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**Reconceiving Surrogacy:
Toward a Reproductive Justice
Account of Surrogacy Work in India**

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***ABSTRACT:** My project here is to argue for a reproductive justice approach to Indian surrogacy. I begin by crafting the best picture of Indian surrogacy available to me while marking some worries about the role of discursive colonialism and epistemic honesty in this project. Western feminists' responses to contract pregnancy fall loosely into two moments: Post-Baby M approaches that raised questions about the morality of surrogacy and the new reproductive technologies, and more recent feminist ethnographic engagements that aim to capture how these practices are lived, embodied, and negotiated. Both approaches have shortcomings. Extending Western moral frameworks (e.g. liberal feminist approaches) to Indian surrogacy work raises the specter of colonialism; and with it, worries about how Western intellectual traditions distort, erase, or misread the lived experiences of non-Western subjects. Feminist ethnographic approaches raise the specter of moral absenteeism; and with it, concerns about overlooking very real structural harms and injustices shaping surrogate worker's lived experiences. I conclude with a brief explanation of why Reproductive Justice avoids these twin specters and leave readers to consider the moral implications of outsourcing pregnancy to a country with such an abysmal record on women's health.*

INTRODUCTION:

The challenges posed by new socioeconomic and political developments in a globalized world constantly require new responses and new strategies at a practical level; at an analytical level, they require re-examining old concepts and theoretical paradigms and developing new ones.

- Chandra Talpade Mohanty (2003, 518)

In the context of her observations about science and race Sandra Harding once observed that “the Baby M case could be the forerunner of the use of poor and third world women's wombs to produce children for economically advantaged European American couples” (1991, 203). Harding's conjectures echo Gena Corea's *The Mother Machine*, which forecasts a world where the wombs of ‘non-valuable’ women are used

as “breeders” for the embryos of “valuable women” (1985, 276). <1> These predictions have all the makings of a good second-wave feminist dystopian novel, but it’s difficult to ignore their resemblance to transnational commercial gestational surrogacy today.

Wealthy couples from North America, the Middle East, and Europe travel to fertility clinics in India, Malaysia, Thailand, South Africa, Guatemala, Russia and the Ukraine where services are significantly less expensive. In the United States women of lesser means become gestational surrogates for couples in countries that either ban or regulate the practice. Can Western feminist scholarship on surrogacy work be extended to make sense of this emerging market, or do we need to rethink contract motherhood in third world contexts? In particular, how might feminist scholars and activists best think about surrogacy work in India?

My project here is to argue for a reproductive justice approach to Indian surrogacy. A complete account must theorize with equal attention the position of surrogate workers as agents and the health risks they face working in this emerging industry. My discussion begins by crafting the best picture of Indian surrogacy available to me. I preface it with Chandra Mohanty’s observations on discursive colonialism and some of my own worries about epistemic honesty. Western feminists’ responses to contract pregnancy fall loosely into two moments: Post-Baby M approaches that raise questions about the morality of surrogacy and the new reproductive technologies, and more recent feminist ethnographic engagements that aim to capture how these practices are lived, embodied, and negotiated. Both are problematic: On the one hand, extending Western moral frameworks (e.g. liberal feminist approaches) to Indian surrogacy work raises the specter of colonialism; and with it, worries about how Western intellectual traditions distort, erase, or misread the lived experiences of non-Western subjects. On the other hand, feminist ethnographic approaches raise the specter of moral absenteeism; and with it, concerns about overlooking very real structural harms and injustices shaping surrogate worker’s lived experiences. I conclude with a brief explanation of why I think Reproductive Justice avoids these twin specters and leave readers to consider what it means morally to outsource pregnancy to a country with such an abysmal record on women’s health.

OUTSOURCING SURROGACY TO INDIA:“FIRST WORLD TREATMENT AT THIRD WORLD PRICES” <2>

My account of Indian surrogacy work must be prefaced with a note about epistemic honesty. How much can I know about Indian surrogates' lives from where I sit? Surrogacy workers' voices come to me through the Indian, British, German and American press. Entire conversations are reduced to sound bites and are circulated by the global fertility industry and popular media. They are far removed from the women who tell their stories in Hindi, Gujarati, Marathi, Urdu, and English. Women's stories are translated in front of hospital administrators, intended parents, family members, doctors and journalists. Epistemic honesty requires being conscious of the distorting effects Western feminism has had on third-world women. Chandra Mohanty's "Under Western Eyes: Feminist Scholarship and Colonial Discourses" explains how Western feminists routinely discursively colonize non-Western women's lives by reproducing or representing a composite singular "Indian woman," holding the expectation that Indian feminists will organize around issues Westerners find important, failing to consider Western writing in the context of the global hegemony of Western scholarship, and presenting occidental ideals as liberatory. Western feminists have also historically constructed third world women as poor, illiterate, culturally oppressed and in need of rescue.<3> There is some evidence that these constructions shape Western responses to Indian surrogacy. <4> Western feminists would do well to keep Mohanty's concerns in mind when reading media accounts of Indian surrogacy: our information is selective and limited, but the conversation must begin somewhere. So, I begin skeptically with what I can learn from the international press and from Amrita Pande's interviews with surrogate workers.

India is well positioned to lead the world in making commercial gestational surrogacy a viable industry: labor is cheap, doctors are highly qualified, English is spoken, and adoptions are closed. India's surrogacy boom began in 2004 when Rhadha Patel, then aged 47, gestated and delivered twins for her UK-based daughter at Dr. Nayna Patel's Akanshka Fertility Clinic in Anand, Gujarat (Ruparelia, 2007).<5> In 2007 there

were 600 IVF clinics in India with over 200 offering surrogacy services (Subramanian, 2007). Today the Indian Council of Medical Research (ICMR) and National Commission for Women (NCW) that there are about 3,000 clinics in existence (Sama, 2009a; Kannan, 2009). Contract pregnancies have become a \$445 million business, and the Indian Council of Medical Research expects profits to reach \$6 billion in the coming years (Ghosh, 2006).

There are no laws regulating surrogacy in India, although the Ministry of Health and Family Welfare has established a set of guidelines for this practice. Policies and contracts vary from clinic to clinic and range from corporate five-star hospitals such as the Rotunda Medical Center in Mumbai to well-known smaller practices like Dr. Patel's Clinic. Some clinics present themselves as progressive and woman-centered. Dr. Patel boasts that she provides surrogate workers with room and board, English lessons, computer classes, and savings accounts to ensure that earnings go to each woman's intended project. She is starting a trust to care for women after they leave her service (Haworth 2007, Subramanian 2007). She claims to know if women are being coerced. Seventy-five percent of her clients are non-resident Indians living abroad (Peachy 2006, Chopara 2006). Some intended parents and surrogates continue to correspond after the birth. Dr. Rama Devi's hospital in Hyderabad also seems warm and friendly. She sends infertile couples pictures of "their surrogate" and takes special requests for "Muslim eggs" and Hindu surrogates. She recruits surrogacy workers from among her employees' families and acquaintances (Schultz, 2008). Larger operations such as Planet Hospital and the Rotunda recruit through newspaper advertisements and appear to be less personal. The Rotunda offers DHL-Cryo-Ship programs for couples to ship frozen gametes and embryos to India for implantation. They are starting a Skype Surrogate Connect video conferencing program, so "the parents will have a good idea of how well the pregnancy is going and how well the surrogate is being looked after" (Medical Tourism Corp, 2009).

There is no fixed fee for surrogacy in India, but the costs are significantly less. The entire surrogacy process in the U.S. costs between \$40,000 and \$150,000. Surrogate workers receive between \$20,000 and \$30,000 of this sum. In India the complete medical procedure, surrogate's fee, airline tickets, and hotel stay for two trips to India costs

around \$25,000, but prices can go as low as \$12,000. Of that total cost, Indian women are paid between \$2000 and \$10,000 for their services (Gentleman, 2008). The demand for surrogacy is high, but applicant pools are deep. Critics of globalization fear that surrogacy services will follow the “race to the bottom” pattern paved by previously outsourced industries. Shweta Khanna worked as a surrogate once before and was looking for another opportunity. Initially, she asked for about \$2000, but when another woman offered \$1500, Shweta had to settle half her original amount (Niazi 2009, 1). In other cities the demand has driven up the price! In 2004 surrogate workers received about \$3000 for a successful delivery, but the going rate in Delhi is now \$10,600 (Wade, 2009).

The global press routinely reinforces connections between poverty and surrogacy work creating the impression that it is the opportunity of a lifetime. The median family income in Anand, for example, is about Rs. 2,500 per month (about \$52.00) putting most surrogacy worker’s income at the poverty line (Pande, 2008 and 2009). Many women earn enough to pull their families temporarily out of poverty or debt. Suman Dodia will buy a house with the \$4500 she earns from carrying a British couple’s child. It would have taken her fifteen years to earn that sum as a maid (Shultz, 2008). Najima Vohra moved to Anand to work as a surrogate. She has no job, but helps her husband with his scrap-metal business. They earn about \$1.20-\$1.45 a day. She worked in the wheat fields growing up, was married when she was sixteen, and has little education. The \$5500 she earns will buy the family a brick house, pay for her children’s education, and help grow her husband’s business. Sofia Vohra became a surrogate because she earns \$25 a month as a glass-crusher, her husband is a drunk, and she must pay her daughter’s dowries. “I’ll be glad when this is over,” she says, and quickly adds, “This is not exploitation. Crushing glass for fifteen hours a day is exploitation. The baby’s parents have given me a chance to make good marriages for my daughters. That’s a big weight off my mind” (Haworth, 2007). This is Prayanka Sharma’s second contract pregnancy. She thinks that this is just a means of survival in an unequal world, she argues “there is nothing wrong with this. We give them a baby and they give us much-needed money. It’s good for them and it’s good for us” (Scott, 2007). Surrogacy is also a growing opportunity for single mothers. Rekha left an abusive marriage, and her husband took the children because she could not support them. She became a surrogate to get her children back. A good number of

salaried middle-class women have become surrogates to pay for family medical expenses. Anita, a bank worker, became a surrogate for a Korean-American couple, because her son has a heart condition and needed an expensive operation (Subramanian, 2007). The recent global recession also has had an impact on the fertility industry. Dr. Patel has noticed an increase in middle-class women turning to surrogacy work as their husbands lose jobs (Chandran, 2009).

This is how the global press presents surrogate workers' stories. The rhetorical focus here is on opportunity, choice and fair exchange. A complete picture of Indian surrogacy must move beyond these accounts, which routinely underestimate how race, ethnicity, caste and class mediate expectations and assumptions about pregnancy, mothering, and access to ARTs. If infertility markets are driven by those who can afford these services, and if this demographic is primarily white Westerners, high-caste Indian nationals, Asian and Middle-Eastern couples who want children with culturally valued features (e.g. light skin), then the market will respond to these preferences. Rudy Rupak, president of Planet Hospital, says the client demand for ova from fair-skinned women is so high that he's flying donors from the former Soviet republic of Georgia to clinics in India. A Planet Hospital surrogacy package that includes an Indian egg donor costs \$32,500. One that includes eggs from Georgian donors costs \$37,500 (Cohen, 2009). Color and caste also play a central role in a surrogacy worker's negotiating power. As one clinician admits: "Brahmans get paid more than so-called 'untouchables' or lower castes. A fair-skinned, educated middle-class Brahman who speaks English will fetch that much more" (Subramanian 2007, 9). According to another source many childless couples are interested in the women from Northern India because "they are healthy and whitish in color. Foreign couples are eager to have a white child" (Roy, 2008). One surrogate agent explains how he could not find work for a south Indian woman because she was too dark (Sama, 2006, 75). Dr. Rama's Institute has a "Criteria for Selection of Surrogate" handout that she gives to customers, so that they know that "planned children are in good wombs."

...the surrogate mother should be no smaller than 1.60 meters (5'3")
and should weigh between 50 and 60 kilograms (110 and 132

pounds). She should be married, have her own children and a regular period, be free of sexually transmitted and hereditary diseases, be tested for ovarian problems and chromosomal analyses, be emotionally stableThe skin color should not be too dark, and the appearance should be “pleasant” (Schultz 2008, 3).

In Sama’s analysis of thirty-three surrogacy related advertisements about forty percent specified that intended parents were looking for surrogates that were “fair, good-looking, and beautiful” (2006, 74). Remember, these criteria are for *gestational* and not traditional surrogates. The surrogate is not genetically related to the fetus. So, worries about skin color are more likely worries about moral character. It appears that the racial markers that have historically marked light-skinned women as good *mothers* and dark-skinned women bad mothers have been extended to mark “good” and “bad” *wombs*.<8>

Questions have been raised about surrogate workers’ autonomy under these contracts. One fear is that under so-called “third world conditions” surrogates would be coerced into accepting living conditions where their pregnancies could be more strictly monitored. Most surrogacy programs have hostels where nurses and nutritionists attend to their daily needs. Some clinics allow children to live with surrogates and permit family visits, and others regulate interactions. Surrogates in residence at Patel’s clinic routinely get visits from family and friends, and “are happy never to leave the premises: meals are catered, kids are in the care of husbands or parents, and jobs are on hold. They will get better care for these pregnancies than they had for their own...and for many it’s the first time they have not had to work” (Subramanian, 2007) Another Mumbai hospital offers a voluntary hostel program, which according to Dr. Gautam Allahbadia, does not confine surrogates forcefully. “Right in the beginning, some surrogates move in to the hostel sometimes with their children and some surrogates who have family compulsions stay at home” (Medical Tourism Corp, 2009). Under the contract Nagadurga signed at Dr. Rama’s clinic, she has agreed put her children into a home and to avoid sexual intercourse with her husband during the pregnancy (Schultz, 2008). Surveillance and regulation are sometimes used as selling points. Julie has tried five times to conceive. She is hiring an Indian surrogate because most surrogates stay either in the clinic or in

supervised homes, and “that kind of control would just not be possible in the United States.” In the U.S., “you have no idea if your surrogate mother is smoking, drinking alcohol, doing drugs. You have no idea what she’s doing. You have a third party agency [in India] as a mediator between the two of you” (Scott, 2007).

MORAL-POLITICAL AND ETHNOGRAPHIC FEMINIST RESPONSES TO INDIAN SURROGACY:

Feminist discussions of new reproductive technologies are shaped largely by the discourses configuring them. To date, this scholarship has fallen loosely into two camps: Post-Baby M accounts that were attentive to the moral and political dimensions of surrogacy and more recent feminist ethnographic works. The birth of Melissa Stern (aka Baby M) in 1986 put the biomedical reproductive techniques permanently on the radar of feminist scholars and activists, including feminist philosophers, who reached for the most popular disciplinary theoretical tools available to them at the time—the liberal, radical, and materialist “feminist frameworks” outlined three years earlier in Alison Jaggar’s *Feminist Politics and Human Nature* (1983).⁹ Early feminist responses to surrogate motherhood were organized along these lines. Liberal feminists typically characterized surrogacy as a natural extension of women’s reproductive liberty and personal autonomy. If women could contract freely to sell their productive labor for wages, then they should be at liberty to sell their reproductive services. State regulation of surrogacy (like the regulation of contraception, abortion, and prostitution) smacks of legal paternalism: it implies that women are not fully rational agents. Liberals, however, parted company over the question of whether gestational services are contrary to Kantian accounts of personhood. Radicals offered non-contractual responses. Unlike liberals—who locate gender inequalities in a constellation of educational, civic, cultural, and occupational barriers—radical *cultural* feminists tied women’s oppression directly to their reproductive capacities and roles (e.g. pregnancy and mothering), compulsory heterosexuality, the hetero-patriarchal family, and social practices that cater to many heterosexual men’s appetites (e.g. prostitution and pornography). Many supported surrogacy bans on the grounds that contracts co-opt women’s reproductive labor in the same way that the sex industry co-opts women’s sexual labor. Some share materialist

concerns that higher rates of female poverty make women vulnerable to selling sexual and reproductive services. Contract motherhood is dehumanizing because it commodifies birthing, reduces women to incubators, and alienates surrogate mothers from their reproductive labor. By contrast radical *libertarian* feminists argued that surrogacy was not reproductive slavery. If handled properly, it might actually strengthen connections between infertile couples, surrogates, and their children. Surrogacy has the potential to produce new familial models that challenge the traditional hetero-patriarchal family. Western feminist thinking also invoked Marxist and socialist traditions to explore the implicit economic inequalities in surrogacy arrangements. Surrogacy arrangements are made under capitalist patriarchy mask how race, gender, and class shape a person's particular relationship to the means of (re)production. Some invoked Marx's theory of alienation to account for the ways women are alienated from the "products" of their reproductive labor. Others explored new reproductive technologies potential for alleviating class differences.

It's a mistake to assume *a priori* that post-Baby M moral frameworks can be extended to accurately theorize Indian women's lived experiences with surrogacy without writing Western values onto Indian women's lives.<10> Post-Baby M discussions are historically, culturally and geographically grounded in white Anglo-European middle-class women's experiences with infertility in the global north.<11> Moral questions were crafted around white women's experiences, and expressed in the language and values of Western morality. Attention to commodification, alienation, contracts, autonomy, personhood were fruitful in post-Baby M first world contexts, but these tools don't always translate into Indian contexts. For example, liberal political values, feminist or otherwise, colonize Indian surrogate workers' stories when narratives are framed strictly in the language of autonomy, choice, and liberty.<12> Consider how the media co-opts liberal political values in the services of the infertility industry. A recent *Maclean's* editorial describes surrogacy work as "an important expressions of *free choice* between informed adults" which "fulfill[s] a modern need in a civilized way to everyone's advantage, and ensure[s] a loving and stable environment for the child" (n.a. 2007, my emphasis). The press is fond of pointing out that Dr. Patel herself views surrogates as practical decision makers: "These women are doing this willingly," she

explains, “They are not dumb or exploited.... The money allows these families to get proper shelter and educate their children... surrogacy and egg donation are ‘legitimate choices’ that women make in return for financial compensation” (Wade, 2009).

Observant readers will notice a dramatic shift in surrogate mothers’ public persona since the Baby M era. The magic of the global market has transformed surrogate mothers from selfish, crazy, deceitful, and manipulative con artists like Mary Beth Whitehead and Anna Johnson, into the rational, autonomous ends-choosers of liberal theory. Suman Dodia and Najima Vohra are altruistic and make good choices for their families. As Sama—a resource group for women and health-- puts it, “[t]he fertility market issues a price tag to reproductive tissues and then appropriates them in order to sell the unfulfilled dream to millions of people, under the rubric of choice and rights” (2009b). Choice talk’s discursive strength Occidentalizes Indian surrogacy work: it makes it difficult to raise contextual questions about the kind of life one has to lead to make this work count as a “good choice,” or as a way of attaining basic social goods like housing and medical care. The lengths to which some surrogate workers’ avoid of choice talk evidence resistance to this colonizing effect. Amrita Pande’s interview with Salma, a 25-year-old housewife, makes this clear:

Who would choose to do this? I have had a lifetimes’ worth of injections pumped into me. Some big ones in my hips hurt so much. In the beginning I had about 20-25 pills almost every day. I feel bloated all the time. But I know I have to do this for my children’s future....This is not work, this is *majboori* (a compulsion). Where we are now, it can’t possibly get any worse....in our village we don’t have a hut to live in or crops in our farm. This work is not ethical—it’s just something we have to do to survive. When we heard of this surrogacy business, we didn’t have any clothes to wear after the rains—just one pair that used to get wet—and our house had fallen down. What were we to do? (2009, 160).

Autonomy and liberty obscure the nuances implied by *majboori*. As Pande continues: “[M]ost surrogates’ narratives worked towards downplaying the choice aspect in their

decisions to become surrogates, as if they are saying ‘It was not I my hands, so I cannot be held responsible, and should not be stigmatized.’ They do this by highlighting their economic desperation, by citing higher motivations or by emphasizing the role of a higher power (God) in making decisions for them” (2009,162). It’s important not to lose sight of surrogate worker’s agency, but liberal accounts of agency can be colonizing when they obscure the economic, social and cultural conditions that make women vulnerable to surrogacy.

Fortunately there are non-colonizing ways of capturing surrogate worker’s agency. By the late-1990s post-Baby M approaches were eclipsed by feminist biomedical ethnographies. Feminist scholars working in poststructuralism, cultural studies, science and technology studies, health sciences, and especially medical anthropology, began to focus directly on women’s agency in navigating the complex cultural terrains of infertility medicine.<13> Attention to the moral status of new reproductive technologies gave way to a broader examination of their culturally specific meanings as part of lived, contested, and negotiated relations. Women’s situated narratives and experiences replaced the moral evaluation of medical practices. Charis M. Thompson characterizes this as a shift from moral certainty to moral ambivalence where “over time, moral pre-emptiveness has given way to a greater sensitivity to the moral complexities of technoscientific practice, and practices of agency, resistance, and other dimensions of stratification have been added to gender as a foci of concern” (2002, 63 and 2005, 18). The feminist ethnographic turn is perhaps an effort to balance out an earlier overreliance on abstract moral principles and to redirect discussion toward infertile women’s agency as positioned subjects in particular cultural contexts.<14> The ethnographic turn responds to two of my earlier concerns. By foregrounding particular local actors’ experiences ethnographic approaches can avoid Mohanty’s general concerns about discursive colonialism. Ethnographies contextualize “reproductive choice” by highlighting how factors such as living in a pro-natal culture, religiously mandated gender-role expectations, the importance of population growth to a particular nation-state’s military needs, or socio-economic constraints operate to limit women’s reproductive agency. In general they steer clear of post-Baby M master narratives that reduce discussions “into one of two binary logics: the unqualified principled good of free

choice or the twin moral evils of denatured commodification and/or patriarchal determinism” (Farquhar 1996, 17). Or in the case of Indian surrogacy between competing characterizations of this work as either a choice with a win-win outcome, or as an exploitive practice from which Indian women must be rescued.

Yet for all their virtues much ethnography suffers from a weak form of moral absenteeism that I find troubling. In keeping with the goals of the genre moral dilemmas are raised in the context of particular women’s “local moral worlds,” as part and parcel of women’s total health experiences, or are side-stepped altogether.<15> For instance, Marcia C. Inhorn’s work examines the role religious morality plays in how infertile Egyptian couples reconcile their desires for children with some Muslim prohibitions on IVF (2003, 85-129). Dion Farquhar’s *The Other Machine: Discourse and Reproductive Technologies* recognizes that the moral status of entities (e.g. extracorporeal sperm, eggs, and pre-implantation embryos) and relationships created by these new technologies “generate ethical and political questions.” But, she redirects the conversation to the meaning given to these entities by particular people in the complexities of their biographical situations. Her central concern is not the moral status of these new entities, technologies, and relations; it is with the new narrative possibilities with for kinship and social relations these entities potentially express (1996, 37 and 160). The organizing rubric for most of these approaches is women’s agency, but not the variety of moral agency behind “choice talk.” It’s a chance to better theorize women’s general agency as situated subjects. Unlike philosophical accounts, which define agency as simply the power to act, agency in ethnographic contexts “refers to definitions and attributions that make up the moral fabric of people’s lives, and that have locally plausible and enforceable networks of accountability assigned to them” (Thompson 2005, 180).

Amrita Pande’s research on Indian surrogate workers in Anand, Gujarat illustrates both the virtues and shortcomings of ethnographic approaches. Her remarkable sets of interviews provide a sobering counterpoint to the global media accounts I outlined in the first section. They also echo Mohanty’s concerns about the distorting effects of Western normative approaches. For Pande an accurate account of globalized commercial surrogacy work requires seeing it as “sexualized care work;” that is, as labor that falls

somewhere between sex work and care work (2009, 142). If surrogacy can be treated as an extension of the work poor women have done historically as nannies and domestics, then we can extend existing feminist literature on care work to cover it. Focusing on surrogate workers' accounts of their *labor*, instead of the *moral* issues their labor raises, enables Pande to give a wonderfully nuanced account surrogacy work's oppressive, empowering, and resistant features. Here's Pande:

These (Eurocentric) portrayals of surrogacy cannot incorporate the reality of a developing-country setting—where commercial surrogacy has become a survival strategy and a temporary occupation for some poor rural women.... In such a setting, surrogacy cannot *merely* be seen through the lens of ethics or morality but is a structural reality, with real actors and real consequences.... If we are able to understand how surrogates experience and define their act in this new form of labor, it will be possible to move beyond a universalistic moralizing position and to develop some knowledge of the complex realities of women's experience of commercial surrogacy (2009, 144-45, my emphasis).

Pande offers convincing reasons for sidestepping the normative dimensions of surrogacy work in the third world contexts. Contract pregnancy is neither morally good nor bad, neither virtuous nor vicious; it is simply just the way things are for many Indian women. And, like or not, poor women will continue to rent their wombs and sell their eggs, just as they will continue to work as nannies and domestics. Pande is not suggesting that we abandon moral questions altogether. She seems to acknowledge that Indian women's lived experiences have moral dimensions, so her work only suffers from weak form of moral absenteeism. The problem is not that Western accounts of surrogacy have made moral issues their primary focus, it's that post-Baby M frameworks identify moral issues in Western contexts, along western theoretical lines, and so they are unfit for addressing the lived realities of surrogate workers in the global south. Understanding surrogacy work as an extension of (and no morally different than) the caring labor poor women have always done for wealthy women is a step toward removing surrogacy's moral

stigma in India. Removing stigma takes precedence over moral judgments. My preference, however, is to retain a strong moral focus. Pande is right about the distorting, abstract, and universalizing effects Western moral frameworks have on Indian surrogacy, but it does not follow that we ought to bracket *all* moral discourses, just those with distorting and colonizing effects. So, I want retain the conviction that moral questions are central to this discussion while taking to heart Pande and Mohanty's concerns about Western universalizing moral positions.

REPRODUCTIVE JUSTICE AS A SITUATED MORAL APPROACH

In the early 1990s U.S. women of color involved in grass-roots health work began searching for a way to talk about reproductive rights that avoided the pitfalls of choice talk and that aligned reproductive rights with social justice. They found promising models in global women's health movements. Three years after attending the 1994 United Nations International Conference on Population Development (ICPD) in Cairo sixteen autonomous U.S. women of color's organizations collectively formed SisterSong Women of Color Reproductive Health Collective. They coined the term "Reproductive Justice," built alliances, and applied the insights from Cairo to their home communities. Reproductive Justice suggests a middle road between post-Baby M moral universals and feminist ethnographic particulars. It offers an on-the-ground approach that fleshes out the material dimensions of surrogate worker's lived experiences that feminist ethnographies value, while raising context-specific concerns about the harms of outsourcing contract pregnancy to countries with abysmally poor track records on women's reproductive health. Reproductive Justice takes as its starting point women's real-life experiences with reproductive *oppression* in their communities. Historically reproductive health has been defined from the standpoint of U.S. white women's struggle for access to contraception and abortion. SisterSong affiliates broaden the conversation to recognize how race- and class-based histories of population control, sterilization abuse, high-risk contraception, and the effects of environmental pollution on fertility and maternal health have shaped the reproductive lives of third-world women (including women of color in the first world). As SisterSong's National Coordinator, Lorretta Ross explains: "Instead of focusing on the means—a divisive debate on abortion and birth-control that neglects the

real-life experiences of women and girls—the reproductive justice analysis focuses on long-term ends: better lives for women, healthier families and sustainable communities” (2007, 17). This goal recognizes that life conditions such as a living wage, quality education, affordable healthcare, freedom from environmental hazards and state violence must be in place for women to make *fully* autonomous health decisions. Reproductive justice will be achieved only when women and girls have the economic, social and political power and resources to make healthy decisions about their bodies, sexuality and reproduction for themselves, their families and their communities in all areas of their lives (ACRJ, 2006, 1).

Like ethnographic approaches, Reproductive Justice focuses on the material conditions of women’s lives— a woman’s sexual and reproductive health and destiny is linked directly to the conditions of her community, geographical climate, environmental cleanliness, her experiences in the home, at work, with family, and on the streets. Asian Communities for Reproductive Justice’s “A New Vision for Advancing our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice” (2006) outlines three overlapping lenses for identifying, addressing and organizing against reproductive oppression: *reproductive health* (which focuses on reproductive service delivery), *reproductive rights* (which focuses on legal and policy advocacy), and *reproductive justice* (which focuses on coalition building). <16> These components operate collectively to expose the injustices and tensions in women’s reproductive lives. The *reproductive health* component focuses on women’s access to reproductive health services. It emphasizes the importance of women’s access to, and understandings of, medical services such as pap smears, pre- and post-natal care, abortion services and counseling, family planning, access to safe and effective contraception, the prevention and treatment of cancers, HIV/AIDS, and other sexually transmitted infections. It solves health disparities by the creation of clinics, educational outreach, and agencies designed to provide women with a full range of affordable, culturally sensitive, health services. Next, the *reproductive rights* component is a legal-advocacy based model designed to protect women’s access to reproductive health care at the state and federal levels. This component protects woman’s reproductive rights “by protecting her right to privacy, her right to make choices, her right to be free from discrimination, her right to access services

and her actual access to social resources” (ACRJ, 2006, 2). Discussions of reproductive rights in the U.S focus primarily on keeping abortion legal and increasing access to family planning services. As I explain below it’s more complicated in India. The final *reproductive justice* component works to organize individuals and communities to create structural change and challenge power inequalities. It focuses centrally on how state and commercial control and exploitation of women’s bodies, sexuality and reproduction are often strategies for controlling communities of color. Social justice for entire communities requires a complete vision of health for women and girls including an understanding of issues such as sex trafficking, youth empowerment, women’s health, family well-being, educational justice, unsafe working conditions, domestic violence, immigration injustices, environmental racism, and globalization.

Reproductive Justice is not a universalizing methodology. Both movement and method spring from U.S. women of color’s experiences and cannot be extended uncritically to non-U.S. women of color’s experiences. As Ross explains, it is a “conversation starter” designed to generate “new patterns of thinking” and to offer a “fresh approach to creating unifying intersectional language” with which to build bridges across racial and class fissures that prevent productive conversations on race, rights and reproduction (2007, 16-17).<17> Reproductive Justice more than adequately replies to Pande’s concerns about Western universally moralizing approaches. It’s one thing for post-Baby M moral frameworks to be applied to non-Western lives, and quite another to fashion new approaches from global collective dialogues that re-frame moral discourses with an eye toward making connections between women’s lives at home and abroad. Pande’s weak moral absenteeism brackets the former, Reproductive Justice s advances the later. Both aim at revealing the unexplored vantage points from which to re-conceptualize women’s lived experiences with reproductive oppression and infertility respectively.

WHAT CAN REPRODUCTIVE JUSTICE TELL US ABOUT INDIAN SURROGACY?

Reproductive Justice points to reproductive *oppression*—to barriers that prevent women from having children on their own terms-- but what can it tell us about having children for others? What can it reveal about the emerging global market for commercial gestational surrogacy in India? Reproductive justice expands on Pande's insights by exploring Indian surrogacy work against the background of reproductive oppression. These are not mutually exclusive: it's possible to define surrogacy work as a kind of sexualized extension of care work, while simultaneously recognizing the moral dimensions of surrogate worker's reproductive oppression in their communities. The Reproductive Justice movement, however, has yet to offer an analysis of surrogacy work in either the U.S or global contexts.

Reproductive Health and Indian Surrogacy Work

Since I'm concerned primarily with the reproductive health backgrounds against which Pande's interviewees made their decisions my focus will be primarily on the reproductive health lens. Unlike post-Baby M discussions, which consider surrogate workers' health only *in the context of contract pregnancy*, the reproductive health lens emphasizes a surrogate worker's health *over her entire lifetime*. This shift is important. post-Baby M discussions raise questions about whether maternal-fetal bonding interfered with contracts, and whether unhealthy lifestyle habits (e.g. eating junk food, using drugs) or pre-existing conditions (e.g. a history of miscarriages, mental illness) increased the contracted pregnancy's risks. <18> This focus privileges the *intended parent's* rather than the *surrogate worker's* fears and desires. It makes reproductive oppression difficult to see. A lifetime health focus raises new moral concerns. Here is the first: India is an international destination for infertile couples seeking affordable IVF and surrogacy services, and India also has one of the highest maternal mortality and pregnancy-related morbidity rates in the world. The Center for Reproductive Right's report on *Maternal Mortality in India* estimates that around 117,000 maternal deaths occur in India every year (CRR 2008, 9).<19> In fact maternal deaths in India make up almost one quarter of the maternal deaths that occur annually worldwide. Every five minutes an Indian woman dies of pregnancy-related causes, and for every women that dies, thirty more develop

chronic and debilitating conditions that affect her quality of life (2008, 11). Maternal deaths are causally linked to poverty, education, and social status. In India 70% of women are poor and women continue to earn half of what men earn (2008, 17). The National Human Rights Commission (NHRC) reports that merely 30 percent of the population receives services through the public health system, less than 50 percent of women give birth with the assistance of a skilled attendant, and only 40 percent of births happen in a hospital setting.<20> The CRR attributes this to a range of gendered medical, socio-economic, caste, age-related and health-system-based factors including inadequate nutrition, early marriage, lack of access to medical care and family reluctance to seek out medical care for women and girls (2008, 14-20).

Child marriage is still widely practiced in many parts of India. The statistics are elusive, but the India's Ministry of Family Health and Welfare Survey (NFHS-3) estimates that between 40 and 50 percent of marriages involve girls under 18 and boys under 21--the legal ages for marriage nationally.<21> The national average is 28.1 percent for urban families and 52.5 percent for rural families, but these figures are higher in some states than in others. For example, child marriage rates are lower in Gujarat (where Pande's interviews took place), where 27.3 percent of urban women and 37.9 percent of rural women between the ages of 20-24 were married by the age of 18. They are more predominant in Rajasthan where 35.5 percent of urban women and 65.7 percent of rural women were married by their eighteenth birthday (NFHS, 2006). International child support agencies catalogue the impact of early marriage on girls and women's health. Young brides are more susceptible to domestic violence. Adolescent pregnancies carry greater health risks (e.g. fistulas) that increase when medical care is scarce. Pregnancy-related deaths account for one-quarter of all fatalities among women aged 15-29, with well over two-thirds of them considered preventable. Babies born to girls under 17 years old are more likely to die within their first year (NFHS, 2006).

Common maladies such as anemia, malaria, and HIV/AIDS indirectly increase chances of maternal death. The risks of anemia (a condition associated with poor nutrition) are greater in India than anywhere else in the world. In some Indian subcultures girls and women are fed last and least, and these social practices leave

85% of pregnant women anemic—a condition far more common in women (55%-85%), than in men (24%). Anemic women are more susceptible to communicable diseases such as tuberculosis and malaria. They also face additional risks of falling into a cycle of multiple pregnancies in their efforts to have children that survive. Unfortunately the persistence of gender-based discrimination in food, nutrition, and healthcare has increased anemia rates over the past ten years. Even some of the most basic health services are beyond the reach of most Indian women. The National Human Rights Commission reports that only 30 percent of the population receives public health services. Less than 50 percent of women give birth with the assistance of a skilled attendant, and only 40 percent of births happen in a hospital setting. Although the Indian government has promised to ensure that women get four antenatal examinations through the National Rural Health Mission (NRHM), less than three-quarters receive any antenatal care at all. The National Family Health Survey reveals that only about 36.4 percent of women across the country receive any postnatal care within two days of giving birth. For every maternal death in India, an estimated 30 more women suffer injury, infection, and pregnancy-related disabilities.<22>

Reproductive Rights, Reproductive Justice and Indian Surrogacy

A full Reproductive Justice account requires applying the remaining reproductive rights and reproductive justice lenses to Indian surrogacy work. Space restrictions prevent me from developing an extensive analysis here, but for the sake of completeness a few comments are in order. Recall that the reproductive rights component is a legal-advocacy based model designed to protect women's access to reproductive health care, and by extension women's health while doing surrogacy work.<23> In general reproductive rights are more restricted in countries where women's political voices are constrained, economic opportunities limited, and social movements curtailed, and less restricted in places where these conditions do not hold. But civil liberties do not always guarantee reproductive liberties. India has a vibrant feminist movement, democratic traditions, and liberal abortion and contraception laws, but its historical focus on population control, combined with a culture whose

preference for sons encourages the abuse of technologies like ultrasound for sex selection effectively insure the continuation of conditions inconsistent with women's autonomy. In 1951 India became first country in the developing world to have a state sponsored family planning program.<24> Seven years later sterilization became an accepted practice. By the late 1960s health care workers implemented a state-sponsored "target method" to persuade poor women to adopt permanent or temporary sterilization. Later, family planning programs under the Janata Party temporarily shifted away from targeted population control to family welfare programs that treated fertility as a part of women's health care, but in time population reduction concerns reasserted themselves. Following the 1994 International Conference on Population Development (ICPD) in Cairo efforts were made to improve public health services, but a predictable lack of financial and medical resources gave rise to low-quality services, and a pool of relatively unskilled and unmotivated workers meant that women were unlikely to receive the information, counseling, medication and contraceptive devices they needed. A study of government-sponsored contraceptive programs reveals a shift from simple woman-controlled contraceptive technologies (e.g. pills, diaphragms) to clinically controlled methods (e.g. IUDs, Depo-Provera and Norplant). Sterilization remains the most popular contraceptive method. Still most women have to subsidize their own health care, and this means buying what they can afford—inexpensive and sometimes unregulated contraceptives that have been dumped on third world markets. Given the costs and risks of contraception many women rely on abortion services. The 1971 Medical Termination of Pregnancy Act made abortions up to 12 weeks legal in India, but these services are either unavailable or unaffordable for many women, leaving them to seek out local services offered by untrained traditional health providers. Today illegal abortions outnumber legal ones. Many Indian women face insurmountable obstacles in the realization of their reproductive rights.

Indian surrogacy work needs to be explored against this background. In response to the rising demand for surrogates in the infertility industry Indian feminists groups like Sama Resource Group for Women and Health are challenging laws and practices that permit the commercial control and exploitation of women's bodies, sexuality and reproduction. SisterSong affiliates offer no reproductive justice

framework analysis of surrogacy because it is not an issue (yet) for U.S. communities of color. The fact that India is a destination for infertility treatments, however, makes this a local issue for Indian women. There is no telling whether SisterSong and Sama's grassroots work will find a common cause in the future. It's worth noting, however, that Sama's decision to "locate the discussions and debate on ARTs within the framework of women's health, rights and social justice" mirrors exactly the three components of the reproductive justice approach (Sama, 2009b).

CONCLUDING THOUGHTS

Surrogate workers in Pande's interviews raise important questions about their work as a means of survival in an unjust world, but exploring the tensions between a surrogate worker's own pregnancies and with her contract pregnancies is not central to this project. I've tried to fill in some of the background above, using statistics on women in Gujarat. A more complete analysis of contract pregnancy in the context a surrogate worker's reproductive health over her lifetime requires pairing Pande's interviews with local data about these women's reproductive health histories, and unfortunately, no studies currently exist. So we can't be certain of the degree to which the population of women working as surrogates in Anand, Gujarat overlaps with the population of women with limited access to medical care over their lifetime. But, as Ross reminds us--this is a conversation starter.

In conclusion, I think Reproductive Justice offers a more complete picture of surrogacy work in India: one that avoids both the discursive colonialism of choice talk and win-win situations, and the moral absenteeism of many ethnographic approaches, while raising larger questions about reproductive injustice. *If basic reproductive health needs are more available to Indian women as surrogates than as mothers of their own children, then Indian women have more rights when they are birthing for others than they do while having their own families.* A description of medical care available to surrogates on the Rotunda Medical Center's website illustrates this gap all too clearly.

[What] is the nine months journey like with surrogate? The surrogate is treated as a high-risk pregnancy and is cared for by two consultant

gynecologists in our hospital. Appointments are scheduled with the consultants every three weeks for the first 6 months, then every 15 days for the next 2 months and then weekly / biweekly in the last month. Blood tests and ultra sound are done as and when required.... Special care and tests are done to pick up any obstetric or medical complications... The baby's growth is monitored stringently...Fetal well being tests like non stress test are done as and when required. Detailed information is given to the surrogates about diet during pregnancy. They are regularly provided with supplements from the hospital...Thus it is taken care that adequate nutrition reaches the baby and baby's growth is maintained.<25>

The discourse here is revealing: concern for the woman's health and nutrition is restricted to her "nine month journey," rather than over the course of her life. The surrogate is not treated as a person; she is treated as a "high risk pregnancy." The focus is on monitoring fetal development and seeing that "adequate nutrition reaches the baby." There is no mention of the surrogate's welfare during or after the pregnancy. If the resources directed at a pregnancy are a strong indicator of the pregnancy's social value, then one might infer that Indian women's reproductive health and rights are tied to the social or market value of the fetus they are carrying. It's worth remembering that Soman Dodia's own three children were born at home and that she never visited a doctor during those pregnancies. We need to listen when she says that her contract pregnancy is "very different with medicine. I'm being more careful now than I was with my own pregnancy" (Dolnick, 2007).

Reproductive Justice raises new moral questions. Should commercial gestational surrogacy be promoted in a country with such an abysmally poor record on women's health? What does it mean when women who have been historically targeted for sterilization and aggressive contraception policies are sometimes the same women targeted for surrogate work? Isn't there something unsettling about pushing women to limit their own family sizes while offering them huge incentives to carrying children for wealthy couples? I hope that as we learn more about the lives of Indian surrogate workers, that the normative dimensions will become more central to feminist inquiry. A

morally sensitive understanding of Indian surrogacy suggests that surrogate workers face more than surrogacy-or-poverty moral dilemmas: the compulsion (*majboori*) to take on surrogacy work is the product of deep injustices. These realities must be taken wholesale, because they are lived wholesale by surrogate workers; and, it is here that our conversations must begin.

NOTES

<1>As early as 1985 John Stehura considered bringing in “girls from the Orient, from Korea, Thailand, and Malaysia” to be surrogates for U.S. couples. His goal was to shorten waiting lists and “cut costs for middle-class [white] American couples, who would pay Filipinas roughly \$2000 for bearing a child from artificial insemination, instead of the going rate of \$10,000-\$15,000 for an American woman’s services. See Corea (1985, 245).

<2>This unsettling phrase comes from the title of a medical tourism conference sponsored by the India’s tourism ministry.

<3>I have in mind Victorian feminists in Britain who deployed images of Indian women (especially prostitutes) as backward, helpless and subject to barbarian cultural traditions that were in keeping with the goals of empire building (Burton, 1994). More recently the Coalition Against Trafficking in Women (CATW) positions ‘third world prostitutes’ as ‘injured bodies’—helpless victims in need of rescue. In international debates the ‘injured body’ of the third world trafficking victim serves as a metaphor for advancing certain feminist interests which do not match third world sex workers interests. See Doezema (2001).

<4>One Korean-American couple explains, “Of the four surrogate mothers who were matched up to us, we chose a widow who really needs the money for the family. Her husband died a year ago from cancer and she has three kids — fourteen, nine and five — so they’re really young. I feel for them” Nurluqman, et. al., (2009).

<5>This case marks the beginning of the surrogacy boom, but credit for bringing surrogacy to India goes to Dr. Kamala Selvaraj, a Chennai-based doctor (Subramanian, 2007). For a history of IVF in India see Bharadwaj (2002).

<6>The guidelines for accreditation, supervision and regulation of ARTS clinics were drafted by the Indian Council of Medical Research (ICMR) in 2005, but are legally non-binding and directed primarily at promoting rather than regulating new technologies. Women’s groups and health activists were not consulted during the drafting of the bill. In September 2008 Sama issued a joint statement and other women’s groups, demanding a national policy on ARTs and surrogacy that reflects the government stand with respect to human, social, medical, and moral health issues.

<7>The racial dimensions of bioethics have been under theorized. See Dilloway (2008), Ragoné (2000), Roberts (1996 and 1996), Ikemoto (1999), and Wolf (1996, 1999).

<8>It’s worth paying attention to comments like these as the industry develops. Historically color, caste, class, and race have been used informally to mark maternal character. For accounts

of how race and class mark good and bad mothering in the United States see Solinger (2001 and 2005).

<9>I use the term “post-Baby M approaches” to refer collectively to liberal, radical, Marxist and socialist feminist responses to surrogacy in the wake of the Baby M case. The essays in Laura Purdy’s co-edited “Ethics and Reproduction” (1989) issue of *Hypatia* organized discussion primarily along these lines. For applications of Jaggar’s frameworks to surrogacy see Tong (1996 and 2005). Examples of liberal approaches include Ketchum (1989) and Andrews (1989). Examples of radical approaches include Arditti (1987), Arditti, Klein and Minden (1984), Corea (1985), and Raymond (1994). For Marxist discussions see Belliotti (1988) and Rothman (1989). For an interesting discussion on the discourses attached to these movements see Farquhar (1996, 95-127).

<10>A Stanford human biology class Web site does exactly this. See Murray (2008).

<11>At the time conversations on race focused primarily on the Anna Johnson case and failed to interrogate the role whiteness and kinship play in reproduction. See Davis (1993), Dillaway (2008), Grayson (1998) and Katz (1998).

<12>I don’t mean to paint all Western frameworks with the same liberal feminist brush. I focus on liberal discourses simply because they have become the *lingua franca* of Western reproductive politics, and liberal political values often inform discussions in the infertility industry. Regretfully space restrictions prevent me from spelling out materialist and radical contributions.

<13>For a detailed account of the rise of feminist ethnography see Thompson (2002). Some popular approaches include Stacy (1992), Ginsberg and Rapp (1995), Cussins (1998), Franklin and Ragoné (1998), Goslinga-Roy (2000), Inhorn (2003, 2007), and Inhorn and Van Balen (2002). I’m grateful to an anonymous *Hypatia* reviewer for encouraging me to engage this literature more thoughtfully.

<14>See for example Cussins (1998), Goslinga-Roy (2000), Inhorn (2003), Sarah Franklin and Ragoné (1998), Thompson (2005), Teman (2010).

<15>The term “local moral worlds” comes from Inhorn (2007) 27-28.

<16>To avoid confusion over the two uses of reproductive justice I capitalize Reproductive Justice when referring to the general methodological approach, and use reproductive justice when referring the coalition-building lens.

<17>Both SisterSong and Sama-Resource Group for Women and Health locate women’s health and well being in the larger context of socio-historical, economic and political realities. See: <http://www.samawomenshealth.org/>

<18>For a lengthy discussion of media coverage in the wake of Baby M and *Johnson v. Calvert* cases see Markens (2007, 102-138).

<19>The statistics in this section are drawn exclusively from the Center for Reproductive Rights (CRR), the United Nations International Children’s Fund (UNICEF), and the International Center for Research on Women (ICRW) and the India’s Ministry of Family Health and Welfare Survey (NFHS-3).

<20>In 2005, the number of maternal death worldwide was 536,000. World Health Organization (WHO) *Maternal Mortality in 2005: Estimates*. Available: http://www.who.int/reproductive-health/publications/maternal_mortality_2005/mme_2005.pdf

<21>See UNICEF, Monitoring the Situation of Children and Women, www.childinfo.org/marriage.html (last updated July 2008, (accessed September 30, 2009). And, Amelia Gentleman, "India's Effort to Stop Child Marriage Hits a Wall." *New York Times*, June 2, 2005, World-Asia Pacific Section. (<http://www.nytimes.com/2005/06/01/world/asia/01iht-india.html>). See also, India's Ministry of Health and Family Welfare's Factsheets by state. Available: <http://www.nfhsindia.org/pdf/IN.pdf>

<22>See NFHS-3. Available: <http://www.nfhsindia.org/factsheet.html>. Data is listed by state.

<23>For a complete discussion on legal regulation see Smerdon (2008). My discussion of rights loosely follows Shanthi (2004).

<24>My summary follows Eager (2004).

<25>Rotunda Hospital, "Low-Cost Surrogacy: FAQ and Procedure Overview." Available: <http://www.medicaltourismco.com/assisted-reproduction-fertility/low-cost-surrogacy-india.php>

REFERENCES:

- Andrews, Lori. B. 1988. Surrogate motherhood: The challenge for feminists. In *Surrogate motherhood: Politics and privacy*, ed. Larry Gostlin. Bloomington, IN: Indiana University Press.
- Arditti, Rita, R. D. Klein and S. Minden, eds. 1984. *Test-tube women: What future for motherhood?* London: Routledge & Kegan Paul.
- Arditti, Rita. 1987. The surrogacy business. *Social policy* 18(2): 42-46.
- Asian Communities for Reproductive Justice (ACRJ). 2006. *A new vision for advancing our movement for reproductive health, reproductive rights, and reproductive justice*. http://www.reproductivejustice.org/download/ACRJ_A_New_Vision.pdf (accessed: March 30, 2008).
- Belliotti, Raymond. 1988. Marxism, feminism and surrogate motherhood. In *Social theory and practice* 14(3): 389-417.
- Bharadwaj, Aditya. 2002. Conception politics: Medical egos, media spotlights, and the contest over test-tube firsts in India. In *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies*, eds. Marcia C. Inhorn and Frank Van Balen. Berkeley: University of California Press, 315-333.
- Burton, Antionette. 1994. *Burdens of history: British feminist, Indian women and imperial culture, 1865-1915*, Chapel Hill: University of North Carolina Press.
- Center for Reproductive Rights. 2008. *Maternal mortality in India: Using international and constitutional law to promote accountability and change*. New York: Center for

- Reproductive Rights. <http://reproductiverights.org/en/document/maternal-mortality-in-india-using-international-and-constitutional-law-to-promote-accountab>. (PDF accessed: November 11, 2009).
- Chandran, Rina. 2009. As crisis bites: Indian women turn to surrogacy. Reuters. <http://www.reuters.com/article/idUSTRE53705T20090408> (accessed: April 7, 2010).
- Chopara, Anuj. 2006. Childless couples look to India for surrogate mothers. *Christian science monitor*. 98:88. <http://www.csmonitor.com/2006/0403/p01s04-wosc.html> (accessed: April 17, 2010).
- Cohen, Margot. 2009. A Search for a surrogate leads to India. *Wall street journal*, (October 9).
- Corea, Genea. 1985. *The mother machine: Reproductive technologies from artificial insemination to artificial wombs*, New York: Harper and Row.
- Cussins, Charis. 1998. Ontological choreography: Agency for women Patients in an infertility clinic. In *Differences in medicine: Unraveling practices, techniques, and bodies*, eds. Marc Berg and Anne Marie Mol. Durham and London: Duke University Press.
- Davis, Angela Y. 1993. Outcast mothers and surrogates: Racism and reproductive politics in the nineties. In *American feminist thought at century's end: A reader*, ed. Linda S. Kauffman. Cambridge: Blackwell.
- Dillaway, Heather E. 2008. Mothers for others: A race, class, and gender analysis of surrogacy. *International journal of sociology of the family* 34(2): 301-326.
- Doezema, Jo. 1991. Western feminists' 'wounded attachment' to the 'third world prostitute'. *Feminist review* 67 (Spring): 16-38.
- Dolnick, Sam. 2007 Giving Birth Becomes Latest Job Outsourced to India. *USA Today*, (December 30). http://www.usatoday.com/news/health/2007-12-30-surrogacy_N.htm (accessed: April 5, 2010).
- Eager, Paige Whaley. 2004. *Global population policy: From population control to reproductive rights*. Burlington, VT: Ashgate Publishing Company.
- Franklin, Sarah and Helena Ragoné. 1998. *Reproducing reproduction: Kinship, power, and technological innovation*. Philadelphia: University of Pennsylvania Press.
- Farquhar, Dion. 1996. *The other machine: Discourses and reproductive technologies*. New York: Routledge.
- Gentleman, Amelia. India nurtures business of surrogate motherhood. In *New York times*, March 10, 2008, A9.
- Ghosh, Aditya. 2006. Cradle of the world. *Hindustan times*, (December 23).
- Ginsberg, Faye. D. and Ranya Rapp, eds. 1995. *Conceiving the new world order: The global politics of reproduction*. Berkeley: University of California Press.

- Goslinga-Roy, Gillian. 2000. Body boundaries, fiction of the female self: An ethnographic perspective on power, feminism, and the reproductive technologies. In *Feminist studies* 26, 113-141.
- Grayson, Deborah R. 1998. Mediating Intimacy: Black Surrogate Mothers and the Law. In *Critical inquiry* 24 (Winter), 540.
- Harding, Sandra. 1991. *Whose science? Whose knowledge?: Thinking from women's lives*. Ithaca, NY: Cornell University Press.
- Haworth, Abigail. 2007. Surrogate mothers: Wombs for rent. In *Marie claire*. <http://www.marieclaire.com/world-reports/news/international/surrogate-mothers-india> (accessed: January 16, 2009).
- Ikemoto, Lisa. 1999. Lesson from the Titanic: Start with the people in steerage, women and children first. In *Mother troubles: Rethinking contemporary maternal dilemmas*, eds. Julia E. Hanigberg and Sara Ruddick. Boston, MA: Beacon Press.
- Inhorn, Marcia C. and Frank Van Balen, eds. 2002. *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies*. Berkeley: University of California Press.
- Inhorn, Marcia C., ed. 2003. *Local babies, global science: Gender, religion, and in vitro fertilization in Egypt*. New York: Routledge.
- Inhorn, Marcia C., ed. 2007 *Reproductive disruptions: Gender, technology and biopolitics in the new millennium*. New York: Berghahn Books.
- International Center for Research on Women (ICRW). 2001. Reproductive rights and choice: The role of abortion in India. Washington, D.C.: ICRW, 1-4.
- Jaggar, Alison. 1983. *Feminist politics and human nature*. Totowa, NJ: Rowman and Littlefield.
- Kannan, Shilpa. 2009. Regulators eye India's surrogacy sector. *BBC News*, (March 19). <http://news.bbc.co.uk/2/hi/business/7935768.stm> (accessed: April 17, 2010).
- Katz Rothman, Barbara. 1988. Cheap labor: Sex, class, race—and surrogacy. In *Society*. 25(3): 21-23.
- Ketchum, Sara Anne. 1989. Selling babies and willing bodies. In *Hypatia*, 4(3): 116-127.
- Markens, Susan. 2007. *Surrogate motherhood and the politics of reproduction*. Berkeley: University of California Press.
- Medical Tourism Corporation. 2009. Interview with Dr. Gautam Allahbadia—surrogacy expert India. <http://www.medicaltourismco.com/assisted-reproduction-fertility/dr-Gautam-Allahbadia-India-Surrogacy-Expert.php> (accessed: May 27, 2009).

- Mohanty, Chandra Talpade. 2003. Under western eyes revisited: Feminist solidarity through anticolonialist struggles. In *Signs: Journal of women in culture and society* 28(2): 499-535.
- Murray, Ann Firth. 2008. *Surrogate motherhood in India: Understanding and evaluating the effects of gestational surrogacy on women's health and rights*. Stanford University. <http://www.stanford.edu/group/womenscourage/Surrogacy/index.html> (accessed: April 10, 2010).
- n.a. 2007. Outsourcing life itself: What India teaches us. In *Macleans* 120(25): 4. http://www.macleans.ca/canada/opinions/article.jsp?content=20070702_107034_107034&page=1 (accessed: April 10, 2010).
- National Family Health Survey, India [NFHS-3] 2006. Mumbai: International Institute for Population Services. <http://www.nfhsindia.org/nfhs3.shtml> (accessed: April 4, 2010).
- Niazi, Shuriah. 2007. Surrogacy boom. In *Boloji.com*, (October 14). <http://www.boloji.com/wfs6/wfs1027.htm> (accessed: March 23, 2009).
- Nurluqman, Murd, Tan Wei Xin, and David Lee Shijhan. 2009. A couple's last resort. *The Indian surrogate: A look into India's surrogacy industry*. <http://theindiansurrogate.com/?p=98>. (accessed April 10, 2010).
- Pande, Amrita. 2009. Not an 'angel', not a 'whore.' In *Indian journal of gender studies* 16(2): 141-173.
- Pande, Amrita. 2008. Commercial gestational surrogacy in India: Nine months of labor? In *A quest for alternative sociology*, eds. Kenji Kosaka and Masahiro Ogino. Nishinomiya, Japan: Trans Pacific Press, 71-88.
- Peachey, Paul. 2006. Doctor hails 'reproductive tourism as Indians make outsourced babies. *Middle East Times* [March 29, 2006].
- Purdy, Laura M. ed. 1989. Introduction: Ethics in reproduction. In *Hypatia*. 4(3): 1-2.
- Ragoné, Helena. 2000. Of likeness and difference: How race is being transfigured by gestational surrogacy. In *Ideologies and technologies of motherhood*, eds. Helena Ragoné and France Winddance Twine. New York: Routledge.
- Raymond, Janice G. 1994. *Women as wombs: Reproductive technologies and the battle over women's freedom*. New York: HarperCollins.
- Roberts, Dorothy. 1996. Reconstructing the patient: Starting with women of color. In *Feminism and bioethics: Beyond reproduction*, ed. Susan Wolf. New York: Oxford.
- Roberts, Dorothy. 1999. *Killing the black body: Race, reproduction and the meaning of liberty*. New York: Vintage.
- Ross, Loretta J. 2006. Understanding reproductive justice. *SisterSong: Women of Color*

- Reproductive Health Collective.*
http://www.sistersong.net/publications_and_articles/Understanding_RJ.pdf (accessed: April 10, 2010).
- Ross, Loretta J. 2007. Understanding reproductive justice: Transforming the pro-choice movement. In *Off our backs* 36(4): 16-20.
- Rothman, Barbara Katz. 1989. *Recreating motherhood: Ideology and technology in a patriarchal society*. New York: W.W. Norton.
- Roy, Sujit. 2008. Surrogate motherhood: Should it be allowed? In *Merinews.com*.
<http://www.merineews.com/article/surrogate-motherhood-should-it-be-allowed/136765.shtml> (accessed: November 11, 2009).
- Ruparelia, Rakhi. 2007. Giving away the “gift of life”: Surrogacy and the Canadian assisted human reproduction act. In *Canadian journal of family law* 23(1): 11-54.
- Raymond, Janice G. 1994. *Women as wombs: Reproductive technologies and the battle over women’s freedom*. New York: HarperCollins.
- Sama. 2006. *ARTs and women: Assistance in reproduction or subjugation?* New Delhi: Sama Resource Group for Women’s Health.
- Sama. 2009a. Assisted reproductive technologies: For whose benefit? In *Economic and political weekly* 46(18): 25-31.
- Sama. 2009b. Unraveling the fertility industry: Challenges and strategies for movement building. <http://samawomenshealth.wordpress.com/2009/11/27/unraveling-the-fertility-industry-challenges-and-strategies-for-movement-building/> (accessed: April 17, 2010).
- Schultz, Sandra. 2008. In India, surrogacy has become a global business. *Der Spiegel* Online. trans. Christopher Sultan.
<http://www.spiegel.de/international/world/0,1518,580209,00.html> (accessed: March 23 2008).
- Scott, Amy. ‘Wombs for rent’ grows in India. Marketplace NPR December 27, 2007 [MP3 file]
- Shanthy, K. 2004. Feminist bioethics and reproductive rights in India: Myth and reality. In *Linking visions*, eds. Rosemary Tong, Anne Donchin, and Susan Dodds. Oxford: Roman and Littlefield, 119-132.
- Smerdon, Usha Rengachary. 2008. Crossing bodies, crossing borders: International surrogacy between the United States and India. In *Cumberland law review* 39(1): 15-85.
- Solinger, Rickie. 2001. *Beggars and choosers: How the politics of choice shapes adoption, abortion, and welfare in the United States*. New York: Hill and Wang.
- Solinger, Rickie. 2005. *Pregnancy and power: A short history of reproductive politics in America*. New York: NYU Press.

- Stacy, Meg, ed. 1992. *Changing human reproduction: Social science perspectives*. London: Sage.
- Subramanian, Sarmishta. 2007. Wombs for rent: Is paying the poor to have children wrong when both sides reap such benefits? In *Maclean's* 2 July.
- Teman, Elly. 2010. *Birthing a mother: The surrogate self and the pregnant self*. Berkley: University of California Press.
- Thompson, Charis M. 2002. Fertile ground: Feminists theorize infertility. In *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies*, eds. Marcia C. Inhorn and Frank Van Balen. Berkeley: University of California Press, 52-78.
- Thompson, Charis M. 2005. *Making parents: The ontological choreography of reproductive technologies*. Cambridge, MA: MIT Press.
- Tong, Rosemarie. 1996. Feminist bioethics: Toward developing a “feminist” answer to the surrogate motherhood question. In *Kennedy Institute of Ethics Journal* 6(1): 37-52.
- Tong, Rosemarie. 2005. Surrogate motherhood. In *A companion to applied ethics*, eds. R.G. Frey and Christopher H. Wellman. Malden, MA: Wiley-Blackwell, 369-381.
- UNICEF. 2008. *State of the world's children: Maternal and newborn health*. New York: United Nation's Children's Fund. www.unicef.org (accessed: April 3, 2010).
- Wade, Matt. 2009. Take away baby boom. In *Brisbane times*.
<http://www.brisbanetimes.com.au/news/world/the-takeaway-baby-boom/2009/01/30/1232818725697.html> (accessed: April 10, 2010).
- Wolf, Susan ed. 1996. Introduction: Gender and feminism in bioethics. In *Feminism and bioethics: Beyond reproduction*. New York: Oxford University Press, 3-43.
- Wolf, Susan. 1999. Erasing difference: Race, ethnicity, and gender in bioethics. In *Embodying bioethics*, eds. Ann Donchin and Laura Purdy. Oxford, England: Rowman and Littlefield Publishers, Inc., 65-81.