# A Synopsis of

# Psychosocial Experiences of Surrogate Mothers in Gujarat, India: An Ethnographic Exploration

**A thesis to be submitted for the award of the degree of**

**Doctor of Philosophy**


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**October, 2016.**

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# 1. Abstract

Practice of ‘surrogacy’, an extension of the Assisted Reproductive Technology, has raised concerns over ethical, moral and social issues associated with it. As a result, several nations have banned its practice, India being one of the exceptions. Surrogacy provides rays of hope to people experiencing infertility; however wellbeing of surrogate mothers involved is contested. Surrogacy is a rapidly increasing phenomenon in the contemporary Indian society with culture specific implications for the individual and family that need to be unravelled. An ethnographic study was conducted at an infertility clinic in Anand, Gujarat, India with 41 surrogate mothers to understand their experiences of participation in surrogacy. Data was generated using in-depth interviews and participant observation during intense nine months of engagement at the infertility clinic. The study explored motivations of surrogate mothers, psychological agency they exercised in seemingly oppressive conditions, construction of maternal identity in the context of surrogacy, and impact of surrogacy on the their lives and their families. Results indicated that women entered surrogacy to overcome limiting life circumstances and transform lives of their children. In the context of stigma, women viewed institutionalisation during surrogacy as advantageous; nevertheless such an arrangement also put forth new challenges. Women selectively used bio-medical and indigenous discourses of conception to emphasise own maternal identity for subjective advantage. Nuances of the psychological agency of Indian women in the context of surrogacy were explored. Findings offer new insights with significant implications for policy and guidelines for introducing a counselling component during surrogacy are proposed.

# 2. Introduction and Review of Literature

Advent and spread of Assisted Reproductive Technology (ART) in India has juxtaposed socio-cultural notions of parenting, economy, and medical ethics. The spectacular development of ART in the last century is considered revolutionary however, has also brought forward with it challenges that must be faced both, at the level of health service delivery and society (Fathalla, 2002).

## 2.1. Surrogacy: A Global Perspective

Commercial surrogacy is increasingly used to realise parenting aspirations by individuals experiencing infertility. It is an arrangement wherein a healthy woman agrees to be impregnated through artificial insemination, carry pregnancy to term, and relinquish the child thus born and all associated parental rights to another person or a couple experiencing infertility in exchange of money (Wilkinson, 2003). Its practice is banned in Germany, France, several Australian states, Japan, and Korea; and is severely restricted in Israel, UK, and most of the US states. Unequal access to reproductive health services across the globe has resulted in its cross-border trade (Spar, 2005). Scholars have scrutinised the bi-polar legal framework wherein commercial surrogacy is either banned or is permitted without adequate legislation and recommend developing measures to safeguard interests of the various stakeholders involved in surrogacy, especially the surrogate mothers. Damelio and Sorensen (2008) suggest a ‘soft-law’ – an approach requiring pre-surrogacy education to enhance autonomy of surrogate mothers and curb their exploitation. Gagin, Cohen, Greenblatt, Solomon, and ItsKovitz (2005) created a counselling program to consult and support surrogate mothers and commissioning parents at various stages of commercial surrogacy in Israel.

**2.1.1. Nature of Surrogacy Programmes.** Ragone (1996) characterised surrogacy programs in the U.S. as 'open' or 'closed'. Open surrogacy allowed mutual selection of surrogate mothers and commissioning parents and encouraged regular interaction amongst stakeholders. Closed surrogacy programs limited liberty of surrogate mothers. 'Organisational sub-culture' at the infertility clinics was pivotal in determining success of surrogacy and governed various practices including criteria for the selection of commissioning parents and surrogate mothers, counselling offered and interactions between different stakeholders (Tieu, 2009).

**2.1.2. Recruitment of Commissioning Parents and Surrogate Mothers.** The prerequisite conditions to avail surrogacy services remain more or less common across practicing nations and are restricted to certain medical conditions like congenital absence of the uterus, hysterectomy, recurrent abortion, repeated failure of IVF, cancer surgery, and other medical conditions like severe heart or renal disease wherein pregnancy could be life threatening **(Brinsden, 2003)**. However, socio-cultural landscape of the practicing nation may result in further detailing of these criteria. Surrogacy services are often restricted to married and heterosexual couples in Israel, U.K., and some parts of the U.S. (Teman, 2001; van den Akker, 2007). Recruitment procedures for surrogate mothers vary - in the U.S. they are recruited by private agencies, while in UK surrogate were selected from family or friends or through support from patient infertility support groups **(Brinsden, 2003)**.

**2.1.3. Profiles and Motives of Surrogate Mothers.** Empirical evidence across cultures reveals that surrogate mothers are often less educated, and come from lower socio-economic strata compared to intended parents, medical practitioners, and people who brokerage gestational services of the surrogate mothers (Pande, 2009[a]; Vora, 2009; van den Akker, 2007; Ciccarelli & Beckman, 2005; Gagin et. al. 2005; Temen, 2001; Ragone, 1996) and thus are most vulnerable in the arrangement. Through her ethnographic study in the US,

Ragone (1996) revealed that, many surrogate mothers viewed surrogate role as an opportunity to move out of domestic realm and participate in work which could bring appreciation for their rarely acknowledged reproductive role. However, surrogates often engaged in devaluation of monitory compensation as a means to comply with the cultural construction of selfless and altruistic motherhood as well as of children as invaluable entity.

#### 2.1.4. Relationship among Surrogate Mothers, Intended Parents, and the Child.

Ethnographic studies in the U.S. have revealed that surrogacy programmes often hold a great potential in determining interpersonal relationships between surrogate mothers and intended parents. Blyth (1994) stated that for surrogate mothers, the relationship moved much beyond a mere business. Experiences prior to birth and post birth, surrogate mothers' relationship with the commissioning parents, and fulfilment of their expectations from commissioning parents were major determinants of the satisfaction of surrogate mothers. Feeling of abandonment by commissioning parents was found to be particularly disturbing (Ciccarelli & Beckman, 2005).

### 2.2. Challenges in the Practice Commercial Surrogacy

Surrogacy holds eugenic potential wherein cultures stressing importance of a male child may abuse it for selective abortion of female foetuses (Ferraretti, Pennings, Gianaroli, Natali, & Magli, 2010; Qadeer, 2009; Sama, 2008). Men and women of a particular race may form a highly sought after group for gamete donation because of highly valued genetic, intellectual and physical traits where as women from the "less worthy" race are involved as surrogate mothers or 'incubators' (Corea; 1985). Surrogacy has been critiqued as a form of objectification of women's bodies which reduced women to mere 'wombs' or 'incubators' at the cost of their bodily integrity (Gupta Agnihotri, 2000; Corea, 1985). It essentially involves exposing a healthy woman to medical interventions for people experiencing infertility and health risks for surrogate mothers have not received deserved attention (Fathalla, 2002; Sama,

2009). The notion of 'choice' to participate in surrogacy is also challenged on the premises of how informed it is (Curtis, 2010; Qudeer, 2009; Gupta Agnihotri, 2000). Surrogacy poses challenge to normative assumptions of 'kinship', 'family' and 'parenting' and creates legal dilemmas especially in the context of inadequate legal frameworks based on traditional concepts of kinship and family.

### 2.3. Surrogacy: An Indian Overview

Advent and spread of ART in India has juxtaposed socio-cultural notions of parenting, economy, and medical ethics. In the last decade, increasing number of private and corporate hospitals and ART clinics in major Indian metros including Delhi, Mumbai, Ahmadabad, Calcutta, Chennai, and Hyderabad offered commercial surrogacy services (Srinivasan, 2004) and India had emerged as a hub for transnational surrogacy services (Ferraretti et al, 2010; Chang, 2009). In a strong patriarchal social setup of India, commercial surrogacy is often compared to sex-work and is a highly stigmatising experience. Limited education and poverty may expose surrogate mothers to high risk of subordination and exploitation in the surrogacy arrangements. Gupta Agnihotri (2000) expressed the possibility of subjugation of women at familial level to enter surrogacy. Pande (2009[a]) revealed that family members of the surrogate mothers viewed surrogacy as a familial obligation of woman and women may be forced in surrogacy. Sharyn and Anleau (1990) voiced concern that altruistic surrogacy within the family may involve higher risk of oppression of women compared to commercial surrogacy. The racial and class differences women may experience are further compounded by hierarchical relationships between patients and doctors in India (SAMA, 2008), where surrogate mothers may not freely express their concerns and demands.

A handful of empirical studies conducted with surrogate mothers in India have revealed unique features of their experiences. In a nutshell, empirical evidence suggests that Indian surrogate mothers were from poor families and were often forced to participate in

surrogacy by prevailing social circumstances (Saravanan, 2010; Pande, 2010[a,b], 2009[a,b], Vora, 2009; Gupta Agnihotri & Richters, 2008). A study by Saravanan (2010) revealed that ART clinics selected only those women as surrogate mothers who were submissive to the demands of medical practitioners and comissioning parent/s. Surrogate mothers experienced tremendous psychological pressure and hid their pregnancy from extended family members and society. They secluded themselves to hide their pregnancy from immediate society by living in surrogacy hostels provided by the hospitals or clinics facilitating surrogacy (Pande 2010[b], Qadeer & John, 2009). Such institutionalisation reduced their mobility, alienated them from their immediate family and put them at the additional risk of constant surveillance by medical practitioners. This may further lead to medical practitioners and commissioning parent/s exerting higher control over surrogate mother's life (Pande, 2010[b]) and surrogate mothers may experience loss of freedom (Saravanan, 2010). Indian surrogate mothers often expressed a sense of attachment and bond with the foetus (Pande, 2009[b]) and constructed duty based 'pseudo kinship ties' with commissioning parents wherein comissioning parent/s were visualised as lifelong patrons (Vora, 2009). These expectations of Indian surrogate mothers for long term support from commissioning parent/s of higher socio-economic strata and/or a privileged race were rarely communicated and were least likely to be fulfilled.

### 2.4. 'Psychological Agency' of Women in India in the Context of Surrogacy

Application of Euro-American individualistic thought often fails to capture local realities in the relational cultures. Individualistic conception of agency frames agents as individual actors and when applied in the settings where self is constructed in relation with the others does not yield a coherent account of actions agents engage in. Individual embedded in significant social relations is proposed as an apt unit of analysis to generate a more nuanced understanding of agency in Indian context (Ganesh, 1999). A plea for widening the limited and bipolar view of women's agency as resistance or passive acceptance of oppression

has reflected in the writings of scholars of Asian origin including Ganesh (1999), Menon (2004) and Raval (2009). Agency viewed from a individualistic lens often obscures Indian women's compliance to the social roles or primacy to the needs of their kin as 'victimisation' and fails to recognise the constructive potential of negotiatory processes women engage in. Ganesh (1999) therefore identifies exploration of the nature of agency exercised by Indian women and their active processes of negotiation as fruitful endavors for future research. On similar line, Ahearn (2001) proposes that multiple forms of agency may guide a single action. Therefore, acts of acceptance, accommodation, ignorance, resistance or protest could all be viewed as manifestations of agency. With this background, this study questioned the unilateral view of surrogate mothers in Gujarat as 'victims' and explored exercise of agency by surrogate mothers, process involved, and the contexts in which agency was actualised.

### 2.5. Conceptual Framework for the Study

Conceptual framework for the study (Figure 1) heavily drew on the contemporary cultural psychological perspective of individual development by Shweder (2006). It demonstrates course of surrogacy as an intentional action in the macro context of poverty, global economy, and incongruent ART laws that promote national and transnational trade in reproductive health services. Surrogate mother in the context of her family relations was considered as a primary 'relational agent'. Such an agent was considered to be a self-reflective being that interprets her world and through her imaginative capacity makes plans for the future. Futuristic plans are oriented towards meeting her needs in the context of her family relations. This process may involve complex covert mental activities which are transformed in reality through intentional decisions. Participation in surrogacy was conceived to be an intentional activity which came into being after much deliberation and was oriented towards attainment of some specific goal in the future. During this period surrogate mothers are exposed to a new set of circumstances, people, and ideologies and required adaptation to such

changes. They experienced several barriers as well as facilitators during this process towards the attainment of their goals. Though the practice of mothering took a new form in the context of ART, the underlying mentalities associated with the practice of mothering may not change quickly thus creating a conflict between practice and associated mentalities. This conflict results in role ambiguity and may require surrogate mother as well as commissioning mother to reconstruct their sense of motherhood. Though participation in surrogacy was an intentional, goal oriented action on the part of surrogate mother, it invariably resulted in some unintended outcomes. These unintended outcomes may spill over different aspects of surrogate mothers' lives including health and family relations. It thus appears that surrogate mothers actively construct their own experiences albeit with varying degrees of agency in several forms throughout the process of surrogacy. The exercise of agency takes place in varied situations and in context of several interpersonal relationships. The character of the situational and relational context may determine how agency is exercised or in which form it is manifested. Such a complex process of exercise of agency however may not occur at a conscious level. The underlying mental foundations that guide the practice of agency are represented through a predictive model of a 'custom complex' of agency in Indian context. Based on the different theoretical perspectives and empirical evidence, the study conceptualises agency as,

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

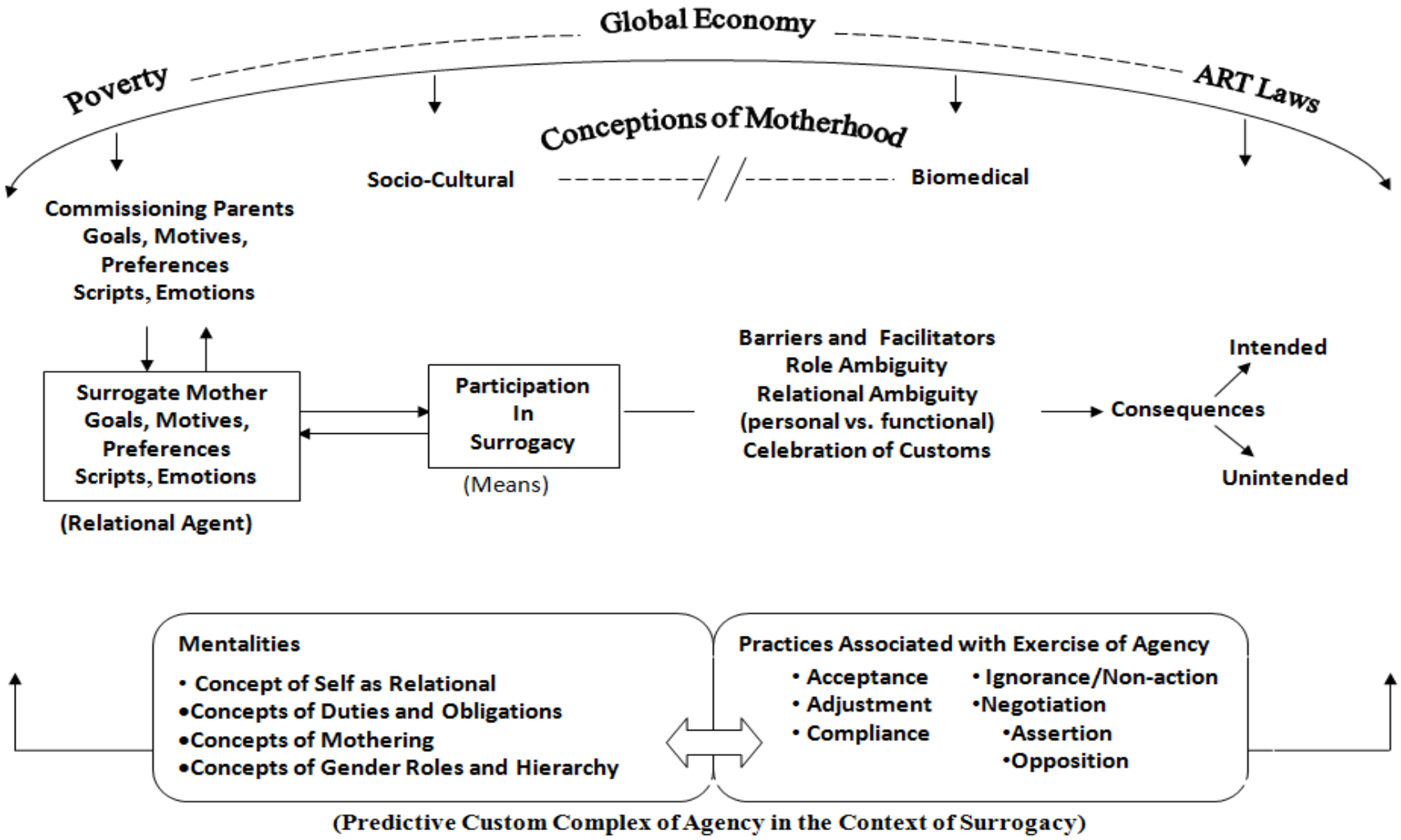



**Figure 1: Conceptual Framework**

### 2.6. Significance of the Study

- Commercial surrogacy is a rapidly increasing phenomenon in the contemporary Indian context with culture specific issues and implications on the individual and family that need to be unravelled.
- Understanding surrogacy and documenting experiences of surrogate mothers is crucial for promoting an evidence based policy.
- Study would contribute to the understanding of changing notions of 'motherhood' in the context of surrogacy
- It would expand understanding of the psychological agency of women from the relational perspective.
- The study will help develop insights on the implications of surrogacy for surrogate mothers and their families.

### 2.7. Research Objective

The study aimed to understand socio-culturally mediated experiences of surrogate mothers in Anand, Gujarat, India.

### 2.8. Research Questions

- What are the experiences of surrogate mothers participating in surrogacy in Gujarat, India?
- How do surrogate mothers negotiate 'agency' in the process of gestational surrogacy?
- How is the maternal identity of a surrogate mother constructed in the context of gestational surrogacy?
- How does participation in surrogacy influence the lives of surrogate mothers and their families?

# 3. Methodology

## 3.1. Research Genre

A qualitative research approach was best suited to meet the goal of understanding lived experiences of surrogate mothers for the following reasons:

- Though ethical dilemmas associated with practice of surrogacy in the context of poverty have invoked attention of media, feminist groups, and legal scholars, limited empirical data is available on the issue in the Indian context. Inductive nature of qualitative enquiry was thus beneficial for the study.
- Exploration of the socio-culturally mediated experiences of surrogate mothers required a context specific approach to capture their subjective interpretations/ 'meaning making' associated with behaviours and events they engaged in.
- Process oriented nature of the qualitative research facilitated study of the issues linked with exercise of psychological agency by the surrogate mothers.

## 3.2. Research Design

An ethnographic research design was adopted for this study. Though, historically this meant use of ethnography to study small, traditional, and culturally isolated societies, scope of contemporary ethnography has expanded to study 'communities of interest' (Angrosino, 2007). Ethnographic approach was ideal to meet aims of the study as:

- Novelty of research phenomenon could be addressed using ethnographic approach equipped to investigate groups apart from the mainstream and less studied social issues and behaviours.
- Participation in surrogacy required surrogate mothers to live in the geographical boundaries of the infertility clinic/ surrogate hostel for a year or more. Albeit temporary in nature, shared living with fellow surrogate mothers and close

contact with medical professionals, created a community with its own distinct ideologies, shared beliefs, practices, and language. Thus, ethnographic approach was used to capture essence of this 'community of interest'.

- Application of ethnographic approach supported exploration of the phenomenon from ‘emic perspective’- crucial to develop insights into policy implications.

In line with the views expressed by Gobo (2008) and Angrosino (2007) the term ‘ethnography’ is conceived as a 'methodology' and not merely a 'method' for this study.

**3.2.1. The Setting.** Sites for the ethnographic study are selected such that the issue ethnographer intends to study is most likely to be seen in a reasonably clear fashion. This study was therefore situated in Gujarat widely recognised as the surrogacy hub in India. An infertility clinic in Anand, three infertility clinics in Ahmadabad and one clinic in Surat, Gujarat were identified through desktop research as probable sites for the study. Preliminary interviews with the ART practitioners from these clinics revealed that ART clinics differed on the nature of surrogacy cases they undertook as domestic and/or transnational cases of surrogacy. Clinics also varied in their practice of providing a temporary shelter to surrogate mothers during surrogacy. A clinic in Anand was purposively selected for the study based on the high number of surrogacy cases handled, both domestic and transnational.

**3.2.2. Entering the Field and Gaining Access.** In ethnographic research, gaining access to the field is not a onetime exercise; instead access is negotiated and renegotiated at multiple levels of the research project **(Gobo, 2008)**. Official permission from the infertility specialist was the stepping stone for my fieldwork; and later I navigated access through surrogate house matrons and surrogate mothers. Initial observational and interview data from surrogate mothers provided clues for new relevant sites for further data collection as listed in

the figure 2. Access to newly identified sites was often ushered by informal friendly network I had established also termed as gaining ‘social access’ by Gobo (2008).

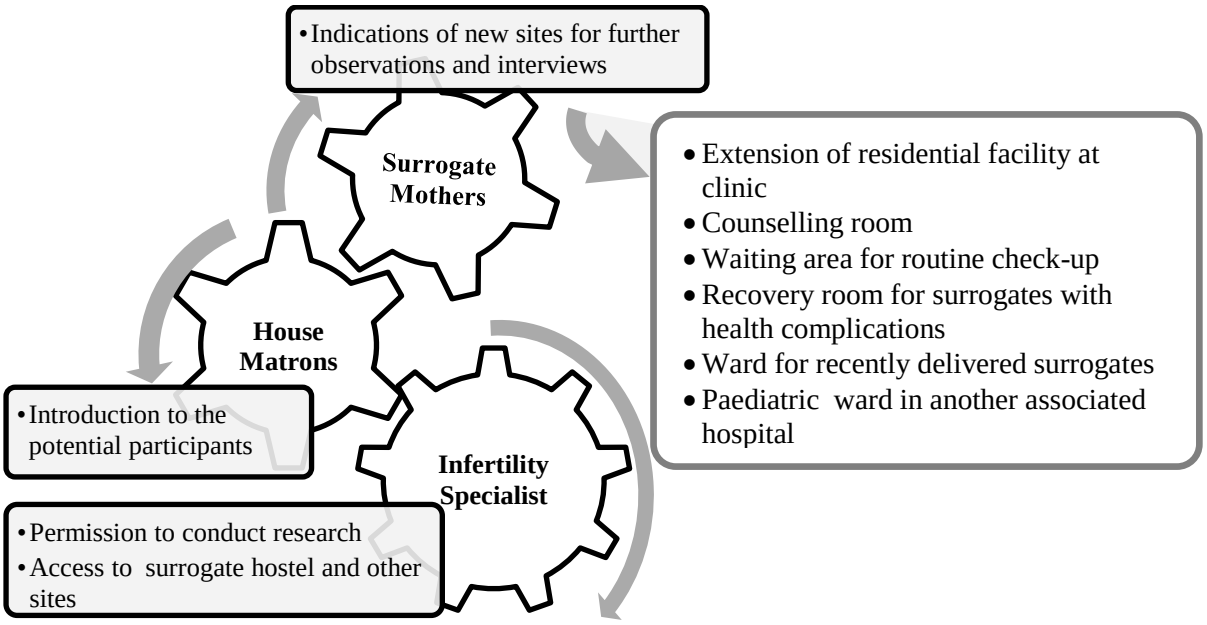



**Figure 2: Process of Gaining Access**

**3.2.3. The Participant Role.** Participant observation is the hallmark of ethnographic research methods and often requires researcher to take up a participant role in the field. Angrosino (2007) clarifies that,

> *"Participant observation is not in itself a 'method' of research - it is the behavioural context out of which an ethnographer uses defined techniques to collect data" (pp. 17).*

The 'behavioural context' Angrosino refers to is also commonly known as 'the participant role'. Researcher is considered as an 'instrument' of the ethnography and is immersed in the realities of people she studies by becoming a participant. For this study, I adopted the role 'Participant-as-Observer' wherein; I was completely immersed in the field to observe daily routines of surrogate mothers and was known to them as conducting research with prior permission and their consent. My relationship with the women I studied was as much a friend

as a researcher. Surrogate mothers often anticipate stigma for participation in surrogacy and it was largely a secretive endeavour for them; therefore winning trust of the women was crucial for their participation in the study. My personal attributes of age, gender, and marital status helped me establish friendly ties with the women I studied and win their trust. I carefully managed my identity as a married woman wearing cultural symbols of 'mangal sutra', 'bindi', and traditional Indian clothing, which was crucial to establish an identity of a married woman - a mature member of the society with whom one could talk of intimate issues associated with family, marriage and reproduction. In the initial months of fieldwork, I spent time getting to know the setting, identifying boundaries for my free movement at the clinic, identifying key-contact persons, befriending surrogate mothers, hostel matrons, and receptionists, nurses, and doctors at the infertility clinic. This involved engaging in casual talks, asking questions pertinent to plan fieldwork, participating in daily routines of surrogate mothers like cleaning vegetables and eating lunch with them regularly, participating in their leisure activities, and a lot of self-disclosure. At the later stages of my fieldwork, my participant role also involved providing emotional support and comforting the surrogates experiencing especially difficult circumstances like health complications and miscarriages. Thus, establishing a 'participant-as-observer' role was a continuous process - both planned and spontaneous - that established my credibility not only as a researcher but also a trustworthy person which greatly aided and shaped the research process. Data collection was spread across a period of nine months with an average of 15 to 20 days spent on the field every month. An average field day lasted six to seven hours spent on the field and over 2 hours of travelling.

**3.2.4. Sampling.** A dilemma in designing qualitative research is to determine the extent of pre-structure a researcher may accord to the methods and Maxwell (2005) advocates pre-structuring especially for the novices. However, Miles and Huberman (1994) state that regardless of the extent of pre-structure, design decisions are almost always revised in

qualitative research. Sampling parameters for the study as summarised in the figure 3 were determined on the basis of the conceptual framework for the study and the research questions. The choice of settings, people, and events to be studied was largely based on the observations and interactions made during fieldwork.

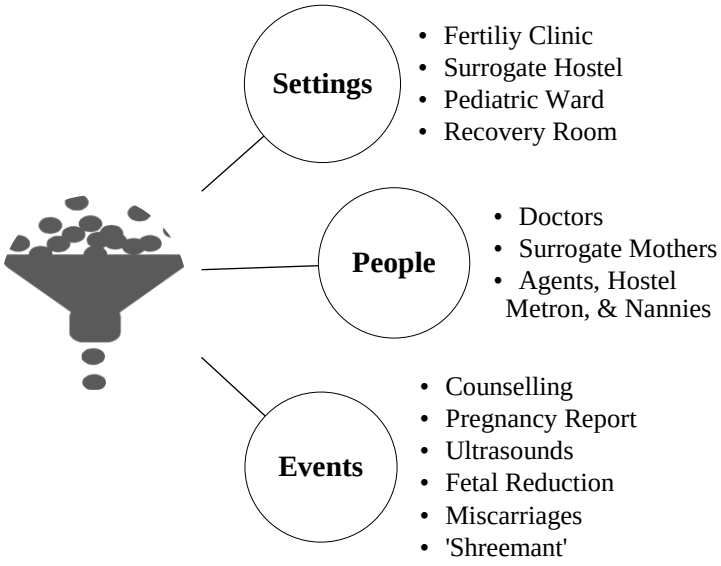



**Figure 3: Sampling Parameters**

***Sampling Strategies.*** A combination of sampling strategies was used to guide the process of data collection. Hammersley & Atkinson (cited in Cresswell, 2007) suggest that sampling decisions be informed by understanding of the 'chronological time in the social life of the group', demographic representation of the social group being studied and circumstances that may lead to variation in behavioural patterns of the members. Stratified purposive sampling was used as a primary rubric for data collection to ensure inclusion of women across various stages of surrogacy. A combination of techniques- maximum variation, snowball and opportunistic sampling- was used to select participants. Ethical considerations also shaped sampling decisions. It was difficult to interview women who had recently delivered babies and were in their phase of recovery often after a caesarean section surgery. Instead, interviewing women who were repeating surrogacy was a viable option.

**Table 1: Emerged Sampling Distribution**

| Surrogate Mothers | First Timers | Repeaters | Total |
|---|---|---|---|
| Pre-Conception | 6 | 2 | 8 |
| Trimester 1 | 7 | 4 | 11 |
| Trimester 2 | 5* | 2 | 7 |
| Trimester 3 | 5 | 4 | 9 |
| Post Delivery | 3 | 3** | 6 |
| Totals | 26 | 15 | 41 |

* Special Case 1: Series of opportunistic interviews spread over 4 weeks for one of the participants
** Special Case 2: Included a woman working as nanny, last surrogacy completed 2 years prior to the interview

### 3.3. Methods of Generating and Handling Data

Triangulation of qualitative and quantitative data collection methods as well as primary and secondary data was specifically planned to understand the experiences of surrogate mothers from multiple vantage points. A brief structured survey was used to capture socio-demographic details of women. Qualitative data was generated using participant observations, structured observations of the specific events, semi-structured in-depth interviews with the surrogate mothers and the medical practitioners, and brief interactions with the key informants and family members of the participants. In-depth interviews lasted for 45 minutes to one and half hour, were conducted in Gujrati or Hindi as per the preference of the participants and were audio recorded with prior permission. Transcriptions noted changes in voice tone, force in voice, and long pauses and laughter. Archived materials including documentary films, TV series episodes, and newspaper publications featuring the infertility clinic were used as secondary data to enhance understanding. Essentially, varied methods of data collection were used in parallel rather than in a sequential manner.

### 3.4. Methods of Data Analysis

Data analysis began early during data collection with writing field notes, transcribing data and jotting down reflective memos and leads. Merging of data collection and analysis greatly aided in refining research focus to explore new unanticipated key concepts. Thematic analysis was used to identify recurring themes or patterns in the narratives of women. It facilitated both - rich descriptions and interpretations – explaining how different components of data fit together (Braun & Clarke, 2006). The analysis aimed to provide a rich thematic description of the entire data set to provider reader an accurate reflection of the complete data set. As Broun and Clarke (2006) point out, this approach to data analysis was crucial as surrogacy in Indian context was a particularly under researched area. The analysis was primarily inductive – data driven – in nature and progressed from a descriptive to interpretive analysis to produce socio-culturally situated meanings. The specific steps in data analysis involved listening to audio recordings and transcribing the narratives, expanding field notes, reading and re-reading completed transcripts and writing marginal remarks, writing analytical notes and memos, developing a list of codes, developing code definitions and continuously refining them as analysis progressed, collating and rearranging codes in major themes and naming and refining them. Prevalence of the themes was counted at the level of the data item.

### 3.5. Ensuring Quality

Following measures were adopted to ensure quality of the research.

- Merging data collection and analysis allowed switching emic and etic perspectives through a regular reflective process and facilitated refining research focus
- Establishing inter-rater reliability with the help of another researcher during early phases of analysis allowed maximum variation in coding and helped generate a preliminary code book and at the later stages of analysis helped to minimise coding differences

- Exploring experiences of the participants in sufficient details and triangulation of data sources – interviews, observations of critical events/episodes, participant observations, and field notes – helped to establish credibility of interpretations
- Detailed documentation of the research methods and codebook and retaining the research data to helped ensure replicability of the study

### 3.6. Ethical Considerations

- Research proposal, research tool, data collection and methods of analysing and interpreting data were reviewed by research committee at the department of human development and family studies and one external independent researcher.
- Involvement of hostel matrons was kept minimal to ensure free will for participation. Informed consent obtained from all the 45 participants. Detailed consent form contained purpose and use of research, participants' role and rights in research, methods used to ensure confidentiality and anonymity, and contact details and affiliations of the researcher.
- Privacy was ensured during interviews unless participants chose to participate in presence of a fellow surrogate mother.
- Researcher was equipped with skills, maturity and experience which minimised any emotional harm to the participants given the sensitivity of the topic

# 4. Results and Discussion

This ethnographic study aimed to unravel experiences of surrogate mothers in Anand - Gujrat, influence of participation in surrogacy on their lives and families, construction of maternal identity in the context of surrogacy and the psychological agency of the surrogate mothers. The main findings of the study are organised in sub-sections below:

## 4.1. Profile of the Participants

Table 2 and Figure 4 provide a comprehensive understanding of the surrogate mothers' background, crucial to contextualise their experiences.

**Table 2: Demographic and Socio-economic Indicators of the Surrogate Mothers**

| | |
|---|---|
| **Demographic Indicators** | |
| Mean age | 31 (Min 22, Max 39) |
| Mean age at marriage | 19 (Min 15, Max 28) |
| Mean age of spouse | 35 (Min 26, Max 45) |
| Religion | Hindu (27, 66%)<br>Christian (12, 29%)<br>Muslim (2, 5%) |
| Caste | S.C. and O.B.C. (25, 62%) |
| Marital Status | Currently Married (36, 88%)<br>Widowed (2, 5%)<br>Separated (2, 5%)<br>Remarried (1, 2%) |
| Family Type | Nuclear (26, 64%)<br>Extended (10, 24%)<br>Joint (5, 12%) |
| **Reproductive Indicators** | |
| Mean number of children | 02 (Min 1, Max 4) |
| Mean number of own and surrogate pregnancies | 3 (Min 2, Max 5) |
| **Socio-economic Indicators** | |
| Mean family size | 05 (Min 3, Max 7) |
| Mean number of dependents in family | 02 (Min 2, Max 4) |
| Mean monthly family income | INR 5900 (Min 1,500, Max 18,000) |
| Unemployed Women | 13 (32%) |
| Unemployed Spouse (n=37) | 04 (11%) |

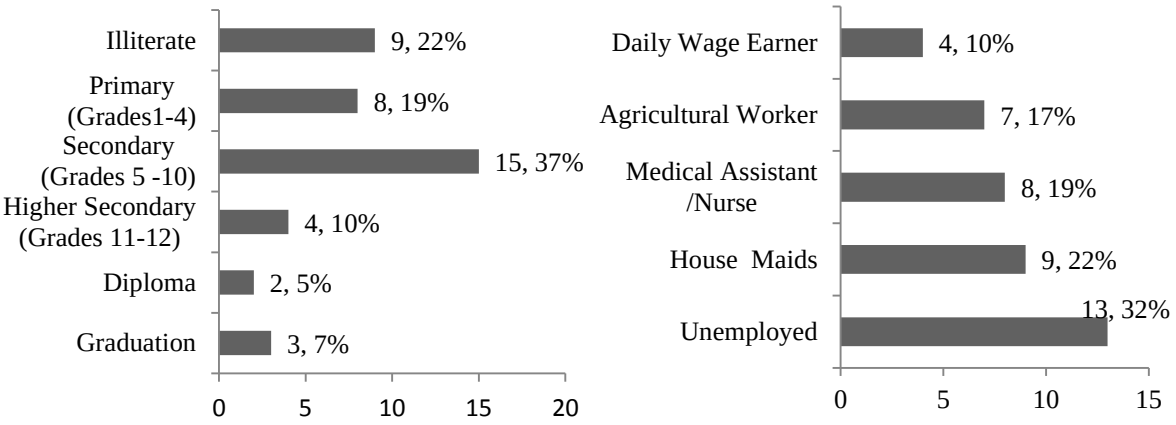



**Figure 4: Educational and Employment Profile of the Surrogate Mothers**

The socio-economic profile of women indicates a macro context of poverty where poor educational attainments have led to limited livelihood options for men and women largely from the marginalised sections of the society. Average monthly income for a five member family with 2 dependents was merely 5,900 rupees. Economic necessities forced these women based in Anand and nearby regions - Nadiyad, Petlad, Borsad, Dacor and Ahmedabad to participate in surrogacy. Women had crossed their prime reproductive age with mean age at 31 years. On an average, women had carried a total of three pregnancies to term and highest number of pregnancies reported was five for four of the women. This reproductive profile of women needs careful scrutiny to determine health risks involved.

### 4.2. The Surrogacy Process

A typical surrogacy lasted for anywhere between 12 – 18 months depending on the number of treatment cycles women underwent before attaining a surrogate pregnancy, whether women carried pregnancy to term, and the time commissioning parents took to take charge of baby/babies post-delivery. Surrogacy involved a fixed chronology of events spread across three distinct phases – pre-pregnancy phase, during pregnancy phase and a post-delivery phase with few exit points (Table 3).

**Table 3: Chronology of Events during Surrogacy**

| Phases | Events | Exit Points |
|---|---|---|
| Pre – pregnancy | Initial visit to the infertility clinic and ascertaining of the facts | Lack of conviction about authenticity of surrogacy |
| | Counselling, background check, intake and signing consent, and physical examination | Lack of identity documents / lack of physical fitness |
| | Decision whether to participate in egg donation prior to surrogacy | Four egg donation cycles prior to surrogacy permitted |
| | Hormonal treatment to supress ovulation and preparation of uterus | - |
| | Introduction to commissioning party, signing agreement, and Embryo Transfer (ET) | |
| | INR 3,000 post ET (additional money/ gifts possible) | |
| | Stay at surrogacy clinic/ hostel and adhere to medical regimen | Pregnancy Failure – Dropout or Repeat treatment cycle next month, up to ten repeat treatment cycles allowed |
| | 1st pregnancy test day 17 post ET | |
| | 2nd pregnancy test on day 21 post ET | |
| | Additional money/ gifts possible post pregnancy confirmation | |
| During Pregnancy - First Trimester | Stay at surrogacy clinic/ hostel and adhere to medical regimen along with bed rest | Spontaneous abortion Medical Termination of Pregnancy |
| | Foetal reduction in case of congenital defects detected / abdominal crowding | |
| | INR 3,000 – 5,000 per month as stated in the agreement | |
| During Pregnancy - Second Trimester | Stay at surrogacy clinic/ hostel and adhere to medical regimen along with bed rest | Spontaneous abortion |
| | Additional medication for any complications | |
| | INR 3,000 – 5,000 per month as stated in the agreement, INR 25,000 at the completion of fourth month of pregnancy | |
| During Pregnancy - Third Trimester | Stay at surrogacy clinic/ hostel and adhere to medical regimen along with bed rest | Spontaneous abortion |
| | Additional medication for any complications | |
| | Shreemant Poojan/ Baby Shower at 7 months | |
| | C-section / normal delivery | |
| | INR 3,000 – 5,000 per month as per agreement, Additional money/ gifts possible for Baby Shower, INR 25,000 at the completion of eighth month | |
| Post Delivery | Mechanically extract breast milk for baby for up to 15 days or more (optional) | Post relinquishment of the baby born through surrogacy |
| | Care for baby by the time commissioning parents take charge of the baby (optional) | |
| | INR 400/day for breast feeding and caring for the baby. Full payment as per the agreement after relinquishment of the baby. INR 300,000 for one child, INR 375,000 for twins (Additional money/ gifts possible). Revisit clinic for any post-natal complications, second surrogacy possible after a gap of one year | |

**4.2.1. Pre-pregnancy phase.** Women and their spouses visited infertility clinic to clarify their doubts about surrogacy, underwent pre-surrogacy counselling, and made decision to participate in surrogacy. Physical examinations to determine fitness for participation in surrogacy were performed for women and both men and women were screened for sexually transmitted diseases. Women were offered an option of egg donation prior to participation in surrogacy and accordingly underwent hormonal treatment for egg donation/ surrogacy. They were routinely introduced with their commissioning parents and a surrogacy agreement was signed prior to embryo transfer (ET) for surrogacy. Women were paid INR 3000 for embryo transfer and stayed at the clinic for 21 days until confirmation of surrogate pregnancy. Women who conceived were moved to a surrogate hostel to carry pregnancy to term. In case of failed conception women were discharged from the clinic and returned for a fresh hormonal treatment cycle in the following month. At the clinic women were allowed a maximum of 10 treatment cycles.

**4.2.2. During-pregnancy phase.** Women continued their stay at surrogate hostel post conception and received monthly remuneration of INR. 3000. Participant observations revealed that hostel matron and fellow surrogate mothers guided new surrogates into routine. Informal casual talks emphasised meticulously following medical routine and restrictions over diet and movement, constant risk of miscarriage and associated financial loss, stories about women's experiences with commissioning parties, and heroic instances where medical practitioners successfully handled medical complications. These informal casual conversations weaved a unique culture with rules of conduct at the surrogacy hostels that indoctrinated new comers in no time. Narratives of women captured during in-depth interviews corroborated these observations wherein women shared approaching their fellow surrogates for advice and reported that medical regimen was informally monitored by the fellow surrogates. In cases any congenital anomalies or multiple gestations, foetal reduction

was conducted with the consent of commissioning parents. Women looked forward to 'shreemant' – baby shower celebration – in the seventh month – an opportunity they never had during their own pregnancy. At the completion of fourth month of pregnancy women were paid INR 25,000 and another INR 25000 at the completion of eighth month. As the months passed, women eagerly looked forward to a safe delivery and reunion with their family. At these advanced stages of pregnancy women experienced discomfort, often requested for an early caesarean and were moved to the infertility clinic for close monitoring of their health. In unfortunate circumstances of spontaneous abortions or medical termination of pregnancy, women were treated and then discharged and could resume a fresh treatment cycle as per medical recommendation.

**4.2.3. Post-delivery phase.** Women hoped to see the new-born which was shifted to a neonatal care unit immediately after birth. Women were expected to provide breast milk to the new-borns, used breast pumps to extract milk to be handed over to commissioning parents and were paid additional money for it. Rarely, commissioning parents allowed direct breast-feeding by the surrogate mothers. Surrogate mothers also provided paid care for the new-born by the time commissioning parents arrived and took complete charge of the baby. A major sum of over INR 300,000 was paid to surrogate mothers only after successfully handing away the new-born. Women received need based post-natal medical care.

### 4.3. Women's Experiences of Participation in Surrogacy

Lived experiences of women's participation in surrogacy were broadly organised as initiation of surrogacy and women's motivations for participation, counselling and intake, barriers and facilitators experienced, and impact of surrogacy on their lives as described next.

**4.3.1. Initiation of Surrogacy and Motivations for Participation.** Largely, people known to women and men acted as intermediaries (31, 76%) who linked them to infertility clinic as prospective surrogacy participants. These included close family members and relatives, friends, neighbours, and colleagues. In other cases (7, 17%) intermediaries were barely known to women - co-passengers while travelling and indirect contacts of people known to them. One woman was directly recruited by a commissioning mother and another directly approached the clinic after reading an article in newspaper.

**Table 2: Source of Knowledge for Participation in Surrogacy**

| Knowledge Source | Women | Men | Total |
|---|---|---|---|
| Sister | 03 | 03 | 06 |
| Brother | 00 | 01 | 01 |
| Brother's Wife | 01 | 00 | 01 |
| Brother-in-Law's Wife | 03 | 00 | 03 |
| Husband's Sister | 01 | 00 | 01 |
| Other Relatives | 05 | 00 | 05 |
| Neighbour | 08 | 00 | 08 |
| Friend | 04 | 02 | 06 |
| Colleague | 01 | 00 | 01 |
| Mere Acquaintance | 07 | 00 | 07 |
| Commissioning Party | 01 | 00 | 01 |
| News Paper | 00 | 01 | 01 |
| Total | 34 | 07 | 41 |

A word frequency count of the text coded at motivations for participation in surrogacy is presented in the figure 5 where a larger cell size represents greater frequency for the word enclosed. Most prominent cells referred to aspirations of women for money (પૈસા), children (છોકરાઓ) and their education (ભણવાના), home (મકાન), happiness (સુખ), hopes (આશા), future (ભવિષ્ય), life (જીંદગી), peace (શાંતિ) and respect (ઈજ્જત). Women shared their hopes of investing money earned to secure a good future for their children by providing them advanced education and attainment of socio-economic stability by purchasing a house. They believed that the earnings and sacrifices they made would also elevate their status and respect in the family.

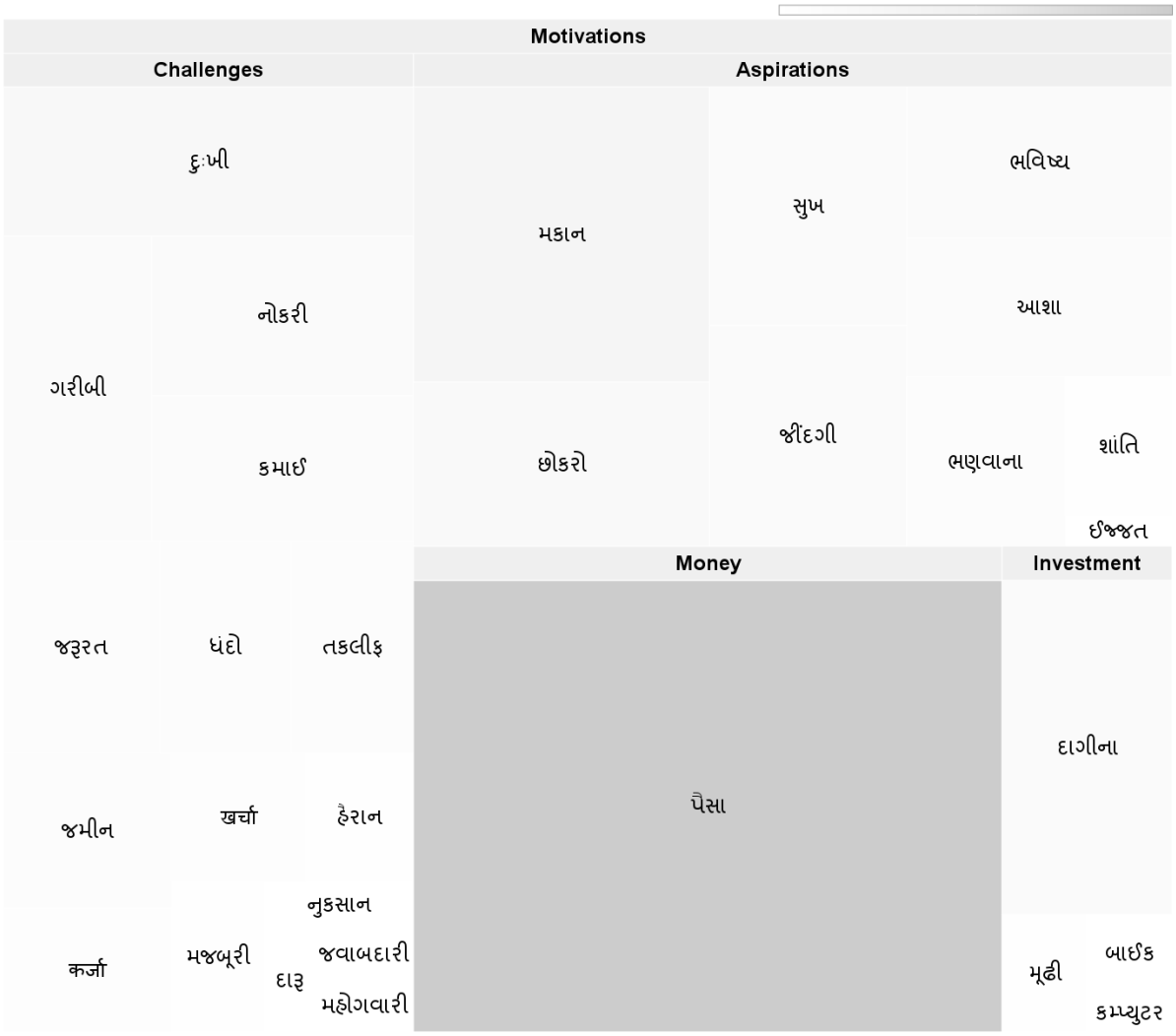
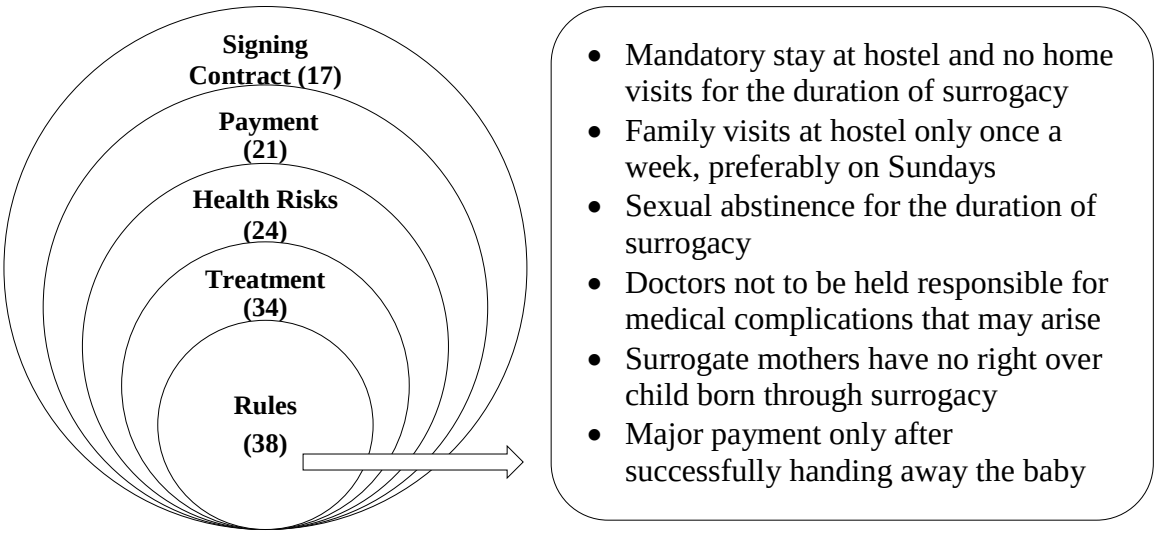



**Figure 5: Word Frequency Chart for Motivations to Participate in Surrogacy**

Women's narratives were also full of limiting factors reflected in the relatively smaller but numerous cells. Words like sad (દુઃખી) and restless (હૈરાન) indicated agony of the women prior to participation. Women experienced burden of responsibilities (જવાબદારી) to meet the needs (જરૂરત) of family and mitigate challenges of poverty (ગરીબી), inflation (મોહેંગવારી), daily expenses (ખર્ચા), loans (કર્જા), financial loss (નુકસાન), and an alcoholic (દારૂ) spouse. In absence of land ownership (જમીન) and limited opportunities for livelihood (ધંદો) they were helpless (મજબૂરી). Contrary to this larger picture, a few women especially second time surrogate mothers were content with their lives and resorted to surrogacy to make most

of their reproductive potential. Women also aspired to acquire wealth in the form of savings (મૂડી) and material assets including jewellery (દાગીના), automobile, and a computer for family. Beyond the overarching economic necessity, women's aspirations were not limited to immediate financial gains but also highlighted their plans for a secure future and a desire for an elevated status in the family.

**4.3.2. Counselling and Intake.** Women and their spouses were jointly briefed about surrogacy process and provided a written consent for their desire to participate in surrogacy. Observations of five counselling and intake episodes and narratives of 41 women from the in-depth interviews revealed key themes that medical practitioners covered during counselling.




***Numbers in bracket represent 'n'- number of surrogate mothers**

**Figure 6: Contents of the Counselling Session**

Almost all surrogate mothers (38) recalled that their counselling session focused on sharing 'rules' for participation in surrogacy. Women were briefed about health risks including high blood pressure, excessive bleeding, miscarriage, hysterectomy, caesarian section, and in rare unfortunate circumstances even death. Doctors emphasised that they could not be held responsible for any health adversities, that the women were mere providers of a womb space and did not have any rights over the child born through surrogacy. Women

(34) reported that the counselling session listed medical procedures involved in the surrogacy. Though most understood that it involved heavy medication and bed rest; they did not know exactly what medical procedures like embryo transfer entailed and experienced anxiety. Only 21 surrogate mothers recalled medical practitioners sharing payment details and 17 reported briefing about the surrogacy agreement to be entered with the commissioning parents. Women along with their spouses were given time to rethink their decision and then signed a consent to confirm their participation in surrogacy. These counselling sessions barely lasted for 10 minutes and did not cover psycho-social implications of participation in surrogacy.

**4.3.3. Barriers Experienced by Surrogate Mothers.** Novelty of the surrogacy arrangement, stigma associated with it and rules of conduct during participation in surrogacy posed varied barriers for the women. At familial level women faced resistance for participation in surrogacy from spouse and family and a couple of women also reported constant surveillance by spouse to rule out infidelity. In few other cases, alcoholic spouses and extended family members nagged and at rare occasions even threatened women for money. Lack of support system to care for children during surrogacy was another major concern. Adverse implications of surrogacy on the health concerned barely any women prior to participation, which seems alarming.

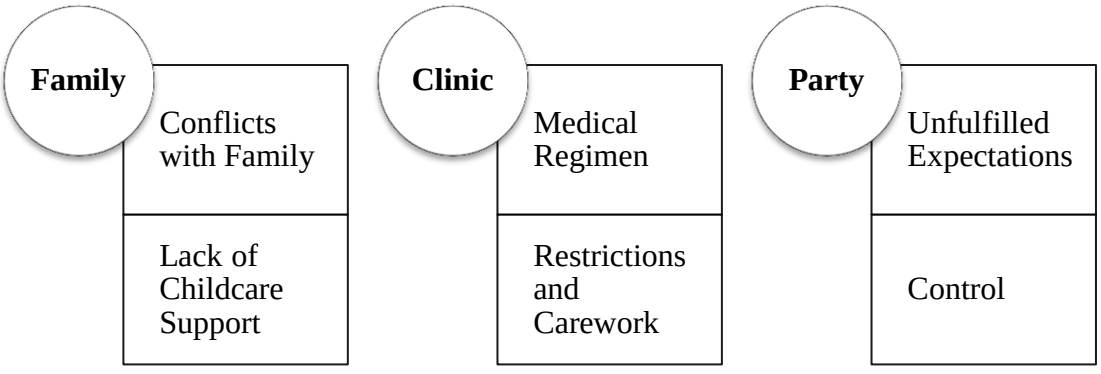
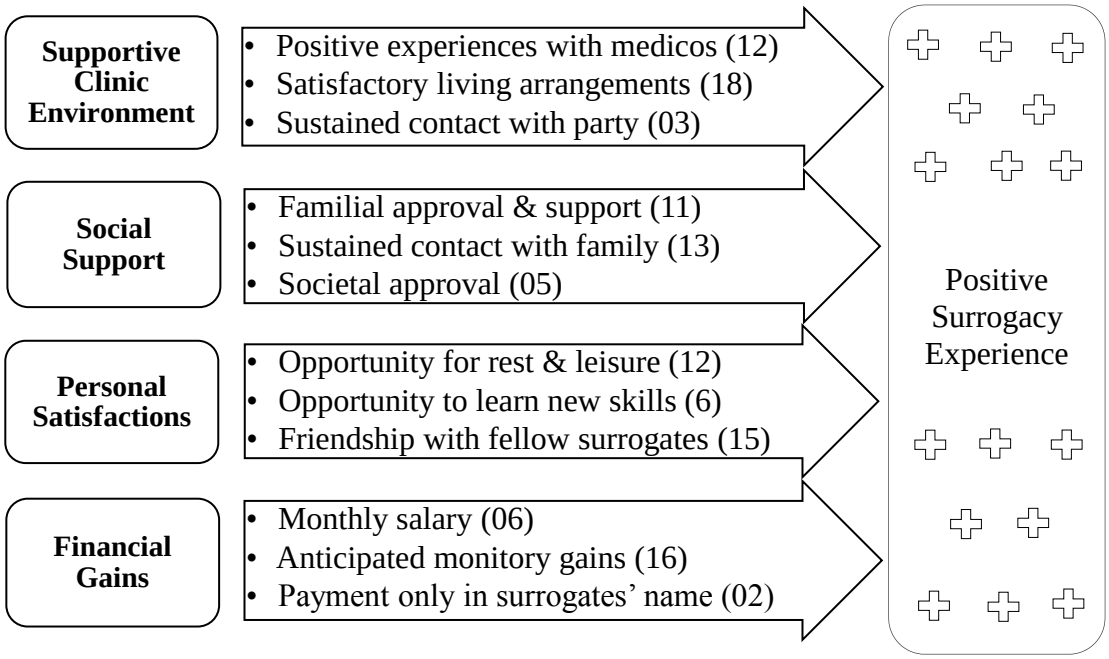



**Figure 7: Barriers during Surrogacy**

Extensive medical regimen was an exhausting experience for women. Restrictions on mobility, sharing of limited resources of space, television, and bathrooms, dissatisfaction with the food available were major challenges during surrogacy. Women also feared spontaneous miscarriages and associated financial loss. Though institutionalisation helped women to hide their pregnancy in the context of stigma they experienced difficulty in justifying their prolonged absence from family. They reported feeling homesick and looked forward to returning their home.

Unfulfilled expectations from the commissioning parents caused disappointment during and post surrogacy. Women expected expression of care and concern by the commissioning parents, expected regular enquires about their health over phone calls and even occasional visits during surrogacy. Women often considered that it was a moral obligation for the commissioning parents to reciprocate all the care work surrogate mother undertook for their child. Stories of generous commissioning parents were quiet prevalent and surrogate mothers almost always expected monitory benefits and gifts beyond the terms specified in the contract agreement. These unfulfilled expectations were a cause of agony among the surrogates. In a couple of cases surrogate mothers found constant presence of their commissioning party too overwhelming. In these cases commissioning parents chose living near surrogate hostel and visited their surrogates on day to day basis and monitored their food intake.

**4.3.4. Facilitators.** Certain facilitators that eased surrogate mother's journey through surrogacy included supportive clinic environment, availability of social support, personal satisfactions during surrogacy and financial gains. Most of the women viewed medical professionals in positive light as they created an opportunity for the surrogate mothers to break cycle of poverty. In a way unquestioning faith in medical practitioners relieved some stress off the minds of women.




*Numbers in brackets represent numbers of surrogate mothers

**Figure 8: Facilitators during Surrogacy**

By and large women were happy about quality of the residential facility provided and timely availability of meals. Sustained telephonic contact with the commissioning party made surrogate mothers feel cared for. Similarly, familial support in terms of a responsible spouse/extended family members to care for children and family visiting the surrogate every week were significant stress busters. Some surrogate mothers shared surrogacy being a well-known practice in the villages they came from and absence of stigma facilitated their positive surrogacy experience. Participation in surrogacy offered women a rare opportunity to relax, rest, and spend time at leisure without any responsibility of running a household or caring for children. Surrogate mothers often formed a friend circle and enjoyed bonds of friendship with fellow surrogate mothers. Lastly, regular monthly salary and anticipated monitory gains helped women make sense of their participation in the surrogacy.

### 4.4. "*Dava Goli Nu Balak*": A Discourse Idealising the Surrogate Role

A central theme that kept reoccurring in the narratives of women was that of *"Dava Goli Nu Balak",* in the literal sense, 'a child conceived through medication'. Women used the

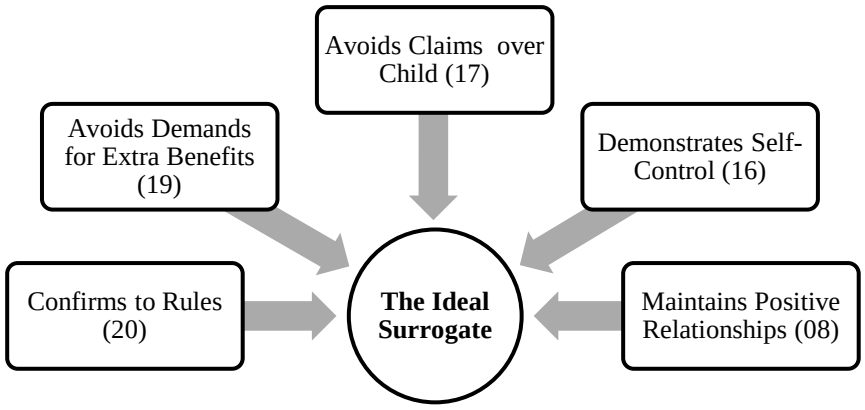
concept to legitimise their participation in surrogacy, to make sense of the rigorous medical regimen and the associated care work they engaged in. Use of the concept was also prevalent amongst surrogacy agents as well as the medical practitioners. Clearly, the concept served distinct purposes for the multiple stakeholders involved in the surrogacy arrangement.

The medical practitioners and the surrogacy agents greatly shaped formation of the surrogate role through carefully propagated discourse in order to ensure success of the surrogacy arrangement. The concept of '*Dava Goli Nu Balak'* placed the stigmatised surrogacy work within the moral realm to encourage participation of women in surrogacy and ensured extensive care work by the women. Medical personnel legitimised surrogacy by stressing involvement of medical procedures in the conception to emphasise asexual nature of the surrogacy. They distinguished the 'artificial' from the 'natural' to subdue maternal identity of the surrogate mother and her claim over the child born – a risk factor in the success of the surrogacy arrangement. Use of the genetic materials other than that of the surrogate mother and her spouse was highlighted during intake counselling sessions and the contribution of the surrogate mother in the surrogacy was presented as a mere provider of the womb space. At the same time, great emphasis laid on the 'fragility' of the artificially conceived *'Dava Goli Nu Balak'* demanded extensive care work by the surrogate mother to ensure its survival.

Surrogacy agents – often experienced surrogate mothers – served as a link between medical practitioners and the new surrogate mothers. They introduced new women for surrogacy and guided behavior of the newly recruited surrogate mothers to ensure success of surrogacy. The agents then played a vital role in the surrogacy management by anchoring on the concept of *'Dava Goli Nu Balak'* and 'fragility' of the fetus conceived to informally propagate rules of conduct amongst the surrogate mothers. The rules mainly involved following a strict medical regimen, diet restrictions, bed rest, limited and careful mobility,

and sexual abstinence. The informal discourse also set out subtle guidelines about what constituted an appropriate and inappropriate behavior on the part of surrogate mothers. Surrogacy agents were paid for their services only after the baby born through surrogacy was handed over to the commissioning parents.

In sync with this carefully crafted discourse, surrogate mothers used the concept of *'Dava Goli Nu Balak'* to justify morality of the surrogacy work to their spouse, extended family members and in rare cases to members of the immediate society they belonged to. Absence of sexual activity in the surrogacy helped surrogate mothers see themselves in a positive light while they engaged in a fairly novel and unusual process of surrogacy. The 'artificial' nature of the fetus conceived allowed them to distance the fetus as 'not fully theirs' and eased the stress of selling 'own child' for money. At the same time, 'fragility' of the artificially conceived fetus required surrogate mothers to care for the fetus as their own. In this manner, the concept of *'Dava Goli Nu Balak'* juxtaposed non-maternal and maternal identity of the surrogate mothers forcing them to idealise the surrogate role. Figure 09 projects multiple dimensions of the ideal surrogate role that surfaced in the narratives of the surrogate mothers.




*Numbers in brackets represent numbers of surrogate mothers

**Figure 9: The Ideal Surrogate Role**

The surrogate mothers strived to abide by the formal and informal rules of the setting and demonstrated moral obligation for successful completion of the surrogacy. The rules included timely consumption of medication, complete bed rest, sexual abstinence, cooperation towards medical professionals and commissioning parents throughout surrogacy, providing breast milk for the newborn, and caring for the newborn by the time commissioning parents took charge of the baby. Surrogate mothers construed surrogacy as an important job for which they were hired and laid great emphasis on fulfilling all their duties especially towards the fetus. The ideal surrogate was expected to be satisfied with the financial terms set out in the surrogacy contract and to avoid seeking any additional monitory benefits/gifts from the commissioning parents. Most of the surrogate mothers were therefore cautious about articulating their needs and preferences to the commissioning party with a few exceptions. Surrogate mothers often conveyed being satisfied about the food and residential facilities provided at the clinic and downplayed need for any external assistance from the commissioning parents. They narrated great self-control over their urge to visit home during surrogacy and following a good diet for good health of the baby. Though surrogate mothers experienced a maternal bond with the baby, they did not resist handing away the baby. Idealising the surrogate role also involved maintaining positive relationships with fellow surrogate mothers, medical practitioners, as well as commissioning parents.

In summary, the theme ‘Dava Goli Nu Balak’ played a central role in the organisation, management and the success of the surrogacy enterprise as displayed in the figure 09. The ‘Dava Goli Nu Balak’ discourse legitimised participation of women in surrogacy and played a dual role in subverting to some extent the stigma associated with it. It negated portrayal of surrogacy as sex work by stressing asexual nature of surrogacy and disassociated genetic relationship between the surrogate and the baby thereby challenging the discourse that equated surrogacy with selling own child for money. When women

participated in surrogacy, the 'fragile' character of the artificial *'Dava Goli Nu Balak'* required women to idealise the surrogate role by engaging in extensive care work and enhanced success rate of surrogacy. Despite its' fragile character, *'Dava Goli Nu Balak'* was considered invaluable for the huge monitory investments made in it by the commissioning parents, the medical practitioner's reputation at stake, and the innumerable unfulfilled dreams of both the surrogate mother and the commissioning parents that vested in the survival of the 'artificial'. As a result, these multiple stakeholders orchestrated together success of the surrogacy arrangement.

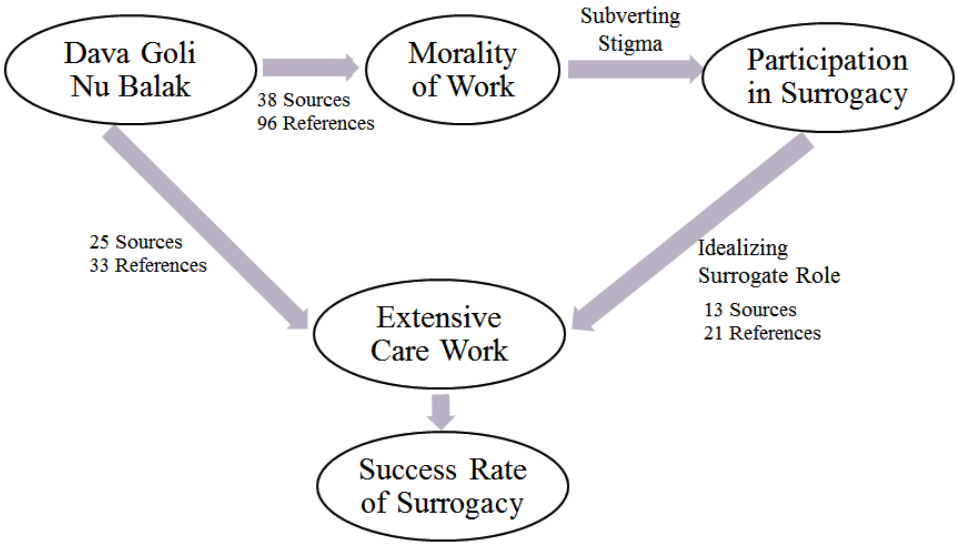



**Figure 10: Management of the Surrogacy Enterprise**

## 4.5. Genetic Disconnect versus Pregnant Connect: Crystallising Maternal Identity of Surrogate Mothers

While women embraced this new form of work, deep rooted cultural mentalities associated with the maternal identity were resistant to change. Practice of surrogacy placed mothering ideologies at the crossroads of the scientific and the cultural realms. Lack of genetic link with the fetus scientifically defied the maternal identity of the surrogate while, socially situated embodied experience of a pregnant personhood ascertained it. Amidst the surrogate role carefully propagated by the medical practitioners, surrogate mothers continued

to uphold traditional Indian mentalities associated with the maternal identity which found varied behavioral manifestations. Majority of the surrogate mothers (35, 85%) ascertained their maternal identity as one of the mothers of the surrogate child if not the primary mother. They justified their maternal identity based on the extensive care work they undertook and pain endured, intense attachment (લાગણી) they experienced with fetus, through the shared blood that nourished the baby, and by the process of birthing. Surrogate mothers relied on several cultural constructs to justify their maternal identity as described below:

***Daan (Alms/Gift).*** Surrogate mothers referred relinquishing the baby to commissioning parents as a 'Daan' – in the literal sense alms. Essentially, a 'Daan' involves giving away something that one rightfully owns and is considered as a 'Punya' – a good deed. The discourse of 'Daan' allowed surrogate mothers to view themselves in a superior position of a 'giver' and helped them overcome to some extent subjugation they experienced in surrogacy. Construing relinquishment of the baby as a 'Punya' helped them subvert the stigmatising public discourse that equated surrogacy with baby selling.

***Devaki, Yashoda, and the Lord Krishna.*** Surrogate mothers revived mythological characters of Devaki, Yashoda, and the Lord Krishna to draw parallels with the surrogacy arrangement. Surrogate mothers associated themselves with Devaki – the birthing mother of the Lord Krishna – claiming higher stakes over the baby born, while referred to the commissioning mother as 'Yashoda' – the adoptive mother of the Lord Krishna.

***The Seed and The Earth.:*** Women largely obliterated significance of the genetic link as a determinant of maternal identity by invoking traditional understanding of the maternal role as limited to the provider of nourishment (the earth) to the male gamete (the seed). This traditional knowledge in combination with the medical discourse that equated

surrogacy with artificial conception sans sex reiterated non-mother identity of the commissioning mother.

In essence, both indigenous and scientific perspectives were selectively used by surrogate mothers to obliterate maternal identity of the commissioning mother; albeit with recognition that the financial contract would eventually lead to relinquishment of the baby. Despite claiming maternal identity, relinquishment of the baby was facilitated for the surrogate mothers due to absence of paternal contribution by their own spouse. Neither flawless acceptance of scientific attitudes towards reproduction nor the rejection of traditional knowledge was reported; rather both were used to reinforce own maternal identity by the surrogates. Alternative to this larger/widespread understanding, six surrogate mothers did not claim maternal identity and exhibited clear understanding of the role maternal gametes played in the process of conception. These six surrogate mothers reported consciously distancing themselves from the foetus early during surrogacy which helped them cope with relinquishment.

### 4.6. Psychological Agency of Women in the Context of Surrogacy

Narratives of women were analysed to identify:

- Who played a lead role in decision to participate in surrogacy?
- What agency practices women used during decision-making and during their interactions with various stakeholders during surrogacy to attain specific goals?
- How women perceived their control over the earnings they made through surrogacy?

#### 4.6.1. Perceived Control over Decision to Participate in Surrogacy.

Counting was used to explore narratives of women pertaining to decision making to participate in surrogacy. A key word analysis was performed to identify how often-singular pronouns like ‘I’, ‘me’, and ‘mine’ were used, as well as plural pronouns like ‘we’, ‘us’, and ‘our’. The

assumption was that the women who played a key role in the decision to participate in surrogacy were likely to use singular pronouns while narrating their experiences of decision-making. Further, narratives were explored for the use of active and passive voice in order to determine role of women in decision-making process. Such an analysis of the narratives of women revealed that majority the women (28, 68%) played a lead role for participation in surrogacy and had to convince their spouse for participation. Less than a quarter of woman experienced participation in surrogacy as a mutual decision among them and their spouse (7, 17%) wherein both of them were equally favourable towards participation in surrogacy. Lastly, narratives of a small number of women (6, 15%) did suggest participation in surrogacy on request or insistence of their spouse (Figure 11).

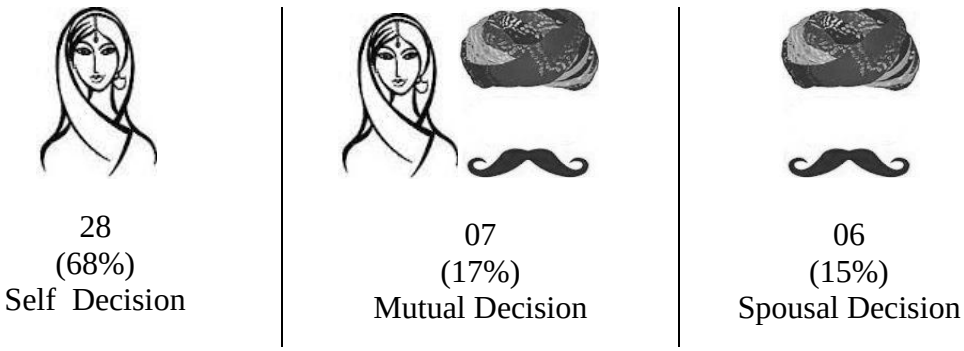



**Figure 11: Perceived Control of Women over Decision to Participate in Surrogacy**

Of the 28 women (68%) who played a lead role in making decision to participate in surrogacy 26 cited resistance of their spouse for one or more reasons (Figure 12).

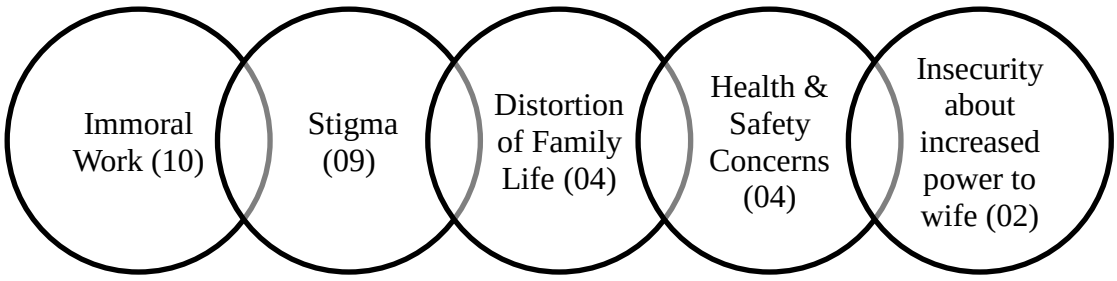



**Figure 12: Reasons for Spousal Resistance to Participate in Surrogacy**

Contrary to the popular belief that a large majority of women are pushed in the surrogacy against their will, most women (35, 85%) appeared to have control over decision to participate in surrogacy. However, even the slightest forms of coercion experienced by women (6, 15%) cannot be overlooked. Nuances of exercise of psychological agency by Indian women in the context of surrogacy are explored next.

**4.6.2. Agency Practices Women Used.** 'Agency Practices' women engaged in to achieve specific goals in course of surrogacy while they interacted with various stakeholders – family, staff at infertility clinic, fellow surrogate mothers, and commissioning parents were drawn out. Figure 13 demonstrates six prominent agency practices used by the women throughout surrogacy.

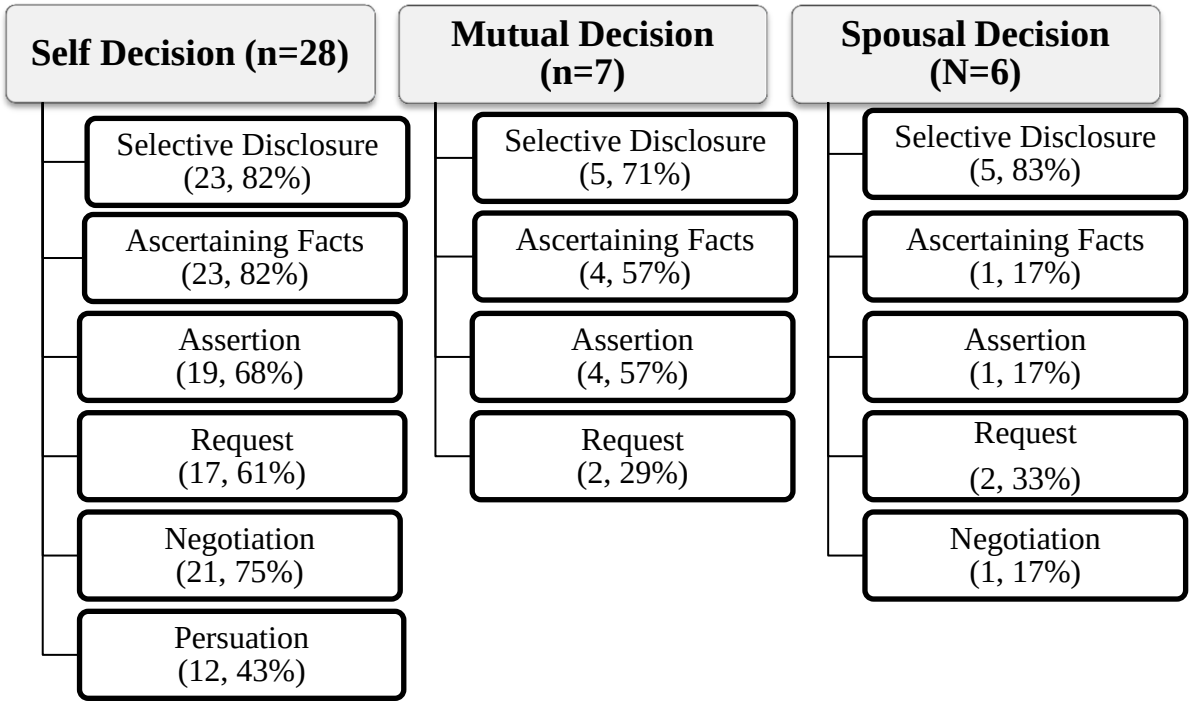



**Figure 13: Agency Practices Used by Women**

***Ascertaining Facts.*** This involved actively verifying accuracy of the factual information received without accepting it at face value. Majority of women (35, 85%)

personally confirmed authenticity of surrogacy process and did not accept information provided by agents at face value.

***Selective Disclosure.*** This involved disclosing limited information to others to evade resistance or stigma, revealing full information at a time when others could not reverse the decision or alter course of events planned by the self, and revealing own agenda at a strategic point in time when others were most likely to accept it. Spouses also influenced decisions pertaining to disclosure. In absence of a strong policy to protect wellbeing of surrogate mothers in India, non-disclosure to family members could strip women off the sole protective net. At the same time, women also revealed their experiences of within family exploitation in context of surrogacy. 'Disclosure to others' therefore is an important element to be discussed with prospective surrogate mothers during pre-surrogacy counselling.

***Negotiation.*** It involved discussions intended to produce an agreement about participation in surrogacy or any other intentional goal planned by the women. Women provided repeated explanations and alternative solutions to resolve barriers. Women reported 'negotiating' their participation in surrogacy not only with their spouses but also with extended family members. Women anchored their negotiation around six core themes – morality of surrogacy (18, 64 %), family responsibilities (11, 39%), advantages of participation (11, 39%), limiting life experiences (10, 36%), down playing health risks (8, 29%) and lending authority of final decision to spouse (12, 43%).

***Persuasion.*** It involved repetitive attempts of convincing other people for participation in surrogacy. These attempts spanned from few days to a year or more. Women were quiet persistent during decision making phase, which at times prolonged from a few weeks or months to an year or more. Women tirelessly persuaded their spouses for their consent.

***Assertion.*** It involved taking a firm stance over an issue like participation in surrogacy and sharing it with other stakeholders including, family, fellow surrogate mothers, commissioning parents, and medical professionals. Women put forth their arguments with conviction and force.

***Request.*** Women used requests to attain their own goals while they engaged with stakeholders who had more power compared to them. This involved acknowledging the power other held and asking for permissions.

### 4.7. Guidelines for Enriching Counselling Component: Implications for Policy

The data revealed vulnerability of women across different stages of surrogacy. They were reaped off significant familial support during institutionalisation for surrogacy. Alienation, novelty of surrogacy experience, and lower social ranking of women can severely curtail potential of surrogacy as an enriching life event. Regular counselling throughout surrogacy can enhance surrogacy experience for all the stakeholders involved. Counselling guidelines were proposed specifying six elements - issues and concerns, counselling session goals, counsellor's role, counselling clients, type of counselling, and essential documentation - for each of the three distinct phases of surrogacy including pre-surrogacy, during pregnancy, and post-delivery. These guidelines can be contextually modified for application in varied infertility clinics across India.

# 5. Conclusions

The study provided insights into experiences of women participating in surrogacy – a rapidly increasing yet under explored phenomenon in the contemporary Indian society with culture specific implications for the individual and family. The study unravelled circumstances under which women participated in surrogacy, role they played in decision making, complexities of the surrogacy process and associated experiences and impact of surrogacy on the lives of women and their family.

Women to a great extent took initiative for participation in surrogacy in the macro context of poverty, limited education and limited opportunities for earning a livelihood. The study unravelled various practices women used to exercise their agency in seeming oppressive context of surrogacy including, 'selective disclosure', 'ascertaining facts', 'negotiation', 'persuasion', 'request', and 'assertion'. Findings provided a fresh understanding on the nature of psychological agency of women in the context of surrogacy.

Women and their spouses were introduced to surrogacy largely through their personal contacts including extended family members/relatives, neighbours, and friends. This facilitated open interaction while women and men delved participation in the novel phenomenon of surrogacy. At the same time despite involvement of known people, women and men did not accept the information received at face value and personally ascertained authenticity of surrogacy process from multiple sources. In a largely segmented Indian social set-up with prevailing class barriers, involvement of third party agencies to recruit women for surrogacy can lead to further isolation of women. Similarly, in a strong patriarchal social setup of India, commercial surrogacy is often compared to sex-work and is a highly stigmatising experience. In effect women and their spouses chose to maintain secrecy about their surrogacy endeavour. Spouses of women greatly influenced decisions pertaining to

disclosure of surrogacy. Findings revealed that women who had lesser control over disclosure of their surrogacy to people whom they trusted were more vulnerable as they were ripped off their only support system. At the same time, there were few instances of women being pressurised by spouses or extended family members for the money they earned through surrogacy. Clearly, the juxtaposition surrogacy and family has nuanced implications for policy.

Surrogacy predominantly involved three phases – pre-pregnancy, during pregnancy, and post-delivery. Social stigma, spousal resistance and lack of child care support were primary barriers women experienced during pre-surrogacy period. Separation from family during institutionalisation, medical regimen and associated care work, constant anxiety about miscarriage, conflicts with spouse/family, and lack of adequate contact and unmet expectation of reciprocal care by the commissioning parents were predominant concerns of women during surrogate pregnancy. Lastly, unmet expectations for extra monetary benefits beyond the terms specified in the surrogacy agreement and a functional approach by commissioning parents were the dissatisfactions reported post surrogacy. Whereas, factors contributing to satisfaction of women involved a supportive environment at the infertility clinic and surrogate hostel, sustained contact with spouse and children during institutionalisation, opportunity to relax and leisure time with fellow surrogate mothers and financial gains earned through surrogacy. Enmeshed personal and functional relationship orientations among surrogate mothers and commissioning parents deserve attention for counselling in the context of surrogacy. Infertility clinics in Gujarat differed in their approach towards institutionalisation of surrogate mothers during surrogacy. Further research is recommended to explore surrogacy programmes that allow surrogate mothers to carry surrogate pregnancy to term at home without institutionalising them.

*'Dava Goli Nu Balak'*, in literal sense a child born through surrogacy, was a central concept that served distinct purposes for the multiple stakeholders involved in the surrogacy arrangement. Medical practitioners used it to subdue maternal contribution of surrogate mothers by reducing their role to mere providers of womb; surrogate mothers used it to convince their spouses for surrogacy by emphasising asexual nature of surrogacy, whereas surrogacy agents and hostel matrons used it ensure extensive care work on the part of surrogate mothers to enhance success of surrogacy arrangement. As a result, these multiple stakeholders orchestrated together success of the surrogacy arrangement. In the process, however, women experienced excessive anxiety over miscarriage of their surrogate pregnancy and associated financial loss. Despite undergoing rigorous medical regimen, women received barely any money in case of miscarriage. Prevailing payment structure wherein surrogate mothers are paid 80 percent of the money only after successfully handing over the baby needs to be reviewed.

Continuous counselling support throughout surrogacy is strongly recommended to ensure wellbeing of the surrogate mothers. Current one-time pre-surrogacy counselling is inadequate to meet shifting needs of women during their participation in surrogacy. The study proposed detailed guidelines for introducing a counselling component in surrogacy process and clearly outlined six elements - issues and concerns to be covered in counselling, counselling session goals, counsellor's role, counselling clients, type of counselling, and essential documentation during different phases of surrogacy. These guidelines can be contextually modified for application at the varied infertility clinics providing surrogacy services across India. The study provides significant insights for a contextually relevant evidence based policy for management of surrogacy arrangements in India.

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