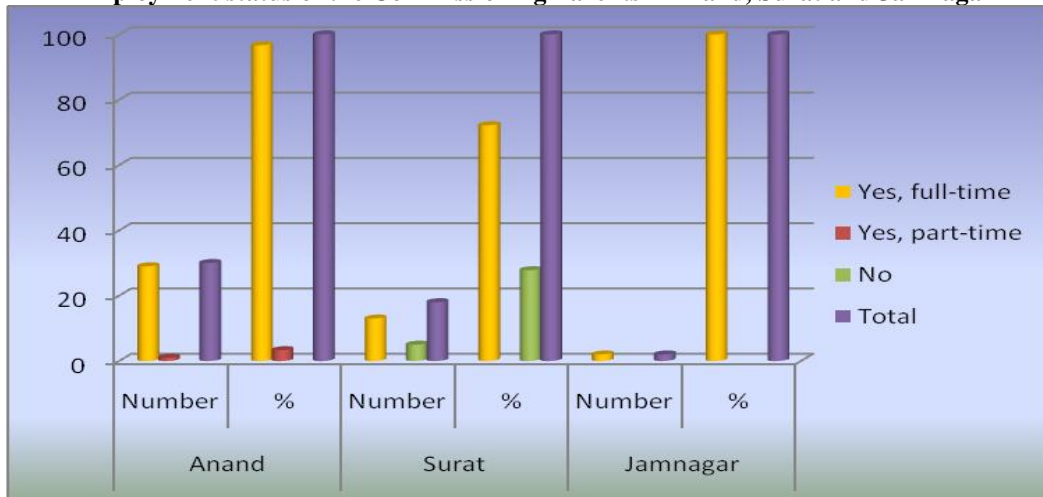
Age of the Respondents' Partners – Anand, Surat and Jamnagar



Further the table below depicts that majority of the couples amongst our respondents were Christians (63.33% in Anand and 55.6% in Surat), educated (equivalent to Master's Degree), and fully employed. Only 23.33% of the commissioning parents in Anand and 22.2% of them in Jamnagar were Hindus. 96.7% in Anand, 72.2% in Surat and all the commissioning parents in Jamnagar had full employment status.

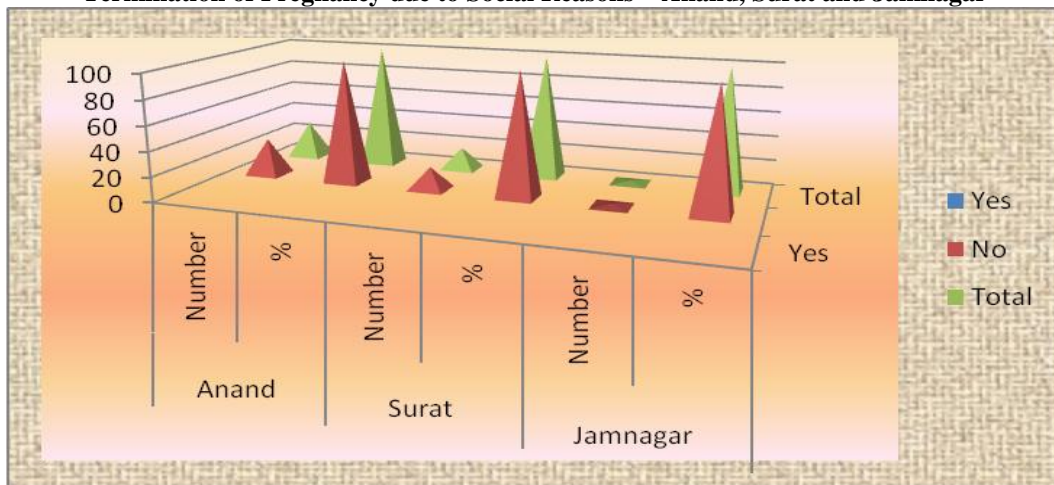
Most of the commissioning couples in Anand and Surat are from nuclear family set up and have an equal say in decision making process in the family. In Anand 90% and in Jamnagar 100% of the commissioning parents are from the nuclear family set up; However, In Surat 61.1% of the intended parents belong to the nuclear family and the rest of them (3.3%) belong to the joint family set up. In Anand, 40% of the commissioning parents' families were male-dominated and the rest of the 60% were female-dominated. In Surat, 55.6% of the families are male-dominated and 44.40% of the families are female-dominated; while in Jamnagar, the ratio is 50:50.

Figure 4.3
Employment status of the Commissioning Parents – Anand, Surat and Jamnagar



More than 50% of the commissioning mothers said that they have been pregnant before but had miscarriages. They claimed that they never had an abortion for social reasons (e.g. desire of a male child etc).

Figure 4.4
Termination of Pregnancy due to Social Reasons – Anand, Surat and Jamnagar



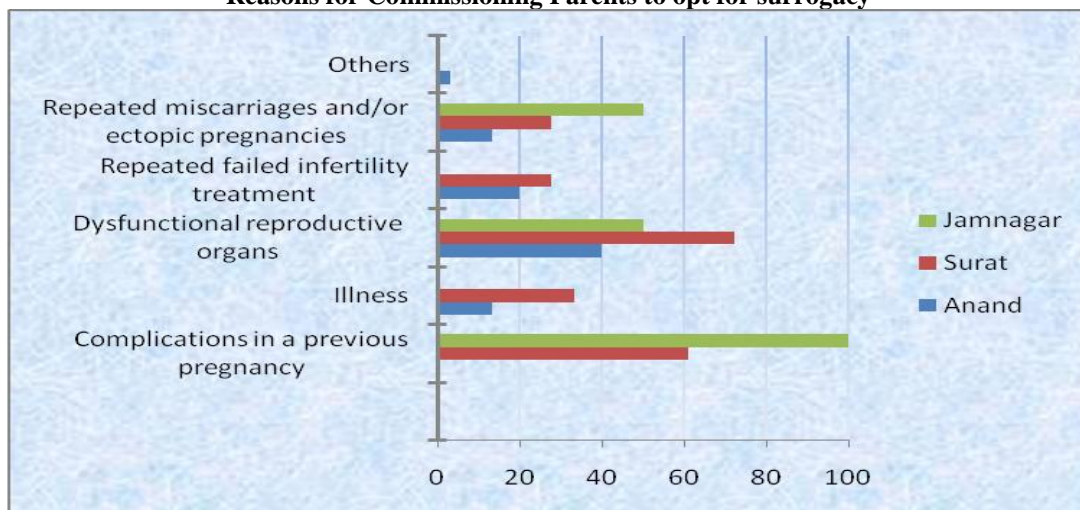
Very few of the commissioning parents (3.3%) have children and around 3% of the commissioning mothers have given birth naturally before. Majority of the commissioning parents have never had any previous experience with surrogacy. However, few of them (26.70%) in Anand had previously attempted to acquire a child through a surrogacy arrangement.

The research findings reveal that 70% of the commissioning parents opted for genetic surrogacy; while 26.70% chose gestational surrogacy. However, almost all of them claimed that they did not know the surrogate mother before. Only 3.3% of the commissioning parents in Anand claimed that they knew the surrogate mother beforehand, for the rest of the respondents in all three areas, the surrogate mother was unknown to the commissioning parents.

4.2 The surrogacy decision

For the majority of the commissioning parents, it is the dysfunctional reproductive organs that appear to be a hindrance to have children in a natural way (40% in Anand, 7.2% in Surat, and 50% in Jamnagar). In some of the cases both the chronic illness and the failure in the previous attempts of pregnancy prompted such couples to opt for pregnancy. The findings depict that 33.3% of the commissioning parents in Anand said that they had to opt for surrogacy due to complications in previous pregnancy, whereas in Surat this percentage rose to 61.1%. Some of them (13.3% in Anand and 33.3% in Surat) said that they had to decide upon surrogacy after illness like high blood pressure or diabetes that made pregnancy complicated for them.

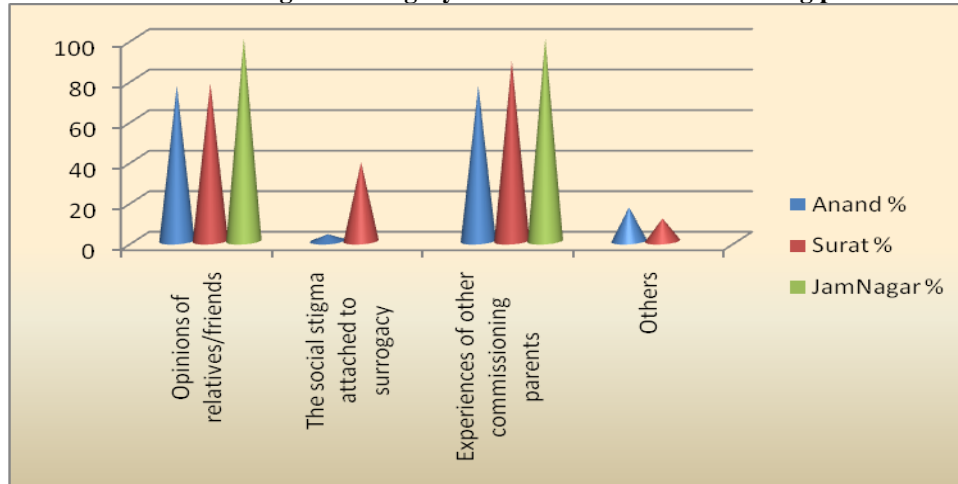
Figure 4.5
Reasons for Commissioning Parents to opt for surrogacy



The research study attempted to find out how important it is for the happiness of commissioning parents to have a baby by any means. It appears that in Anand and Surat, majority of the respondents were ‘not sure’ if they would be happy without a baby (72.20% and 27.80% respectively). However, in Jamnagar, 50% of the respondents said that they would not be happy without a baby and the rest of the 50% said that they were ‘not sure’. When it comes to the partners of the respondents, majority of them in all the three areas said that they were ‘not sure’ whether they would be happy without a baby (66.70% for Anand, 72.2% for Surat and 50% for Jamnagar).

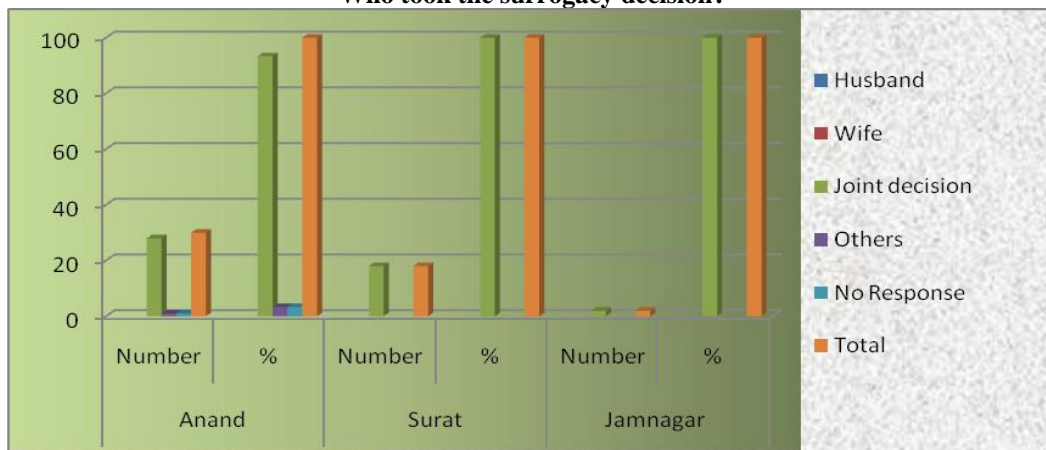
In their pursuit of having a baby through surrogacy, opinions of other commissioning parents and the opinions of relatives and friends appear to be the most important factors influencing the commissioning parents’ decision to opt for surrogacy. However, there is a social stigma attached to surrogacy that makes few of the commissioning parents doubtful till they finally decide to opt for it (3.3% in Anand, and 38.90% in Surat).

Figure 4.6
Factors influencing the surrogacy decision for the commissioning parents



The research study also looked at the different factors that triggered intended parents to opt for surrogacy. Majority of the commissioning parents came to know about surrogacy through media coverage (93.3% in Anand and 100% in Surat and Jamnagar). Secondly, it appears that friends and family members' suggestions also influenced their decision, the findings reveal that 40% of the respondents in Anand and 55,6% in Surat made their decision to opt for surrogacy after hearing the advices from friends.

Table 4.7
Who took the surrogacy decision?



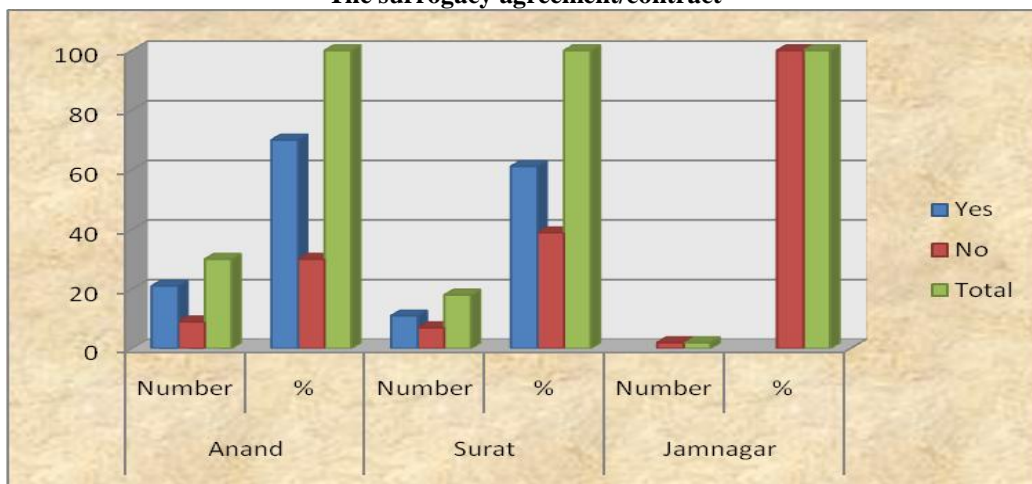
Moreover, advertisements by the surrogacy clinics also have immensely contributed to triggering them to search for the surrogacy arrangements in Gujarat. It is necessary to mention that the surrogacy service in India is cheaper than in other countries (for example, UK). Apart from that, recommendations by other commissioning parents also influenced them to go to these places for surrogacy. The findings reveal that 63.3% of the respondents in Anand, 44.4% in Surat and 50% in Jamnagar stated that they preferred coming to India for surrogacy as it would have been much more expensive in their own countries. It's interesting to note that 88% of the intended parents in Surat stated that recommendations and suggestions by other commissioning parents helped them in a great way to take the decision.

It is interesting to mention that actually, very few of them face any resistance from family and friends. Moreover, the findings confirm that most commissioning parents have taken joint decision to go for surrogacy (93.3% in Anand, 100% in both Surat and Jamnagar).

4.3 The surrogacy arrangement

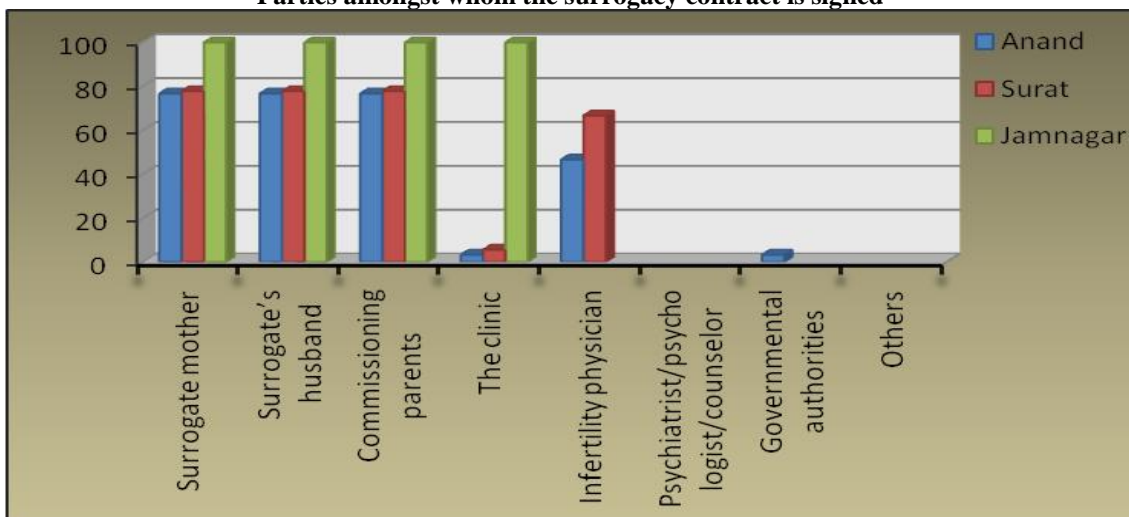
The issue of a written surrogacy contract is a crucial part of the entire process. The matter is that most of the intended parents in Anand (70%) and Surat (61.1%) stated that they had signed an agreement between the commissioning parents and the surrogate mother. Moreover, 66.7% of the commissioning parents in Anand and 61.1% of them in Surat claimed that they had a copy of the contract with them.

Figure 4.8
The surrogacy agreement/contract



In such a way, more often it is an agreement between the surrogate mother including her husband (other relative accompanying her) and the commissioning parents, whereas the clinic usually tries to stay out of any documented agreement in order to avoid transparency in their proceedings.

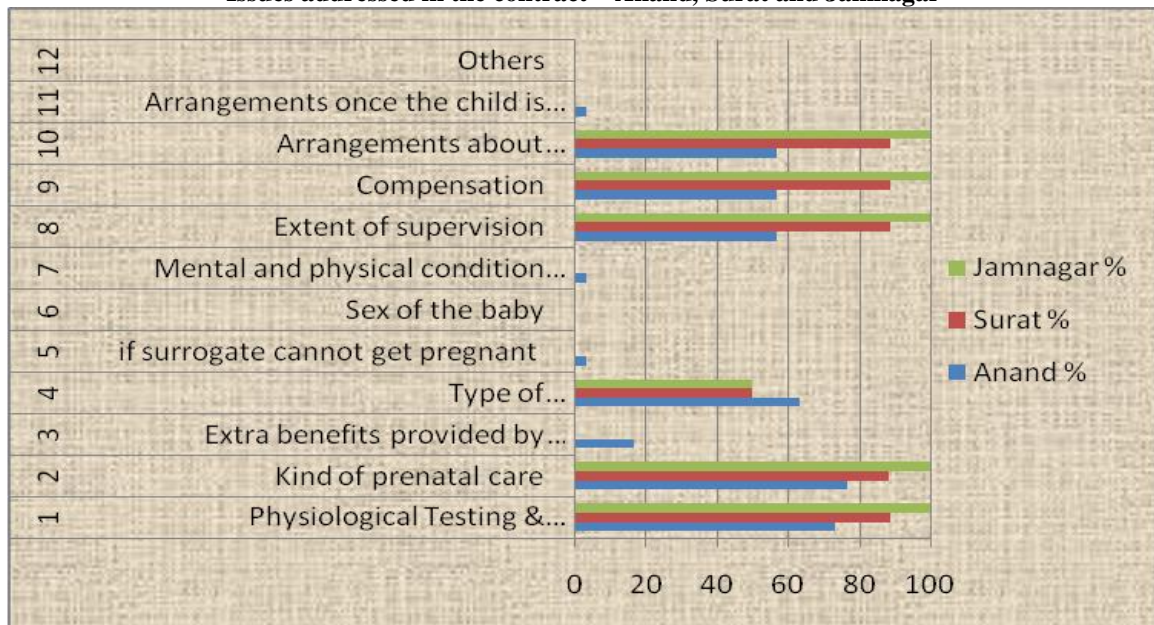
Figure 4.9
Parties amongst whom the surrogacy contract is signed



76.7% of the commissioning parents in Anand, 77.8% of them in Surat and all of them (100%) in Jamnagar have stated that they have signed a contract with the surrogate mother. However, only 3.3% in Anand and 5.6% in Surat said that the contract would also include the concerned clinics.

This type of contract generally includes issues like physiological tests of the surrogate mother, the concomitant psychological/ psychiatric evaluation and the release of results (73.3% in Anand, 88.9% in Surat, and 100% in Jamnagar), Secondly, it includes the type of insemination/implantation and number of tries that is needed before a surrogate gets pregnant (63.3% in Anand and 50% in Surat). The contract also consists of the kind of prenatal care and the extent of supervision needed during her pregnancy and also arrangements in which the baby is legally relinquished.

Figure 4.10
Issues addressed in the contract – Anand, Surat and Jamnagar

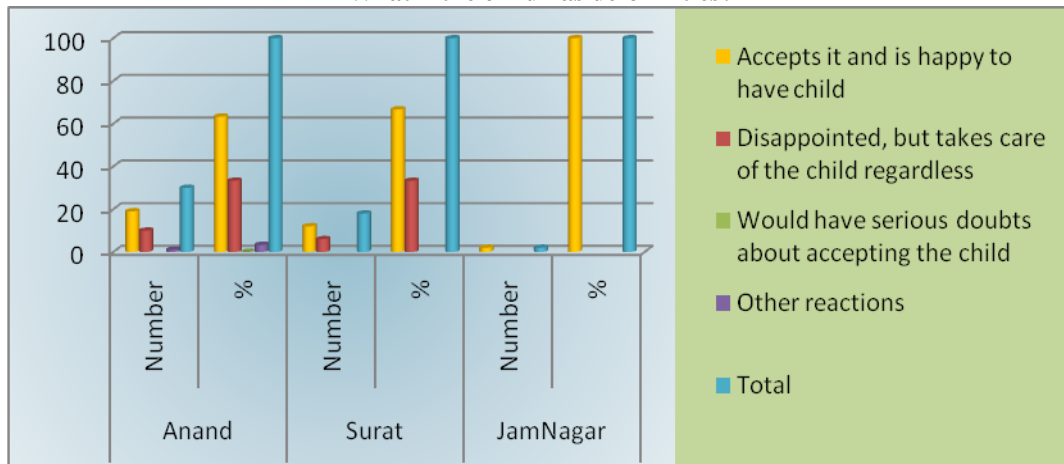


It should be noticed that there is hardly any mention of the kind of extra benefits that the surrogate mother might require from the intended parents during her pregnancy (in terms of diet and medical help), and there remains also a vast silence on the arrangements for the surrogate mother after the baby is born.

It seems to be a noteworthy to mention that most of the commissioning parents in all three places claimed that the sex of the child is not important for them. For instance, 93.3% of the intended parents in Anand and 77.8% of them in Surat stated that they would be equally happy if the child turns out to be a girl. On the other hand, around 3.3% in Anand and 22.2% in Surat said that a boy child is more desirable.

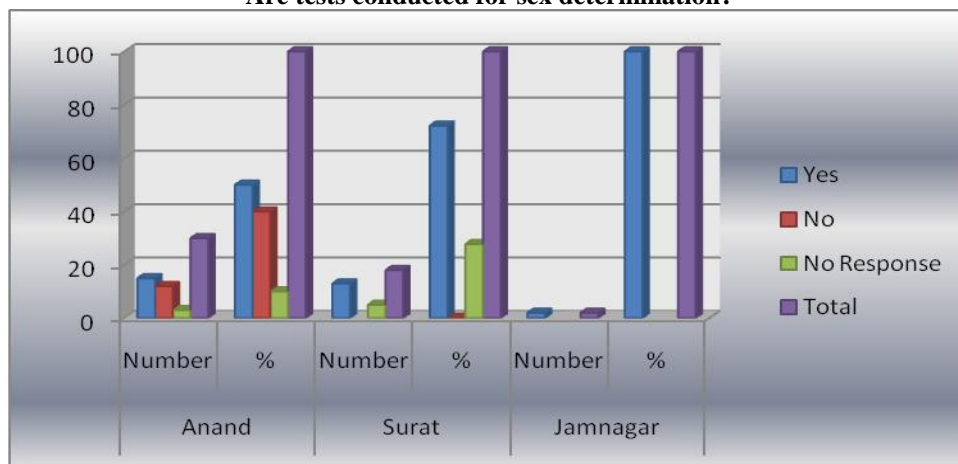
Interestingly, none of the commissioning parents showed disapproval to accept the baby even if the child turns out to have a deformity. However, 33.33% of the commissioning parents in Anand said that they would be disappointed, but still would accept the child, while around 65% of the intended parents in both Anand and Surat stated that they would accept the child happily even if he/she is born with a deformity.

Figure 4.11
What if the child has deformities?



However, most of them admitted (50% in Anand and 72.2% in Surat) that they have opted for tests to determine the sex of the child. In fact large number of respondents expressed that if the tests showed undesired results they would not hesitate going for abortion of the child (30% in Anand, 77.80% in Surat). Only 16.7% in Anand and 22.2% in Surat said that they would keep the child regardless the sex.

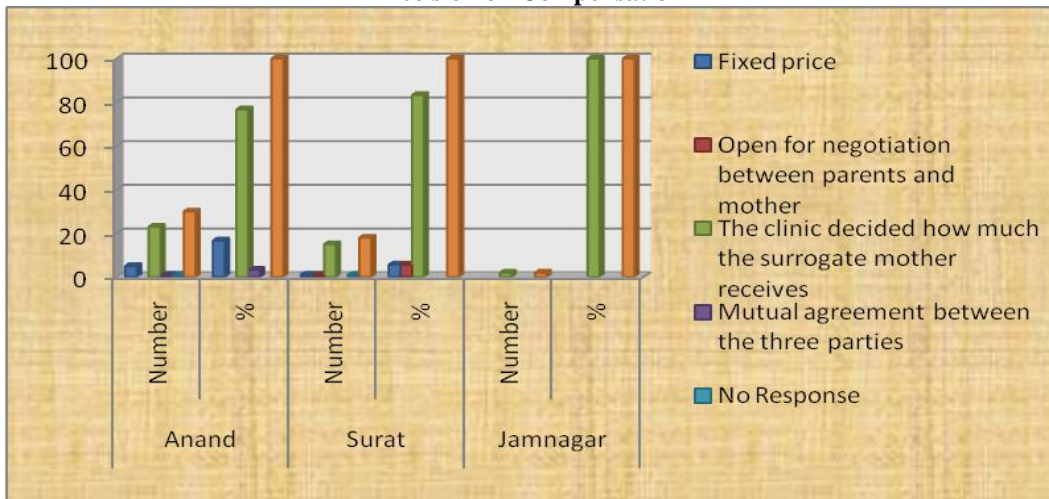
Figure 4.12
Are tests conducted for sex determination?



There are evidences of sex determination being conducted within surrogacy arrangement. All the respondent commissioning parents in Jamnagar, 72.22% of the respondent commissioning parents in Surat and 50% of the respondent commissioning parents said 'yes' to sex selection being performed during surrogacy through Selective Foetal Reduction technique.

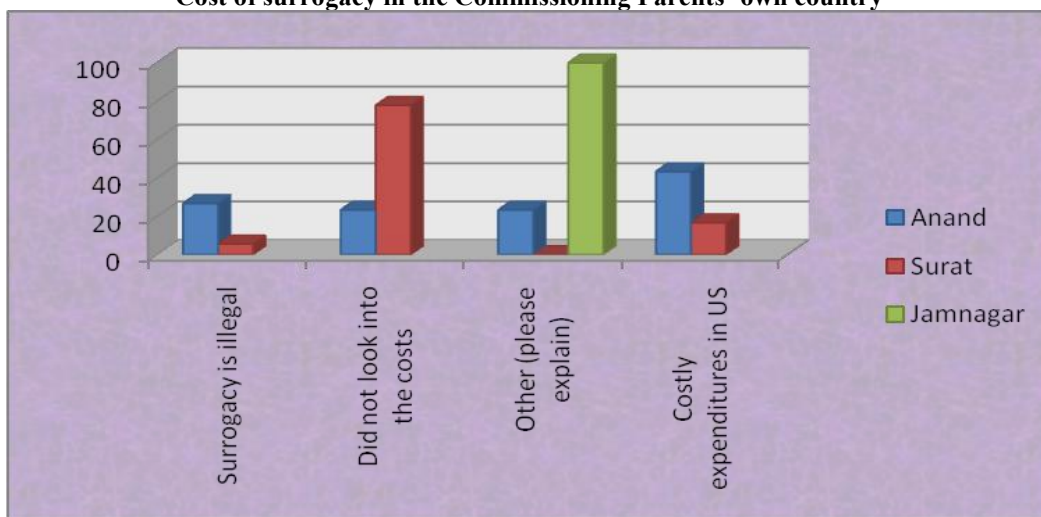
The research findings reveal that the surrogate mother does not have any right to object the compensation she gets from the concerned clinic, which is, in turn, paid by the commissioning parents. Most of the times the concerned clinic decides (76.7% in Anand and 83.3% in Surat) how much the surrogate mother should receive as compensation from the total amount that is paid to the clinic by the commissioning parents. In such a way, it is arbitrary and there is no fixed price for the surrogate mother. Only 16.7% in Anand and 5.6% in Surat said that the surrogate mothers receive fixed compensation.

Figure 4.13
Decision on Compensation



Some research studies argue that the cost of surrogacy service abroad is the reason for the foreign commissioning parents to search for the surrogacy arrangements in India. However, our research study does not fully confirm this statement. The findings reveal that only 43.30% of the respondents in Anand and 16.70% in Surat consider the money factor important, whereas in Surat majority of the intended parents claimed that the cost factor was not important. In such a way, a number of different reasons were put forward by the respondents. For instance, 26.70% of the commissioning parents in Anand and 5.60% of them in Surat stated that surrogacy was illegal in their country.

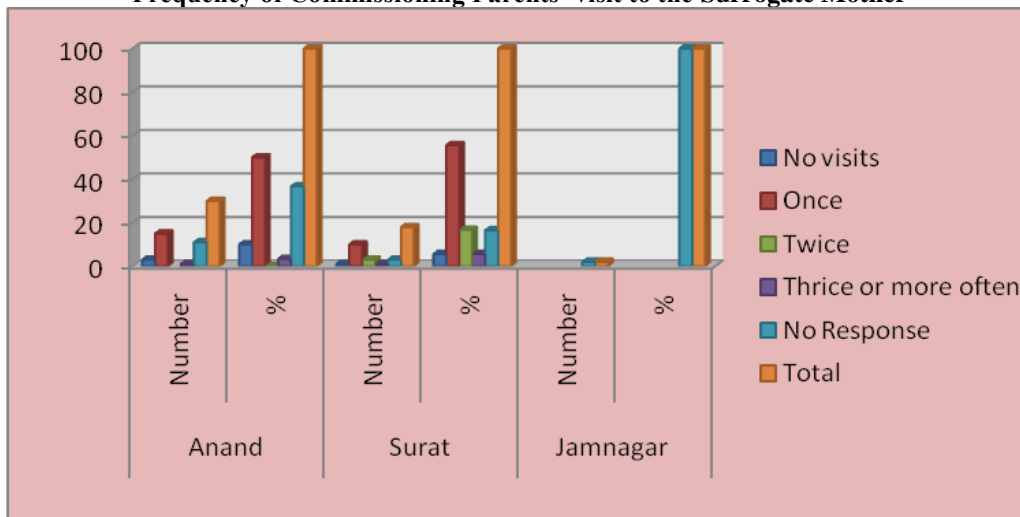
Figure 4.14
Cost of surrogacy in the Commissioning Parents' own country



4.4 Experiences before and during pregnancy

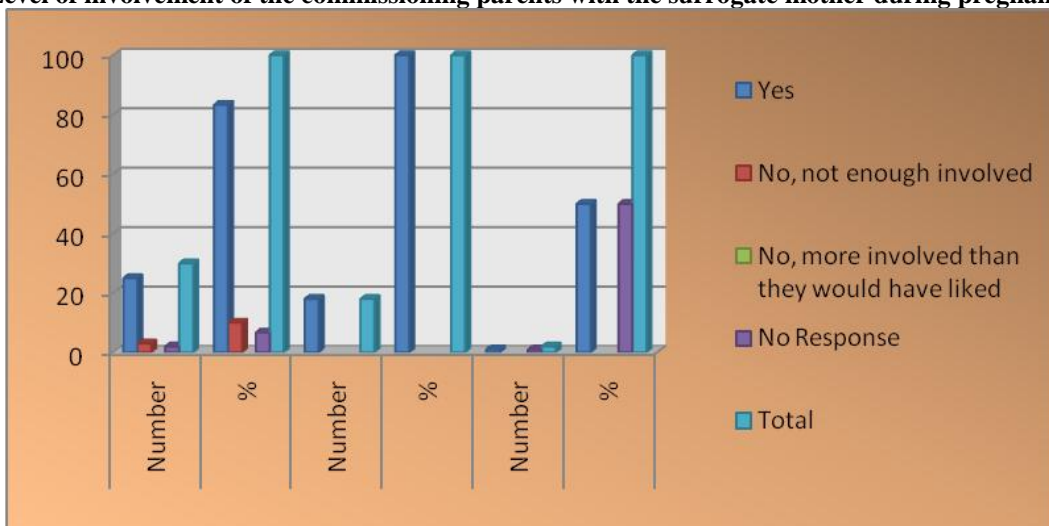
More than half of the respondents in Anand (56.67%) and almost all the commissioning parents in Surat (94.4%) said that they shared a harmonious relationship with the surrogate mother during her pregnancy period. According to the commissioning parents they would have visited the surrogate mother once or twice a month till her delivery, but their visits to the surrogate mother were restricted and they could meet her only once until her delivery.

Figure 4.15
Frequency of Commissioning Parents' visit to the Surrogate Mother



Majority of the commissioning parents (43.3% in Anand and 88.9% in Surat) seemed satisfied with the level of interaction that they had with the surrogate mother during her pregnancy period. Actually, most of the intended parents are foreigners living abroad and they find it comfortable to have rare visits to the surrogate mother.

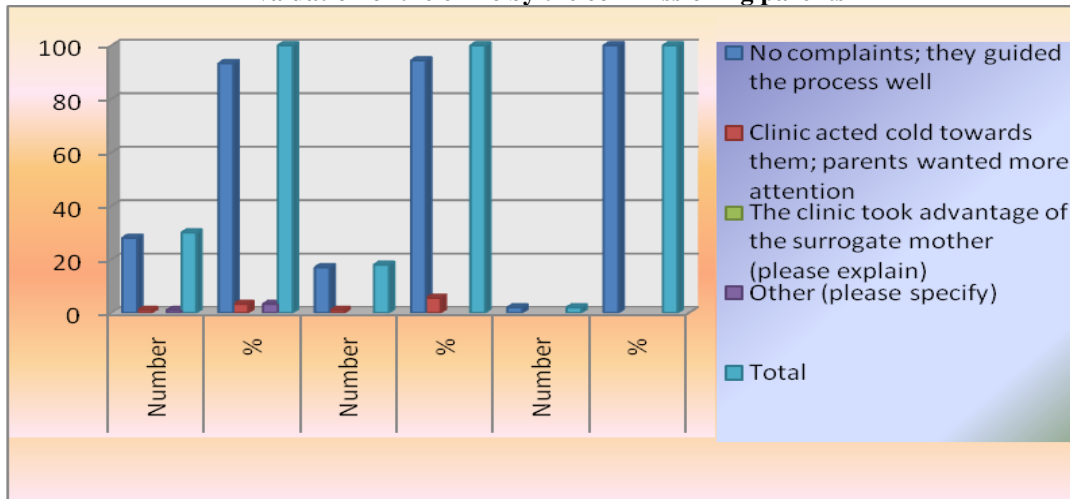
Figure 4.16
Level of involvement of the commissioning parents with the surrogate mother during pregnancy



Majority of the surrogate mothers in all the three areas were of the opinion that the clinics guided the entire process of surrogacy in a proper manner and therefore they had no major complain

against the clinics. It is interesting to note that 93.3% of the commissioning parents in Anand and 94.4% in Surat claimed that they were happy with the clinic; only 3.3% in Anand and 5.6% in Surat showed their dissatisfaction with the service received from the clinic.

Figure 4.17
Evaluation of the clinic by the commissioning parents



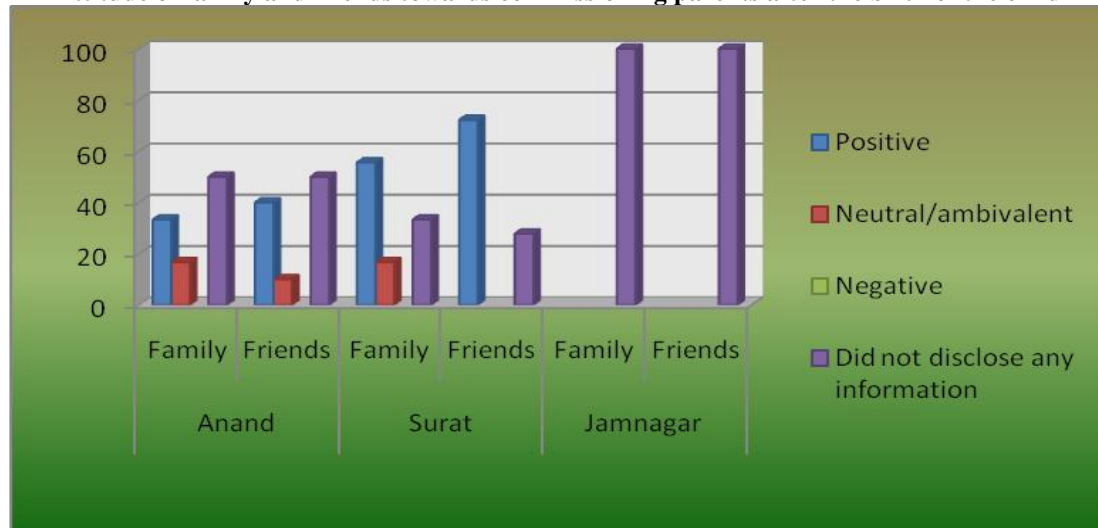
The commissioning parents relied on the clinics to find the suitable surrogate mother for them. For almost all the commissioning parents (93.3% in Anand and 94.4% in Surat) the decision to match a particular couple with the surrogate mother was made in the clinic and the intended parents did not take part in decision making. The interviews revealed that the procedure of matching with the surrogate mother took around two weeks in Surat and three weeks in Anand and Jamnagar. It is interesting to note that the decision when to hand the child over was made by the commissioning parents or the clinic authorities, while the surrogate mother hardly had any say in this regard.

4.5 After the pregnancy- relinquishing the child and consequences of surrogacy for the commissioning parents

Majority of the commissioning parents stated that their family members and friends responded positively to the surrogate baby and they did not face any difficulties in adjusting after bringing the child home. In Anand, 33.3% of the commissioning parents said that after the baby’s birth their family was supportive to them, and in Surat 72.2% of the commissioning parents stated that their family members and friends were happy about the surrogate child. With regards to whether or not the child should be told about his or her origins, majority of the couples seemed uncertain (30% in Anand, 44.4% in Surat and 50% in Jamnagar) whether they would want to disclose to the child the truth about her/his birth, whereas few of them were unwilling to tell the truth.

Figure 4.18

Attitude of family and friends towards commissioning parents after the birth of the child



For most of the commissioning parents (56.7% in Anand, 88.9% in Surat and 100% in Jamnagar) the worst part of the entire surrogacy process was the fear that the surrogate mother might change her mind and refuse to relinquish the baby. Apart from this, there were other disturbing factors such as the level of secrecy that they had to maintain during the entire process of surrogacy and in case of foreign nationals the travel expenses they had to spend to visit India.

Actually, the decision to opt for surrogacy and the fear of the possibility to remain childless are the two main factors that affected the intended parents' family life a lot (56.7% in Anand and 72.2% in Surat). Other factors included the infertility treatment, the news of not being able to have a baby in the natural way, etc.

4.6 Conclusion

- ◆ The majority of the commissioning parents are well educated, fully employed and coming from the higher strata of the society.
- ◆ Most of the commissioning mothers had already tried to get naturally pregnant, but all their attempts failed.
- ◆ The surrogacy agents from the clinic claim that most of the commissioning mothers had missing uterus. However, other reasons for the commissioning parents to opt for surrogacy includes long term illness like diabetes, dysfunctional sexual organ etc.
- ◆ The contract is signed between the surrogate mother and the commissioning parents, so the clinics can skip any legal hassle.

- ◆ The commissioning parents come to India for surrogacy, first of all, because it is illegal in their own country and secondly, in India the entire surrogacy process is far cheaper than in other countries of the West.
- ◆ In most of the cases the surrogate mother is unknown to the commissioning parents and it is decided in the clinic which surrogate mother should match the particular intended parents.
- ◆ Most of the commissioning parents come from nuclear families with apparently equal opportunity for the women in decision-making process.
- ◆ In most of the cases the commissioning parents are desperate to have a baby and they do not have any preference for children of a certain sex. Moreover, some of them even do not hesitate to accept the child with deformities. However, such claims are made by the commissioning parents before the child is born; once a deformed child is born and the process of handing over the baby is about to happen, it is not certain whether the intended parents accept the baby or not.
- ◆ The decision to opt for surrogacy is jointly taken by the commissioning couple; most of the time the extended family members cannot interfere in this matter, because the majority of the commissioning parents belong to nuclear family set up. Hence, very often intended parents' friends' opinion counts even more than their family members. However, the final decision is made by the commissioning parents and they are free to choose.
- ◆ Media coverage of surrogacy in general and advertisements by the surrogacy clinics seems to be the important factor influencing commissioning parents' decision making in Gujarat.
- ◆ The contract signed between the commissioning parents and the surrogate mother does not mention anything about any insurance or emergency needs that the surrogate mother may require during the pregnancy; neither has it mentioned anything about her future after relinquishing the baby.
- ◆ Though most of the commissioning parents claim that the sex of the child is not important, on the other hand, they asking for getting the sex determination tests done in almost all cases. This may indicate the tendency of female feticide occurring in the clinics in the name of surrogacy.
- ◆ The commissioning parents' desperation to have a baby leads them to trust blindly the surrogacy arrangements that the clinics offer. Moreover, they are not concerned about the needs and conditions of surrogate mother other than her pregnancy related needs and hence, they do not develop any significant bonding with the surrogate mothers.
- ◆ The commissioning parents seem to be satisfied with the clinics' performance in conducting and supervising the entire process of surrogacy. In both Anand and Surat, the concerned

clinics have lavish hotels for the commissioning parents with all the state-of-the-art facilities, which easily impress especially the foreigners, and they do not want to get into the intricate details of finding the surrogate mother.

- ◆ It is mainly the clinic and the commissioning parents who decide between themselves when to relinquish the baby after childbirth, whereas the surrogate mother does not seem to be having any say in this matter at all.
- ◆ The commissioning parents have fear of what if the surrogate mother changes her mind and refuses to relinquish the baby. Since the rights of the surrogate mother are not protected and regulated by law in India it is easy to exploit her and hence, seems to be a matter of grave concern.

4.7 Surrogacy clinics

The following inferences are drawn upon from the observation of the surrogacy clinics at the field level in Anand, Surat and Jamnagar. The clinics were not willing to talk much about their work regarding surrogacy.

- The kind of support they provide the surrogate mother during the pregnancy period: the concerned clinics provide food and lodging for the surrogate mothers from the time of her successful pregnancy till she hands over the baby to the commissioning parents. The clinics do not provide any accommodation to the surrogate mother while she is repeatedly undergoing insemination for a successful pregnancy. Also, right after handing over the baby to the commissioning parents, the surrogate mother is left on her own, the clinic does not take any responsibility or care of her in case she is not accepted back by her family and village.
- How are the commissioning parents charged for the surrogacy service? On average the clinics charge around Rs. 12-15 lakh for the surrogacy service. There is no fixed guideline and the cost varies according to the clinic's own criteria. Most of the times, the commissioning parents from abroad are ready to pay the amount which is required in India, because it is much cheaper than in their countries. The clinics usually claim that a fair share of the money received from the commissioning parents go to the well being of the surrogate mother during her pregnancy, however, this is not the case – the clinics keep a big share for

themselves and give only 1-1.5% of the total amount to the surrogate mother as compensation.

- What amount of money is given as compensation to the surrogate mother? The amount of money given to the surrogate mother is not fixed and is usually decided by the concerned clinic. There is no fixed guideline and each clinic decides according to the money they get from the commissioning parents. The surrogate mother does not have any say in this matter and moreover, sometimes payment is delayed for months after she relinquishes the baby.
- Do the clinics provide any assistance to the surrogate mother in her recovery to normal life after the handing over of the child to the commissioning parents? As it was mentioned above, the surrogate mother has to leave the shelter home immediately after she hands over the baby to the commissioning parents. After that the clinics take no responsibility of the surrogate mother's safety, well being and lodging. It happens many times that she is not accepted back by her family and village as surrogacy is a huge stigma in rural India, and hence, she is completely left on her own without any emotional, infrastructural or monetary support system.

Chapter V

Conclusion and Recommendations

The major findings and conclusion drawn out of the study are the followings:

5.1 Conclusion

- ◆ First of all, the study has found out that economically vulnerable women with little or no educational background has been subjected to surrogacy arrangements where handful of clinics and agencies enjoy the maximum benefit. Hence, we are not in favour of commercialization of surrogacy, but, at the same time there is a need for concrete legal framework to monitor and regulate the existing surrogacy system.
- ◆ There are some ethical issues arising from the surrogacy arrangements. It seems not to be ethical for someone to create a human life with the intention of relinquishing it. This appears to be the primary concern for surrogate arrangements since the surrogate mother is providing germinal material only upon the assurance that someone else will take responsibility for the child she helps to create. The surrogate mother provides her ovum with the clear understanding that she has to avoid responsibility for the life she creates and she has to dissociate herself from the child in exchange of some other benefit such as money. In such a way, at the deepest level surrogate arrangements cannot be viewed as ethical, because they involve a change in motive for giving birth for the sake of some other benefits (money). On the other hand, using a surrogacy service when the biological mother cannot bear the child is no more morally objectionable than employing others to help educate, train, or otherwise care for a child.
- ◆ The child can be harmed if the commissioning couple is not fit parents. After all, a desire to spend substantial money to fulfill a dream to rear children cannot be a guarantee of good parenting. In addition, the intended parent may reject the child, but the same possibility exists with adoption or ordinary reproduction.
- ◆ The surrogate mothers, who are coming from poor family, have an average monthly income not more than Rs. 1,000-2,000 (35% in Anand, 42.86% in Surat and 40% in Jamnagar).

- ◆ The majority of the surrogate mothers has experience of giving birth and has at least two kids of her own (50% in Anand, 48.6% in Surat and 40% in Jamnagar); this implies that they are fertile women capable of reproduction naturally, who are made subject to reproductive assistance techniques to become surrogate mothers.
- ◆ The majority of the surrogate mothers are illiterate (51.7% in Anand and 8.6% in Surat) or have primary education (31.7% in Anand, 54.3% in Surat and 60% in Jamnagar); employed as domestic helpers (36.7% in Anand and 40% in Surat), construction workers (20% in Jamnagar) or nurses (40% in Jamnagar). Thus, they are economically vulnerable and desire for some money. Hence, the need of money is the driving force for them to become surrogate mothers.
- ◆ Most of the surrogate mothers are married (96.7% in Anand, 94.3% in Surat and 100% in Jamnagar) and live in nuclear family structure, which makes the surrogacy decision-making easier for the couple (95% of the surrogate mothers in Anand, and all the respondents in Surat and Jamnagar said that their husbands played pivotal role in taking the decision for surrogacy).
- ◆ Most of the time they use the money for educating their children (76.7% in Anand, 91.4% in Surat and 100% in Jamnagar) and also for building their own house or renovating the existing one (35% in Anand, 37.5% in Surat and 60% in Jamnagar).
- ◆ Most of them stay in rented houses (45% in anand, 71.4% in Surat and 100% in Jamnagar), which are kutcha (33.3% in Anand and 40% in Jamnagar) or semi-pucca (41.7% in Anand, 40% in Surata nd 20% in Jamnagar) with poor latrine facilities (55% of the surrogate mothers in Anand, 28.57% in Surat and 60% in Jamnagar said they had kutcha latrine facilities).
- ◆ Although, the husbands do not mind their wives to go for surrogacy, but after the baby is born and handed over, sometimes, the woman is not accepted by her family members. In 40% of the cases in Anand, 82.9% of the cases in Surat and all of the cases in Jamnagar the surrogate mothers have felt left alone by their family members and friends.
- ◆ Very often it is the agent who approaches the particular woman for surrogacy (97.2% in Surat and 100% in Jamnagar) and helps her to get in touch with the concerned clinic.
- ◆ Almost none of the surrogate mothers hold a copy of the surrogacy agreement. Only 1.7% in Anand and 2.9% in Surat stated that they have a copy of the contract.

- ◆ If the Intended parents do not wish to continue with the pregnancy due to some deformities in the baby or sex preference, in most of the cases the baby is aborted without any say of the surrogate mother. Only 2.9% of the respondents in Surat said that they had a say in the abortion decision under such conditions.
- ◆ The amount of money given to the surrogate mother is not fixed and is usually decided by the clinic. There is no fixed guideline and each clinic decides according to the money they get from the commissioning parents. The surrogate mother does not have any say in this matter and moreover, sometimes payment is delayed for months after she relinquishes the baby.
- ◆ Relationship between the surrogate mother and the commissioning parents, in most of the cases, remain harmonious, but from a distance. According to the surrogate mothers, the level of involvement for the commissioning parents with the entire pregnancy experience of the surrogate mother remains restricted to the initial stage of getting introduced to the former and making sure that surrogate mother delivers and relinquishes the baby as per decided. Majority of the surrogate mothers claimed that they shared a harmonious relationship with the commissioning mothers during the first stage of pregnancy (Anand – 86.7%, Surat – 88.6% and Jamnagar – 100%). However, the relationship between the surrogate mother and the commissioning parents seems to take a downturn as the pregnancy period advances to its completion; as towards the latter stage of pregnancy only 55% of the surrogate mothers we interviewed said that they shared harmonious relationship with the commissioning mothers; and for Surat it is 74.3%.
- ◆ Most of the surrogate mothers stay in the shelter homes (98.3% in Anand) during the pregnancy period. According to them, they do not want to disclose their pregnancy to the neighbours and surroundings, as social stigma is associated with it. On the other hand, the clinics also prefer them to stay in the homes instead of their respective villages in the interest of the surrogate baby, as the homes are better equipped to take care of the pregnancy-related issues.
- ◆ Many of the times, the surrogate mother remains in anticipation (71.4% in Anand and 80% in Surat) and fear (63.4% in Anand, 74.3% in Surat and 100% in Jamnagar) of the surrogacy process before the pregnancy.
- ◆ The majority of the commissioning parents are well educated (46.7% of the respondents hold Master's Degree in Anand, 44.4% in Surat and 100% in Jamnagar), fully employed (96% in Anand, 72.2% in Surat and 100% in Jamnagar) and coming from the higher strata of the society.

- ◆ The clinic authorities claim that most of the commissioning mothers had missing uterus. However, there are other reasons for the commissioning parents to go for surrogacy including long term illness like diabetes, dysfunctional sexual organ (40% in Anand, 72.2% in Surat and 50% in Jamnagar), complications in previous pregnancy (33.3% in Anand, 61.1% in Surat and 100% in Jamnagar), repeated failed fertility treatment (20% in Anand and 27.8% in Surat) etc.
- ◆ The contract is signed between the surrogate mother and the commissioning parents, the clinics always attempt to escape from any legal hassle. Only 3.3% of the doctors and other concerned persons in the clinic in Anand and 5.6% in Surat said that they have been a part of such contract, in the rest of the places, only the surrogate mother including her husband and the commissioning parents remain a party to such contract.
- ◆ The commissioning parents come to India for surrogacy mostly because it is illegal in their own country (23.3% in Anand and 22.2% in Surat); Moreover, in India the entire surrogacy process is much cheaper than in other countries of the West (63.3% in Anand, 44.4% in Surat and 50% in Jamnagar).
- ◆ In most of the cases the surrogate mother is unknown to the commissioning parents and it is decided in the clinic which surrogate mother should match the particular intended parents. (only 3.3% of the commissioning parents in Anand knew the surrogate mothers from before).
- ◆ The majority of the commissioning parents belong to the nuclear family (90% in Anand, 61.1% in Surat and 100% in Jamnagar) set up and have an equal say in decision making. 93.3% of the commissioning parents in Anand and all the respondents in Surat and Jamnagar told that the decision to opt for surrogacy was taken jointly by both the spouses.
- ◆ In most of the cases the commissioning parents are desperate to have a baby and they do not have any preference for children of a certain sex (93.3% of the commissioning parents in Anand, 77.8% in Surat and 100% in Jamnagar said that the sex of the child is not important). Moreover, some of them even do not hesitate to accept the child with deformities(63.3% in Anand, 66.7% in Surat and 100% in Jamnagar). However, such claims are made by the commissioning parents before the child is born; once a deformed child is born and the process of handing over the baby is about to happen, it is not certain whether the intended parents accept the baby or not.

- ◆ The decision to opt for surrogacy is jointly taken by the commissioning couple. Often, the extended family members cannot interfere in this matter, because the majority of the commissioning parents belong to nuclear family structure. Hence, very often intended parents' friends' opinion counts even more than their family members. However, the final decision is made by the commissioning parents and they are free to choose.
- ◆ Media coverage of surrogacy in general and advertisements by the surrogacy clinics seems to be the important factor influencing commissioning parents' decision making in Gujarat(93.3% in Anand, and 100% in each of Surat and Jamnagar).
- ◆ The contract signed between the commissioning parents and the surrogate mother does not mention anything about any insurance or emergency needs that the surrogate mother may require during the pregnancy; neither has it mentioned anything about her future after relinquishing the baby.
- ◆ Though most of the commissioning parents claim that the sex of the child is not important, on the other hand, they asking for getting the sex determination tests done in almost all cases(50% in Anand, 72.2% in Surat and 100% in Jamnagar). This may indicate the tendency of female feticide occurring in the clinics in the name of surrogacy.
- ◆ The commissioning parents' desperation to have a baby leads them to trust blindly the surrogacy arrangements that the clinics offer. Moreover, they are not concerned about the needs and conditions of surrogate mother other than her pregnancy related needs and hence, they do not develop any significant bonding with the surrogate mothers.
- ◆ The commissioning parents seem to be satisfied with the clinics' performance in conducting and supervising the entire process of surrogacy (93.3% in Anand and 94.4% in Surat). In both Anand and Surat, the concerned clinics have lavish hotels for the commissioning parents with all the state-of-the-art facilities, which easily impress especially the foreigners, and they do not want to get into the intricate details of finding the surrogate mother.
- ◆ It is mainly the clinic and the commissioning parents who decide between themselves when to relinquish the baby after childbirth, whereas the surrogate mother does not seem to be having any say in this matter at all.

- ◆ The commissioning parents have fear of what if the surrogate mother changes her mind and refuses to relinquish the baby (56.7% in Anand, 88.9% in Surat and 100% in Jamnagar). Since the rights of the surrogate mother are not protected and regulated by law in India it is easy to exploit her and hence, seems to be a matter of grave concern.

5.2 Recommendations

The desire for motherhood leads infertile couples/single persons/gay couples to search for alternative solutions, and surrogacy presents itself as the most viable alternative. In some cases surrogacy is the only available option for parents who wish to have a child that is biologically related to them. Slowly but steadily India is emerging as a popular destination for surrogacy arrangements for many rich foreigners'. Cheap medical facilities, advanced reproductive technological know-how, coupled with poor socio-economic conditions, and a lack of regulatory laws in India, in this regard combined to make India an attractive option.

However, with the entry of financial arrangements in exchange of the surrogate child, surrogate motherhood has raised difficult ethical, philosophical, and social questions. Surrogacy arrangements have made child a 'saleable commodity', and complications have arisen regarding the rights of the surrogate mother, the child, and the commissioning parents. As there is no legal provision to safeguard the interests of the surrogate mother, the child, or the commissioning parents in India, looking at such an issue from commercial or business point of view has complicated the matter further. Though the Assisted Reproductive Technology (ART) Regulation Bill, 2010 did bring forth certain important points for the legal framework to be based on, but, it has also left out on many crucial issues relating to surrogacy arrangements.

The lack of research on surrogacy also poses a problem for Government agencies when it comes to initiating legal provisions and taking substantive action against those found guilty. A number of surrogacy related questions remains unanswered, including: is it legal to become surrogate mother in India? Will the child born to an Indian surrogate mother be a citizen of this country? Who arranges the birth certificate and passport required by the foreign couple at the time of immigration? Whose name will appear on the birth certificate? How will the commissioning parents claim parenthood? What happens if the surrogate mother changes her mind and refuses to hand over the baby or blackmails for custody? Who will take the responsibility of the child if the commissioning

parents refuse to take the child? What would happen if the child is born disabled? What would happen if the sex of the child is not to the liking of the commissioning parents? Such questions need thorough analysis before any policy relating to surrogacy is designed and legal provisions are made. To address these issues relating to surrogacy, Centre for Social Research (CSR) conducted an exploratory study on surrogacy in three of the high prevalence areas: Anand, Surat and Jamnagar of Gujarat state. Anand in Gujarat is quoted as the 'cradle of the world'. The sample size for the study consisted of hundred surrogate mothers and fifty commissioning parents. The research team also interviewed stakeholders of the study such as Shelter home Supervisors, husbands of surrogate mothers, embryologists, cab drivers, hotel employees, agents, slum dwellers, builders, etc.

The recommendations drawn out from the present study on surrogacy are the followings meant for Central government, state government, National Commission for Women (NCW) and Indian Council of Medical Research (ICMR):

Role of Central Government:

- ✦ We are not in favour of commercialization of surrogacy, but, at the same time there is a need for concrete legal framework to monitor and regulate the existing surrogacy system.
- ✦ There should be legislation directly on the subject of surrogacy arrangement involving all the three parties i.e. the surrogate mother, the commissioning parents and the child.
- ✦ A clearly defined law needs to be drafted immediately which will pronounce in detail the Indian government's stand on surrogacy; so that discrete activity leading to exploitation of the surrogate mother can be stopped.
- ✦ Although bearing a child for another couple may be a noble idea, but, then relinquishing it for adoption, not regulated by law may raise a number of confusions.
- ✦ It has to be regulated whether paying the mother a fee for adoption beyond medical expenses is a crime (like in some countries) or not. In case it is recognized as crime and one pays extra charges then it should prevent the adoption from being approved.
- ✦ There should be a substantial regulation designed to protect the interests of the child
- ✦ Legal recognition of termination and transfer of parenting rights
- ✦ There should be an interpreter (other than doctor) for the communication linkage between the surrogate and intended parents in order to convey the message from surrogate mother time to time. As far as often doctors speak on behalf of surrogate mothers, but there is no guarantee that their interests are conveyed without any misinterpretation.

- ✚ Typically, after the birth the surrogate mother is left without any medical support, it is recommended that there should be a provision of intensive care and medical check-ups of their reproductive organs during the 3 months after pregnancy.
- ✚ In case surrogate mother gives birth to twins she should be paid double amount or at least 75% of the price for the second child.
- ✚ The commissioning couple should try to establish a relationship of trust with the surrogate, yet such a relationship creates reciprocal rights and duties and might create demands for an undesired relationship after the birth.
- ✚ The citizenship right of the surrogate baby is also of crucial importance. The Indian government needs to take a stand in terms of conferring the surrogate baby Indian citizenship as s/he is born in the womb of an Indian (the surrogate mother) and in India.
- ✚ The rights of the child should be protected and in case s/he is not taken by the commissioning parents, then the child should be given Indian citizenship.
- ✚ Health Insurance for both the surrogate mother and the child is essential to ensure a healthy life.
- ✚ The government needs to monitor the surrogacy clinics, which generally charge arbitrary prices for surrogacy arrangements. Regulations would enable the government to ensure that the clinics charge fair prices.
- ✚ Proper Monitoring Committee should be established under the ART division of the Ministry of health & Family Welfare (MoHFW) to control and regulate all surrogacy arrangements.

Role of State Government:

- ✚ The government should check and control the proliferation of commercialization of surrogacy.
- ✚ The government needs to monitor the surrogacy clinics, shelter homes and agencies for ensuring the rights of surrogate mothers, commissioning parents and the child born through surrogacy arrangements.
- ✚ The state government must look into poverty alleviation schemes/programmes particularly in and around the areas/localities where surrogate mothers live.
- ✚ The state government should encourage employment generation schemes/programmes in those pockets where surrogate mothers live.

National Commission for Women (NCW)

- ✚ There is a need of right-based legal framework for the surrogate mothers, as far as the ICMR guidelines are not enough.
- ✚ The surrogate mother should be provided by the copy of the contract as she is a party in the agreement and her interests should be taken into account. It happens that very often decision is taken by the intended parents and clinic, while surrogate mother does not have any say in this matter.
- ✚ There is a need of debate and discussion of the stance that public policy and the law should take toward surrogate mothering. Actually, there exists a range of choices from prohibition and regulation to active encouragement.
- ✚ The government needs to monitor the surrogacy clinics, which generally charge arbitrary prices for surrogacy arrangements. Regulations would enable the government to ensure that the clinics charge fair prices.
- ✚ The contract signed between the commissioning parents and the surrogate mother should mention something about insurance and emergency needs that the surrogate mother may require during the pregnancy; it has to mention something about her future after relinquishing the baby.

Indian Council of Medical Research (ICMR):

- ✚ Commercialisation of surrogacy should be dissuaded. However, there should be proper monitoring of existing surrogacy system through concrete legislation.
- ✚ It is crucially important to maintain and monitor the anonymity of the surrogate mothers.
- ✚ The surrogate mother should not undergo more than 3 trials and it has to be monitored.
- ✚ The surrogate mother should have a copy of the contract signed by all parties involved in the surrogacy arrangements including the clinic/hospital and the infertility physician.

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also happens to be five months pregnant with her baby. This is motherhood with a twist, and it is complicated. With honesty, humor, and heartbreaking insight Ashley shares her experience of navigating through this new landscape with no guidebook, no map. “My generation and our children are the subjects of this reproductive revolution, how we live through it must be figured out on a trial and error basis,” Ashley writes. And like motherhood, which demands responsibility and love, Ashley is determined to figure it out, thereby shedding light and possibility on an uncharted place. In the end, *Standing in Two Places* is a memoir about love. If not for love, what other reason is there to willingly throw oneself head long into the unknown?

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- devastating infertility, Pamela MacPhee volunteers to be their surrogate. After navigating the psychological evaluations, doctor examinations, and legal necessities of surrogacy, MacPhee begins a challenging emotional and physical journey. It all becomes real on the day she watches Lauren and Henry stand silently in awe, listening to a rapid pounding ultrasound heartbeat that confirms a pregnancy.
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