'Humanitarian' thresholds of the Fundamental Feminist Ideologies: Evidence from Surrogacy Arrangements in India

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Abstract: *Developments in reproductive technologies and its use for practices such as surrogacy and sex determination has challenged the very ideologies that feminism fundamentally represents; equality, liberty and justice. These challenges have become even more pronounced with a growing transnational movement for the use of reproductive technologies which is embedded in existing global inequalities. Practices such as surrogacy in 'transitional economies' like India has raised concerns of exploitation, commodification of women and children from a structural injustice, racist and colonial perspective and stirred yet again the discourse on violation of women's bodily integrity and reproductive justice. Drawing on the Feminist ideologies of equality (socio-economic, health, legal), liberty (freedom of choice, autonomy) and justice (social and reproductive justice), the paper aims to identify the 'humanitarian' thresholds of Feminist ideologies and its global relevance to reproductive justice using a case of surrogacy arrangements in India.*

This paper observes that the surrogacy practice reinforces the existing global inequalities and causes exploitation, commodification of women and children and violation of basic human rights. Technologies such as surrogacy provides a wider reproductive choice for the affluent people but at the cost of the health, freedom and life of some others (mostly the less affluent women) while designating substantial control and power in the hands of intermediate institutional agencies. While scholars have proposed alternative solutions to reduce inequalities, the debates between 'liberty' and 'justice' are yet to be resolved. The liberals support the idea of procreative autonomy, individual rights and unlimited choices. However, the reproductive justice framework aims at identifying individuals also as social beings in order to be able to analyse the implications of reproductive technologies on women's dignity and integrity as well as in the context of international rights relations.

The Asian Communities for Reproductive Justice (ACRJ) developed a Reproductive Justice framework that acknowledges the histories of reproductive oppression in all communities. This model is based on organizing women/girls to change structural power inequalities by examining the control and exploitation of women's bodies, sexuality and reproduction which has been used as an effective strategy for controlling women and communities, particularly those of color manifested through the multiple oppressions of race, class, gender, sexuality, ability, age and immigration status.

Global markets based on the supply of 'free-of-cost' or cheap and uncomplicated wombs have developed as a solution to 'infertility' or to the 'profound socio-economic inequalities'. However, pregnancy contracts put women offering this service through social stigma, psychological challenges, violation of her bodily integrity and moreover their health, freedom, liberty and even life at stake. Hence this motherhood market does not conform to

the broader reproductive health-rights-justice from a feminist perspective and clearly crosses the 'humanitarian' threshold of the very ideologies that 'feminism' and 'reproductive justice' itself stands for.

Keywords: Surrogacy • Global Inequalities • Reproductive Liberty • Social/Reproductive Justice • Human Rights • Feminist Ideologies • Humanitarian thresholds of feminism

Introduction

Feminists have upheld the inclusion of certain reproductive rights as international human rights especially in using medical technologies for abortion (ICPD 1994, UNFPA 2004). However, in the last two decades, developments in reproductive technologies and its use for practices such as sex selective abortions and pregnancy contracts has challenged some of the very ideologies that Feminism fundamentally represents; equality (socio-economic, health, legal), liberty (freedom of choice, autonomy) and justice (social and reproductive justice). While scholars have proposed alternative solutions to reduce inequalities, the debates between 'liberty' and 'justice' are yet to be been resolved. This paper aims to identify the 'humanitarian' thresholds of these Feminist ideologies using a case of surrogacy arrangements in India and its global relevance to reproductive justice. It is beyond the scope of this paper to include all the feminist discourse, but the aim is to include those that are relevant to transnational surrogacy arrangements especially in the context of 'transitional economies' like India. The paper draws on my research conducted between 2009 and 2010 from participant observation and personal accounts of 13 contract mothers[1], six of their spouses, five intended parents and five doctors in two IVF (In-vitro Fertilisation) clinics in Western India (one clinic had a surrogate home[2] and the other without surrogate homes[3]). Most of the contract mothers (7/13) had relinquished the child(ren), four were in the post-natal stage and were caring for the new born babies and the remaining two were pregnant as a contract mother for the first time.

Some of the known reasons for transnational surrogacy are; legal diversity; resource constraints (cost, expertise, equipment and waiting lists); quality and safety; and

[1] In India, women referred to themselves as 'surrogate mothers' and intended parents as '*party wale*' (a Hindi terminology commonly used for buyers in business dealings) in conformity with the market settings of the practice.
[2] Surrogate homes are hostel like accommodation and some clinics make it mandatory for contract mothers to stay here during pregnancy.
[3] Contract mothers were allowed to stay with their families with conditions depending on what the intended parents wanted them to do such as; change their place of residence if they didn't like the place they lived in, they were not allowed to do any housework, eat spicy food or have physical intercourse with their spouse lest the fetus is affected.

personal considerations (support networks and privacy concerns). Many countries in Europe prohibit all surrogacy agreements; Austria, Bulgaria, France, Germany, Italy, Norway, Portugal, Switzerland, Spain and Sweden. While in some other countries, certain groups of persons are prohibited such as; homosexuals and single parents. In Belgium, Denmark, Ireland and the United Kingdom altruistic surrogacy is allowed. Other countries in Europe and Americas are comparatively permissive (Belgium, Ukraine, Russia, and Poland) creating a patchwork of legally 'restrictive' and 'permissive' countries. People seeking surrogacy options hence move from restrictive countries to comparatively permissive countries. Russia, Ukraine and USA continue to be popular destinations for surrogacy. Although most of the movement for surrogacy is from 'affluent' to 'transitional' economies, it may not always be the case. Affluent people also move from Asia, Europe and Australia to USA.

Until 2014, it had seemed that India was the only prominent destination for global commercial surrogacy in Asia. It was not until Baby Gammy was abandoned by an Australian couple in 2014 because he had downs syndrome that the existing market in Thailand became globally evident. In the same year a Japanese man was found to be a commissioning parent for at least 16 babies born through surrogacy in Thailand and thereafter the government decided to ban surrogacy. Similarly, the hidden markets of surrogacy in Nepal came to light after the earthquake in 2015; when an Israeli government operation airlifted 26 babies stranded in Nepal born to their citizens through surrogacy and callously left behind about 100 contract mothers in a disaster zone. Following this episode, Nepal banned surrogacy in 2015. With a spread of information on women being retained in surrogate homes and evidence of other exploitation within the practice, India too banned commercial surrogacy for foreigners since November 2015. Similar stories from Mexico about poor women desperate for money being involved in surrogacy, also prompted a ban on surrogacy in this country in 2015. Meanwhile Cambodia, Dubai, Iran and Lebanon are the emerging hubs for surrogacy. Despite this ban, some of the concerns on inequalities, exploitation and injustice remain. In India, surrogacy will be allowed only for those needy people seeking this service and a case-to-case review will be conducted for all such requests. Transnational surrogacy is one source but many affluent people who can afford these services from within the country also use the services of poor women through agents and clinics.

India has been a global attraction for transnational surrogacy also because of affordability. The expenses of surrogacy in India is generally only one-third (50,000 USD) of its cost in USA (200,000 USD). However, this may not always be true as the cost largely depends on the number of IVF trials before a successful pregnancy, additional cost charged by clinics for multiple births, neonatal intensive-care units and many other unanticipated costs (Saravanan 2013). Intended parents preferred India also because some of the clinics monitored the contract mothers throughout the pregnancy in 'surrogate homes' and the payment pattern was attractive to many as nothing much had to be paid until the baby was physically handed over to the intended parents (Saravanan 2013). One intended mother from Canada in my study explained, *"Although it is legal in my country (Canada), the process is very complex there. The law makes it mandatory for contract mothers in India to sign off all their rights towards the baby even before the surrogacy begins, which is a big relief"* (Saravanan 2013).

The more affluent source countries have been criticized for allowing their citizens to avail surrogacy services by using the vulnerability of impoverished citizens in 'transitional economies' like India, while protecting their own citizens. The destination countries have also been blamed for viewing surrogacy merely as an opportunity for economic gains and thereby permitting objectification and exploitation of their own citizens, especially when the citizens of their own country do not have adequate access to basic health care services. While high quality reproductive health care is provided to 'contract mothers' during their contract pregnancies, they have had almost no access to any quality health care for their own pregnancies. This disparity brings to light reproductive injustice that accords a higher value to certain pregnancies and babies (Bailey 2011). It is important to overview the kind of existing inequalities in transitional economies like India to understand the socio-economic circumstances in which the contract mothers make choices and decisions.

1.1 Overview of Inequalities in India

Although poverty in India has reduced over time, according to official figures 267 Million (22 %) of the total population in India presently live below the poverty line (NSSO 2013). The McKinsey Global Institute (MGI) developed a revised analytic index, the 'Empowerment line' which estimated that 680 million people, 56 per cent of the population lacks the means to meet their essential needs (Gupta et al. 2014). Also

important to note is the extent of gender inequalities in India. While India has shown considerable improvement in overall literacy levels more than one-third of the women still cannot read and write. Despite a high enrolment rate at primary school, a larger number of girls and boys drop-out from school before completing secondary schooling (52 and 53 per cent for girls and boys respectively) (MHRD 2014). Many of these girls and boys who drop-out from schools are married off young. Data shows that women with no education are six times more likely to be married than those with 10 years or more of education. According to the NFHS (National Family Health Survey) data, 47 per cent of the girls are married before the legal age (18 years) leading to early childbearing (IIPS and Macro International 2007). One in six (16 per cent) girls in their youngest reproductive age group (15-19 years) begin child bearing (IIPS and Macro International 2007). The average age of marriage in India is 17 years and the average age at childbirth is 19 years.

Women usually of the above given socio-economic background are the ones participating in surrogacy. Most contract mothers are illiterate or on an average have completed only up to middle school (Saravanan 2013, Pande 2010). The employment opportunities they can chose from is hence very limited. Contract mothers work as household-help, agricultural labourers and some were even 'homeless' (Saravanan 2013). The remuneration offered through surrogacy, although unequal, is hence of great significance to them. By participating in surrogacy, the contract mothers earned approximately 250000 to 500000 Indian Rupees (USD 4000 to 8000), an amount they would take at least 15 years to earn with their present earnings. They participated in surrogacy mainly to provide their family with basic needs; adequate income, food, education for their children and to avoid slipping further into poverty. Some of their financial needs were to; repay debts, to buy a house and thereby save on the house rent, to add to their savings and to avoid falling further into debts (Saravanan 2013; SAMA 2012; Pande 2010). Some contract mothers had serious health problems in their households which needed immediate medical treatment; either an ailing family member or a child with severe disabilities (Saravanan 2013). These socio-economic circumstances effect their negotiation powers leading to unjust surrogacy arrangements. Pande (2010) observed that the contract mothers with higher education attainment had an enhanced negotiating power in the surrogacy process.

1.2 Inequalities in the Surrogacy Arrangements

Disadvantaged women are more vulnerable to the unjust surrogacy contracts and to face further kinds of exploitation within the contract. Contract mothers in India have comparatively lesser rights over the child, no legal or psychological support, they receive a lesser share of the total surrogacy costs, submit to unfair payment pattern, with no additional payment even for a miscarriage, are not safeguarded with medical/life insurance and some clinics make it mandatory that they remain in 'surrogate homes' away from their families. Contract mothers have to sign off all rights over the child while entering into the contract, according to the ART (Assisted Reproductive Technology) Bill. The clinic with surrogate homes did not allow the contract mother to see the child(ren) as they are whisked away while she is half-conscious after a caesarean section. While the other clinic with surrogate homes expected the contract mother to bond with the child for a lengthy period of time (varying from 3 weeks to 3 months) and then they are abruptly separated from the child(ren) without a plan for future relationship with the parents/baby or much psychological assistance.

Although the success rate of the gestational surrogacy is considerably low, the contract mothers are not given any compensation if they experience a miscarriage at any stage of the pregnancy. Studies reveal that the overall pregnancy rate per cycle after IVF surrogacy was only 24 per cent, with a clinical pregnancy rate of 19 per cent, and a live birth rate of 15.8 per cent, while the clinics usually publish an exaggerated success rates on their websites (Goldfarb et al., 2000). Although legally only 3 embryos are allowed to be implanted into the contract mother's womb in India, up to 5 embryos are known to be implanted with a high likelihood of multiple pregnancies. In case of these multiple pregnancies (triplets), the doctor suggests "selective reduction" of one or more fetuses. This procedure may also result in; miscarriage of the remaining fetuses, preterm labor or infection. The preference of the contract mother is not asked either for the number of embryos to be implanted or in the decision making about selective abortions. In the surrogacy contract, women have to sign off all rights on medical interventions. Only a nominal payment (36 Euros per month) is made to the contract mother, but the bulk amount (2500 Euros) is paid only after she hands over the baby. In the words of one of the intended parent *"it's a good incentive for her (the contract mother) to keep the baby*

and not miscarry as she doesn't really get compensated until the very end" (Saravanan 2013).

Maternal mortality in India is high at 174 per 100000 live births compared to the one digit numbers in most developed countries. One of the major reasons for health problems during birth is deficiency of hemoglobin. More than half the women in their reproductive age group (15 to 59 years) in India are anaemia (55.3 per cent) and more than one-third are underweight (35.5 per cent) (IIPS and Macro International 2007). Although it is known that contract mothers are given the best medical facilities during pregnancy and delivery, a few deaths of contract mothers and egg donors have been reported in India. One contract mother, Premila Vaghela in Anand, reached the hospital for a regular check-up in the eight month of her pregnancy and had convulsions, the first thing the doctors did was an emergency caesarean to remove the child, she died soon afterwards of a severe cardiac arrest (ToI, May 2012). She is also reported to have had hepatises related complications. Another contract mother in South India Easwari, died of severe post-partum hemorrhage. She was referred to another hospital for treatment as the clinic was ill-equipped and was also asked to pay for her own transport expenses; she died en-route. Easwari was a second wife in a polygamous marriage and the husband had seen an advertisement in a local newspaper and coerced her into this process (Global Bioethics Blog 2012). There are also cases of women, even teenagers who have died of egg donation. What goes unreported though is the near-death situations and those causing life-long health or psychological problems. The other unknown health impacts that contract mothers face is from the excessive and repeated doses of hormones as many have to go through several trials before a successful conception. There have been no studies on the health or psychological impacts of surrogacy on the contract mothers, the children or on the intended parents.

The contract mother's consent is not asked regarding their preferred kind of contract (open or anonymous); the payment pattern or the kind of relinquishment (whether they would prefer to see the baby or keep the baby for a particular period before relinquishment). In m study one clinic had not given the contract mothers a copy of their contract and the other clinic had registered the intended mother as the pregnant woman rendering the contract mothers completely anonymous and making it impossible for them to file a legal case against the medical institution (Saravanan 2013). While, in the USA, contract mothers are provided with social support group, insurance for multiple

pregnancies, maternity benefits, life insurance, psychological support, compensation for all expenses and loss of employment and also assisted with legal representation among many other rights and benefits.

The medical practitioners in India earn a much higher share of the surrogacy benefits. In the USA, surrogacy costs approximately 200,000 USD of which 73,000 USD (about 35 per cent) is paid to the contract mother (Surrogacy Source Companies 2015). Whereas in India, they are paid only 15–25 per cent of the total costs (Saravanan 2013). The profits earned by the medical practitioners is evident in a forthcoming building complex planned by one popular clinic in Western India which is published online (Dailymail 2013). It was called the world's first baby factory and was being built as an all inclusive complex including; self-catering apartments for couples, a floor for contract mothers to stay, offices, delivery rooms, the IVF clinic, restaurants and shopping area costing millions of Indian Rupees.

Some clinics in India make it mandatory that women stay in 'surrogate homes' during the entire surrogacy process that can last for almost a year. It is more than three decades since Andrea Dworkin (1983) wrote about 'reproductive brothels' wherein technologies similar to animal husbandry would be used on women. She described 'farming model' within which women will sell their wombs using in-vitro fertilisation. Women will be held in places similar to prisons where they cannot move freely and will be restricted to a strict standard of behaviour and sell themselves to make babies. This might have then sounded like a piece out of science fiction, but the reality of this fiction can be seen in the surrogacy markets in India today.

1.3 Surrogate homes

Within the surrogate homes, beds are lined up in a hostel like environment where women are being over-fed, they are restricted in movement, they are not allowed to use the stair- case, even the elevator cannot be used without the assistance of the nurses or other hospital personnel. They are not supposed to do any work, food is provided to them and all other housework is taken care of. They have to spend their entire time in their beds, watching TV, talking to each other or with their family members on their mobile phones. Their own children and family were allowed to visit their mothers only on Sundays, under restrictive conditions and they are not allowed to go home. One of the clinics I visited had installed cameras in each of their rooms to monitor the contract

mothers. The contract mothers complained of water shortage, cramped conditions, substandard food quality and poor sanitation and hygiene at the surrogate homes for which they have had internal conflicts as well as confrontations with the warden. The contract mothers living in these homes were missing their families but were trying their best to keep themselves cheerful. Pande (2010) deconstructs the contract mother's experiences in order to develop a deeper knowledge of the complex realities of these women. While some authors criticize the concept of surrogate homes as a place where women are detained during the surrogacy pregnancy and how this affect their other children and immediate family, others see these homes as a gender-safe environment providing emotional links and sisterhood among the women through intensive contact to share information and grievances with one another and to come up with strategies for future employment and possibly even acts of collective resistance. This helps to understand the micro level agency but it is also important to take into context the broader socio-cultural issues.

It was normal for contract mothers to be asked to wait after delivery for taking care of the children. There were three kinds of situations that I observed in the clinic with surrogate homes where the contract mothers had to wait after delivery (Saravanan 2013). One contract mother had to wait along with the baby girl in a children's hospital because the intended parents had arrived from abroad late (20 days after the child was born). According to the doctor, there was nobody who could take better care of the child than the contract mother herself. She was breastfeeding and caring for the baby along with her husband (Saravanan 2013). Another contract mother was asked to take care of the babies for 2 months in a hotel room as a full-time nanny while waiting for the children's passports and because the intended mother was unable to look after the twins. And yet another NRI (Non Resident Indian) couple asked the contract mother to remain at the surrogate home after birth so that she could provide her breast milk but through breast-pump as they didn't want the child to bond with her. It is assumed that the contract mothers will be willing to do just anything and the justification given by the medical practitioners and intended parents is that they are paid in return for all their services. Being confined to 'surrogate homes' during their pregnancy hence meant women are denied participation in public life and cannot meet their non-reproductive aspirations such as; educational, occupational and any other social well-being. Many of the above mentioned surrogacy procedures in India are a violation of basic human

rights, dignity and freedom as stated in Articles 1[1], 2[2], 9[3] and 14[4] of the Universal Declaration of Human Rights and The Universal Declaration on Bioethics and Human Rights 2005[5] (UNESCO 2006; UN 1948).

2. Reproductive Liberty

In order to understand the political totality of liberty from a Feminist perspective it is important to reflect on the various levels that may work in conflict or favour of women's equality. The political structures and constitutional rights define liberties, while the familial and micro level organisational agencies operate within this broader political structure (Eisenstein 1981). In the context of surrogacy, the state plays a significant role in determining the policy, while the agencies operate at the micro level and it is here that alienation, commodification and patriarchy plays on the vulnerabilities and inequalities affecting women's autonomy and consent.

2.1 Alienation

A system that expects the contract mother to isolate herself from any emotion or attachment to the fetus growing inside her while considering the genetic connections as superior is described as alienated labour, objectification, commodification and denial of subjectivity (Saravanan 2013, 2010; SAMA 2012; Tieu 2009, Berkhout 2008, Van Niekerk and Van Zyl 1995). Requiring a contract mother to decide even before the pregnancy about her feelings in this relationship (motherhood) during and after birth and thereby repress any feelings that may possibly emerge towards the child during pregnancy or childbirth and then giving others the power to hold her guilty if she diverges is alienation (Pateman 1988). *"What if, despite her initial intentions, she finds herself coming to love her own child?"* (Anderson 2000: 27). Hence some of the arguments that emphasize on women's empowerment reflected in the contract mother's

[1]The Universal Declaration of Human Rights, Article 1 states, ''All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood'' (UNESCO 2006).

[2] The Universal Declaration of Human Rights, Article 2, states, ''Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'' (UNESCO 2006).

[3] The Universal Declaration of Human Rights, Article 9 states, ''No one shall be subjected to arbitrary arrest, detention or exile'' (UNESCO 2006).

[4] The Universal Declaration of Human Rights, Article 14 states, ''Everyone has the right to freedom of movement and residence within the borders of each state''.

[5] The Universal Declaration on Bioethics and Human Rights 2005 recognizes that technological advancements in medical science should be ethically sound, giving ''due respect to the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms'' (UNESCO 2006: 3).

ability and power to be able to detach from the feeling of motherhood with the fetus growing inside her violates the integrity of women who may develop an attachment for the child. The individualistic approach limits the enquiry of reproductive technologies as an institution. Scientifically also there is evidence that the mother and child relationship cannot be completely alienated as it is now a known fact that cells migrate during pregnancy and this exchange occurs not only from the mother to the fetus but also from the fetus to the mother (Dawe 2007). Meaning all the babies and the contract mothers have exchanged DNA (Deoxyribonucleic Acid) material during pregnancy. There is a debate among scientists whether or not 'DNA' can be accepted as 'genetic material' and if it is so, all contract mothers should be considered 'birth mothers' and the entire definition of 'gestational surrogacy' and descriptions of wombs as containers could be questionable. Moreover, erasing a birthmother from her maternal identity and denying her such rights within surrogacy contracts can only be possible under the garb of patriarchy (Cornell, 1998).

2.2 Patriarchy

While some academics consider surrogacy as an arrangement that reinforces stereotypical notions of motherhood and women's social roles, (Berend 2010, Roberts 1998) others say, the contract mothers defy these common definitions of nature and motherhood by being able to define their own pregnancy with the child termed as 'incubated' (Teman 2009, Shalev 1998). Most people seeking surrogacy desire children not merely for themselves but also because they have endured social stigma due to childlessness and to acclaim social dignity. In India, it is known that having a baby is valuable for women as they are symbols of motherhood and it increases their honour and esteem in the eyes of the in-laws, especially so on the birth of a boy child (Mishra and Dubey 2014). This is reflected also in surrogacy practices. In India, it has been observed that having a boy child would entail higher bonus amount for the medical institutions, brokers and the contract mother as intended parents tend to be more contended. Contract mothers are also blamed in case the child has some problems (disability or sometimes even for the birth of a girl child). It is understood that they would not be paid any bonus or sometimes they are not even paid the full amount promised in the contract with the birth of a child with disability. Another stereotypical role of women is the tendency to put other's need and priorities before their own (Baker

1996). This motivation is evident among contract mothers in India who want to sacrifice their lives for the sake of the family (Saravanan 2013, Pande 2010). The surrogacy markets hence operate amongst those who (consciously or unconsciously) subscribe to patriarchy (a subordinate position of women in society) and they may not always necessarily be men. These may include lawmakers, medical institutions, contract mothers themselves, intended parents and brokers consisting of people from different gender categories including 'women'. Another instance of State enforced patriarchy is the example of Israel, where the surrogacy laws is strongly patriarchal (Shalev 1998). Patriarchal control and racial privilege, is reinforced over women's reproductive bodies through law implementation. Only people who are married, heterosexual and both Israeli partners with a Jewish descendent proof can opt for surrogacy in Israel. In Israel, couples have to go through psychological and genetic testing to prove that they are not 'unsuitable' so as to prevent the birth of 'unhealthy children' (Shalev 1998).

2.3 Commodification or Autonomy of Women and Children

Carrying a child for someone else is equivalent to reducing a human being to a 'material object', as a 'means to the gains', a 'baby oven' (Berkhout 2008). The concern is that such reproductive technologies violate the integrity of woman's body and her dignity in ways that are demeaning, also referred to as a form of 'violence against women' (Raymond 1993). The manifestations of objectification in the surrogacy arrangements include; instrumentality, denial of subjectivity, inertness and exchangeability (Berkhout 2008) and there is enough evidence of all these kinds of objectification of contract mothers in India (Saravanan 2013, SAMA 2012, Pande, 2010).

2.3.1 Commodification of Children in India:

The payment pattern in India is targeted towards the child and not for the reproductive services of the contract mother (Saravanan 2013). Some clinics pay the contract mothers according to the weight of the child born putting a pressure on the contract mothers to eat more. The medical practitioners fix an extra charge on the birth of every additional child (in case of twins), a small proportion of which is paid also to the contract mother as a bonus amount. Most babies born, especially of multiple pregnancies were preterm and grossly underweight and hence rushed immediately to the Neonatal Intensive Care Units. It is not known how many of these children survive.

There are instances of disabled children born through surrogacy left in orphanages or on the streets in India. My research also found some children who were left stranded in India without any identification (passport) as their intended parents had been involved in surrogacy illegally. These children were taken care of by strangers while their parents shuttled between two countries as they could visit India only on a tourist visa (Saravanan 2013).

Since several decades, feminists have cautioned about the exploitative aspects of surrogacy contracts, making use of the vulnerability of poor women to produce babies for the wealthy people which has raised further concerns about the racial and colonial dimension of such markets (Mahoney 1988, Rhode 1989). Many of those who are against prohibition too agree that surrogacy arrangements have an exploitative potential due to class, race and structural inequalities (Andrews, 1986; Purdy 1992). This is relevant not merely in India but also all over the world where women of lower socio-economic status are being used for surrogacy by the affluent. Those critiquing surrogacy see such contracts as exploitative especially when women enter into such contracts for money (Field 1988; Pateman 1988, Rothman 1989, Okin 1990). Economic motivations, a contract out of dire economic needs hence cannot be defined as free choice (Raymond 1993, Dworkin 1983, Rhode 1989, Field 1988, 1990; Pateman 1988; Rothman 1989; Okin 1990). The intentions of the intended parents are criticized as being opportunistic towards individualized benefits at the expense of the poor, creating a class of 'breeders' (Mahoney 1988). In India, surrogacy functions as a free-market system where there is a surplus of contract mothers willing to comply to the unjust contracts due to their desperate need for money as well as a long list of intended parents demanding this service. The surrogacy practice in India reinforces inequalities, causes exploitation, commodification of women and children and violation of basic human rights. These technologies provide a wider reproductive choice for affluent people at the cost of the health, freedom and life of others and gives control and power to several intermediate institutional agencies. Raymond (1993) is sceptical about what is being offered to women in the name of reproductive technologies and the ease in which 'right to chose' is becoming more and more a 'right to consume'.

2.4 Subjectivity and power relations

Some academics describe the power of 'agency' and 'subjectivity' of contract mothers in India and celebrate their power and decision making capacities in dealing with complex situations representing negotiations and strategizing at the micro level (Pande 2010, Deomampo 2013). Contract mothers are said to be involved in collective resistance within the surrogate homes regarding food, hygiene and relationships formed within the 'homes'. The same authors also note that such resistance is least likely to change the structural exploitation in the surrogacy process (Pande 2010, Deomampo 2013). The system treats contract mothers in India as nothing more than 'wombs for rent' having relevance to commodification, exploitation and violation of women's bodily integrity Deomampo (2013).

Deomampo (2013) observes 'agency' applied by women in India who convince their husbands to allow her to participate in surrogacy. However, neither the state nor the family consider her 'rational' enough to take her own decisions as she had to legally take the permission of her husband to participate in surrogacy. Surrogate agents (generally ex-contract mothers) looked for desperately poor women who are selling their body by involving in drug trials. Agents also combed the poor-income residential areas in search of women facing financial hardships or family problems and convince them to become contract mothers. One of the important information conveyed to contract mothers was the clarity about chastity in the surrogacy process. On being thus informed, women convinced their husbands. Women generally also try to convince at least one friend or a relative to go along with them into the surrogate homes for the first time as they are scared of the unknown (Saravanan 2013). Where men first received the information, they have convinced their wives and other women in the family into this practice. In my field research I didn't come across any women who had to convince their husbands for repeating the surrogacy process. Some men quit their jobs and coerced women into repeated attempts of surrogacy. Contract mothers who have had their uterus removed in complications during delivery is not unheard of in India. There are no studies that have been conducted as yet to know how much of this agency is exercised by contract mothers after their reproductive capacity becomes dysfunctional. This is not to say that contract mothers are timid, submissive or completely passive in the entire process or afterwards in familial relationship or with the medical institutions but too much focus

on subjectivity and micro-level autonomies that women exercise within the process of surrogacy mystify the larger picture of structural inequalities and injustice.

3. Reproductive Rights

The liberals support the idea of procreative liberty, individual rights and unlimited choices and are against prohibition of surrogacy as it denies the contract mother's right to enter into any contract that she may wish to enter. (Katz 1986, Andrews 1986, Shalev 1989, Shultz 1990, Robertson 1983 1986). From the perspective of the intended parents, Robertson (1983) defines procreative autonomy as *"the notion that individuals have a right to choose and live out the kind of life that they find meaningful and fulfilling"* (Robertson 1983: 230). Hence Robertson (1983) justifies the use of technology for any reason that would realize the couple's 'reproductive goals'. From a Philosophical perspective this notion would be termed as 'Utilitarian' or a 'realization-based' approach which emphasizes on the 'ends' and overlooks the 'means' to the end. The primary criticism of this reasoning is that *"utilitarianism would permit grave injustice in pursuit of general happiness"* (Saravanan 2015: 4).

Feminists have strived for women's freedom from their stereotypical motherhood role in the society to be able to participate in the public sphere to follow non-reproductive aspirations. The contract mother's ability to separate herself from the fetus is described as a liberating experience that increases her autonomy (Baker 1996, Teman 2009, Shalev 1989). But liberation from such stereotypical roles proved by participating in precisely the same roles (reproduction for others, paid or unpaid) for someone else and being involved in an activity that limit women's participation in any other non-reproductive aspirations is highly questionable.

The argument from an individual liberty perspective is that; the state should not have the right to interfere into a woman's will to participate in surrogacy. However, Dworkin (1983) notes that it is *"The state (that) has constructed the social, economic, and political situation in which the sale of some sexual or reproductive capacity (becomes) necessary for the survival of women. The state denies women a host of other possibilities, from education to jobs to equal rights before the law"* and hence there should be more focus on providing women with all these basic entitlements and human rights so that she doesn't have to sell her body in the first place (Dworkin 1983: 182). *"But it is the state intrusion into her selling of sex or a sex-class-specific capacity that provokes a defense of her will, her right,*

her individual self" (Dworkin 1983: 182). There is a surplus supply of women choosing to be 'contract mothers' in countries like India. Women were even willing to travel abroad (from India to Nepal) to evade the law after homosexual surrogacy was banned in India in 2013. This is because they do not have access to essential basic needs such as; food, energy, housing, drinking water, sanitation, health care, education, and social security to be able to achieve a decent standard of living. In this situation of bare subsistence, their choice is between poverty or surrogacy. A similar surplus of contract mothers is not observed in affluent countries allowing altruistic surrogacy. Protest needs to be directed towards enhancing the essential needs of people in transitional economies like India. Any activity that violates a person's dignity or integrity and involves economic exploitation would not be considered a constitutional 'right' (Raymond 1993). She observes that, viewing reproductive technologies and contracts mainly as woman's choice emerges from a Western ideology of individual freedom and value neutrality. An individualistic perception overlooks the impact of surrogacy on a society as a whole and the structural injustice, racial and colonial elements of this industry.

3.1 The Regulation Question

Raymond (1993) observes that legal prohibition can be a useful tool in controlling certain human rights violations. While McLachlan and Swales (2001) draw analogies to the failures in anti-prostitution laws to argue that prevention can be ineffective. However the prohibition of sex determination and sex selective abortions in India has proved to have had a positive impact over a period of time. Despite strong criticism from liberals for being radical, feminists in India have strongly opposed sex selective abortions as a form of 'femicide' and 'violence against women' (Patel 1989, George 2006, Sharma 2001). The Supreme Court of India imposed strict regulations on the use and sale of 'ultrasound machines' since 2001 and a fine and withdrawal of the medical license on medical practitioners if caught guilty with this offence. Twenty years of implementation of the Pre-natal Diagnostic Technology (PNDT) Act has revealed that the law has been affective in controlling further elimination of girls. It is only the most powerful doctors who are confident of evading the law who continue conducting sex determination. A recent analysis of the effect of the PNDT Act using a treatment-effect analysis framework concluded that the law implementation has had a significant impact in preventing any further worsening of the gender imbalance. A possible absence of the

law would have led to at least 106000 fewer girl children in India (Nandi and Deolalikar 2013).

4. Reproductive Justice

Reproductive rights and equality has been widely discussed from a feminist perspective rather than reproductive justice. Raymond (1993) has made reference to 'justice' in the last chapter of her book 'Women as Wombs' in explaining that women's individual bodily dignity and the integrity between individuals and groups in society should be important considerations in determining international human rights. Similar reference to bodily integrity and structural inequalities has also been made from a global gender justice perspective (Donchin 2010). Using a social justice approach, Callahan and Roberts (1996) oppose paid pregnancy contracts as it contributes to subordination of women, poor and people of color. Surrogacy has also been discussed from a 'global justice' perspective as practices that aim for a world that is held together by mutual fellowship of companion as well as self-interest with an overall goal of love of human dignity for all (Saravanan 2015). Bailey (2011) critiques liberal feminism for extending Western frameworks of liberty to Indian contract mothers and criticizes feminist biomedical ethnologists for weak moral absenteeism resulting in under-theorizing structural harms and injustices. The shortcoming of her work as she herself claims is that she has not included the perspectives of radical feminists. In the context of surrogacy practices in India she suggests that in order to theorize 'reproductive justice' the starting point should be to understand the deep injustices that emerge from the surrogacy-or-poverty dilemmas that compel women to take on surrogacy. A key principle of a reproductive justice model is to bring to center the vulnerable people; the poor, people of color people with disabilities and people with non-normative gender expression and sexualities (Luna and Luker 2013). However, it is important to note that reproductive exploitation can occur also within and between these vulnerable groups.

A feminist perspective includes commitments to human rationality along with individual autonomy and to understand the social context of personal choices. Thus questions of individual reproductive freedom needs to be raised in conjunction with human progress which is required for a just society (Ryan 1990). Feminism stands for individual reproductive rights that comes along with responsibilities towards a just and humane society. Procreative liberty achieved by violating women's bodily integrity and

overlooking mutual human fellowship hence cannot be considered as an individual 'right'. According to Janice Raymond (1993), rights needs to address power imbalance, justice, self-determination and international relations which should in turn be grounded in dignity of the individual and integrity of relations between individuals and groups in society.

However, Feminists have been caught up in debates of universalism versus relativism. The difference of opinion has been on the grounds of cultural/gender essentialism and cultural relativism that is based on postcolonial theories. Narayan (1998) has expressed concerns about the disadvantages of this line of thought. Giving due respect to cultural differences and social context, it is also important to understand that women's experiences from different parts of the world even though contextually diverse also meet at some point of their lives. It is important to identify this points of convergence. It is very important that more cross-cultural studies understand this so that feminism can work in solidarity with mutual respect towards certain principles that is universally acceptable regardless of which part of the globe these women may belong to. *"A transnational feminist practice depends on building feminist solidarities across the divisions of place, identity, class, work, belief, and so on. In these very fragmented times it is very difficult to build these alliances and also ever more important to do so"* (Mohanty 2003: 530) To do so would involve building a transnational feminist alliance by uncovering the naturalization of the patriarchal, racist and other such notions of global capitalism that deter women's progress (Mohanty 2003).

4.1 Humanitarian Thresholds of Reproductive Justice

A step towards this would be to examine where reproductive technologies cross the 'humanitarian' threshold of the feminist ideologies of equality, liberty and justice. Asian Communities for Reproductive Justice (ACRJ) has developed three frameworks on reproductive health, rights and justice. The Reproductive Justice framework includes recognizing the histories of reproductive oppression in all communities. This model is based on organizing women/girls to change structural power inequalities. It examines the control and exploitation of women's bodies, sexuality and reproduction as it has been used as an effective strategy for controlling women and communities, particularly those of color which is manifested through the multiple oppressions of race, class, gender, sexuality, ability, age and immigration status. *"Controlling a woman's body*

controls her life, her options and her potential" (ACRJ 2005: 2). This model is based on the human rights framework published by ACRJ along with the SisterSong Collective with an aim to bring 'reproductive justice' into the mainstream 'reproductive rights' and 'social justice' movements.

I add another dimension of identifying the 'humanitarian thresholds' to this existing framework using the fundamental feminist ideologies of liberty, equality and justice. The first question that needs to be addressed and is repeatedly being raised is whether procreation by any means should be considered a constitutional right to be provided by the State. Infertility is universally accepted as a serious problem leading to psychological issues. These include social stigma and the strong desire of parenthood, embedded in the stereotypical concepts of 'motherhood/parenthood' and 'patriarchy'. Radical Feminists have cautioned about the medicalization of infertility, the pervasive nature such technologies and its marketing techniques that exaggerate the success rates (Raymond 1993).

The aim in examining humanitarian thresholds is to identify the humane responsibilities that may be crossed in asserting reproductive rights. Individual reproductive rights come along with responsibilities towards a just and humane society. Those seeking surrogacy face issues such as social stigma, psychological problems, physical stress of infertility treatment and violation of bodily integrity. But by opting for surrogacy in order to resolve this, they are inclined to put another woman through the same set of problems; social stigma, psychological challenges, violation of her bodily integrity and even more, put the contract mother's health, freedom, liberty and even life at stake. The surrogacy market based on the demand and supply of free-of-cost or cheap and uncomplicated wombs hence cannot be a solution to 'infertility' or to the 'profound socio-economic inequalities'. 'Reproductive justice' aims to reduce inequalities and not to use someone's vulnerability as a solution for infertility. These technologies provide a wider reproductive choice for affluent people at the cost of the health, freedom and life of some others. Hence the surrogacy arrangement clearly crosses the 'humanitarian' threshold of the very ideologies that feminism and reproductive justice itself stands for.

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