Contract Pregnancy and Contract Mothers: Partners in Development or Gendered Development?

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'Each of us holds in her lap a phantom, a ghost baby. What confronts us, now the excitement's over, is our own failure. Mother, I think. Wherever you may be can you hear me? You wanted a women's culture. Well, now there is one. It isn't what you meant, but it exists. Be thankful for small mercies.'

(The Handmaid's Tale, Margaret Atwood, 1986)

"The Baby M case could be the forerunner of the use of poor third-world women's wombs to produce children for economically advantaged European-American couples."

(Sandra Harding, 1991: 203)

Prelude

The concept of women's development has now become an integral part of the development discourses and policy initiatives. This development has been informed by a remarkable pathway though gradual shift in the perception about women, from the stature of victims and passive objects to that of independent agents. Women's empowerment has been a key concept and major goal in development discourse since the 1990s. There is a particularly strong narrative linking women's empowerment with women's Capacity building. There has been a gradual shift in orientation of policy approaches towards women from 'welfare', to equity' to anti-poverty' to 'efficiency' and finally to 'empowerment'. The policy reorientation reflects the changes in the basic economic approaches of the time, from modernization policies of accelerated growth, to basic needs strategies of growth with redistribution, to the recent so-called 'compensatory measures' for the neo-liberal ill fare. The process of "development in the developing countries has, by and large, marginalised women and deprived them of the control over resources and authority within the household, without lightening the heavy burden of their 'traditional duties'"

(Haleh Afshar 1991: 15). This view becomes very obvious when we recall Ester Boserup's well-known 1970 study (Women's Role in Economic Development) in the context of Africa, which states that "by their discriminatory policy in education and training the Europeans created a productivity gap between male and female farmers, and subsequently this gap seemed to justify their prejudice against female farmers." (Boserup 1970 [2008: 45]); men were taught to apply modern methods in the cultivation of cash crops, while women continued to use the traditional methods in the cultivation of food crops for family use (ibid: 43-44). In fact, "male hegemony corrupts development initiatives, which are designed to make a positive difference in women's lives and, by extension, the lives of their families and their men" (Rowan-Campbell 1999:12). The welfare approach in developing countries itself has often been a process of 'tokenism' or 'handout', taking utmost care not to meddle with societal norms and customs that have seldom been flexible towards women.

With pioneering developments in biotechnologies and digitization an assurance began to loom large that the so-called umbilical connection between technology and economic advantage has been finally disengaged. But interestingly though not surprisingly, recent innovations in modern medical technology along with business firms have even "created a market for babies" (Spar 2006: xi) and hence commodification of 10pregnancy and birth especially in the form of recruitment of egg donors and surrogate mothers has become a regularized feature of this globality[1]. In a nutshell, "global capitalism is also about deepening commodification of the life world, as the logic of profit-making respects no boundaries but subsumes all within it. Marketization penetrates the most intimate spheres of social life" (Peterson 2003: 78). With digitization, the so-called baby trade in multiple forms is now fully aided by internet which is now an inviting medium, in the form of a marketplace where babies has been added to the shopping cart (sometimes customized) by the intending parents as customers through the convivial ambiance of globalization and ICTs. The idea of (ordered) impregnation of the woman is a part of an oppressive future in which conceiving your buyer's child – as

well as separation from your own - was punishment for seeking freedom. The ownership of woman's body, ownership of the unborn child, issues of the medicalization of woman's body, and female body's generative capacity has been a new 'arena of investment' in the convivial ambiance of globalization and ICTs and also an integral component of social insecurity, uncertainty, pernicious risk and inequality in this neoliberal phase of development for those women.

> Women's reproductive biology has become the focus of extensive biomedical research interest and global commercial innovation. This constitutes another form of neo liberalized life, this time situated at the level of biological processes, and part of a much larger digitized marketization of biological vitality (Waldby and Mitchell 2006: 5f.; Cooper 2007).

Effectively, it can be argued, that the processes of reproduction have been deregulated, privatized and made available for investment and speculative development of digital capitalism. As women in the North have moved in greater numbers into the labour market, the kinds of feminized, domestic work which the welfare state subsidized has been opened up to an increasingly transnational market in female reproductive labour (affective, sexual and domestic), one that is defined along complex lines of racial, ethnic and class difference. Mies (1988) wrote that the transition from "helping the individual infertile woman or man" to a fully fledged "reproduction industry" has been established and the production of children has now become a new "growth industry" (Mies 1988: 3f.). Thus, contract pregnancy or surrogacy turns women's labour into a commodity and the Internet is the major forum about every aspect of surrogacy, including a growing number of threads (i.e., online discussions on a message board) on the pros and cons of various intermediaries (agencies, lawyers, clinics). As brokers increasingly compete for clients, the Internet enabled new forms of connections and support for people interested in surrogacy (Berend 2016: 3f.). This is how production and reproduction, got so interwoven that it is no longer possible to speak just about precarious labour, but rather precarious life for surrogate women in a country like India. Feminist theorists have shown that "contemporary permutations of reproductive, biomedical and

clinical labour lies at the heart of the neo-liberal restructuring of capital" (Waldby and Mitchell 2006: 10). In fact, the sexual division of labour is also inseparable from issues of race, imperialism and unequal exchange, including the power relations that exist between women of different locations, intersectionally speaking.

Interestingly though not unexpectedly, no assortment of development discourse have ever discussed contract pregnancy or contractual mothers as issues surrounding reproduction never mattered even in the sustainable development frameworks except fertility and mortality rates. In the United Nations Commission on Sustainable Development framework, reproduction is perceived as a closed category, so mothers are one type, those who give birth. But those who rent their wombs and enter into contracts are never considered mothers or concern for their reproductive health is still beyond the purview of understanding and conceptualization, although it has been a billion dollar industry especially in India. According to a Report Indian Express in 2014, among the registrations from 149 countries on http://www.surrogatefinder.com, a website offering free registration to egg and sperm donors, surrogate mothers and intended parents, the highest for egg and sperm donors - 5,293 - was from India. The second placed US was way behind, at 1,509. Of the registrations from India, 1,113 are from Maharashtra, 587 from Delhi and 433 from Andhra Pradesh and Karnataka each. The Report further stated that in cities like Delhi and Mumbai or Gujarat where surrogacy was a thriving business, college students, professionals mothers in need of money are walking in to donate eggs. A premium was placed on women who are mothers as "fertility" was guaranteed. Donors are categorised based on looks, height, educational qualification and, most importantly, fair skin. What are called 'diva donors', especially foreign, can earn up to Rs 6 lakh per donation. According to Gaurav Wankhede, director of Becoming Parents, an international company dealing in surrogacy, sperm and egg donation, says: "There may be 50-80 IVF clinics in Mumbai. Every clinic would need at least one donor every week. Every second couple (in need of IVF) requires a donor." A Vadodara-based doctor talks of a jump of 80 per cent in couples seeking infertility treatment

(http://indianexpress.com/article/india/india-others/the-great-Indian-egg-bazaar/Feb 9, 2014).

The classic testimony has been provided by Anand (Gujarat, India) which cemented its place as the world's surrogacy hub, thanks primarily to Akanksha Infertility Clinic, which averaged about two surrogate deliveries a week and has been a cornerstone of India's Rs 1,300-crore-plus surrogacy industry. In fact, from lawyers who drew up contracts to hotels that house foreigners chasing the parenthood dream, Anand had an entire economy built around surrogacy. Uday Londhe, a travel agent in Anand who handled the travel of more than 100 foreigners to and from Anand specifically for surrogacy every year, said the chain started at the airport. After hiring cabs to get from the airport to Anand, there is accommodation and food. While waiting for treatment, the couples explored the state and boost tourism. During their stay, they required everything from mineral water to barbers. This created a peripheral industry, he said. Needless to say, locals speaking English found employment at ease. Ergo, what Gene Corea predicted in her 'The Mother Machine' that a world where wombs of "non-valuable" women are used as "breeders" for the embryos of "valuable" women (1985, 276) seemed particularly fitting. These also are difficult to discount when one looks at the fact that India's rent a womb enterprise has become a two billion dollar industry (Bhatia, 2012). This huge industry of transnational surrogacy has been realizable by real life national boundaries of a globalized world along with a partner in Information and Communication Technologies (ICTs). The intended infertile couple, mediated through agencies and fertility clinics, engaged in transnational reproductive commerce, meet its service provider the Indian surrogate women. This has successfully generated with the shifting reality of a globalized often online marketplace where babies have been added to the shopping cart. Consequentially, it reinforces neo-colonial power hierarchies where the globalized North, the developed world maintains its hegemony over South, the so-called developing world.

Some analysts think that the intended mothers' expressions, sentiments and language use etc make them as a 'nation' that apparently

exhibits many of the features of the nineteenth century European colonizers. In a sense, this "cybernetic nation" naturalizes the relationships between intended mothers (IM) residing in Europe, US, Australia etc. and the foetus residing in the wombs of surrogates in India (Dasgupta & Dasgupta, 2013: 70). That is to say, the unequal exchange is reborn and this time, categorically in reproduction! But, this booming commercial surrogacy industry was hit by the ban of foreign nationals from using surrogate mothers in the country in 2016.

India has long been a place for experimentation and implementation of old and new reproductive technologies which are at best problematic and at worst hazardous. In 1980s poor Indian women were targeted for promotion of Norplant, the infamous hormonal contraceptive. If health is defined 'as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' except for a rhetorical concern for reproductive health, then women's health and well-being in India has certainly been a backbencher and a neglected issue. If India has an international destination (until the new Act of December 2018) for infertile couples seeking low-priced IVF and surrogacy services, then India also has one of the highest maternal mortality and pregnancy-related morbidity rates in the world. The Centre 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). From a global perspective, India accounted for 19 percent of all live births and 27 percent of all maternal deaths (Saha & Saha, 2010: 2). The high incidence of maternal death in India continues to threaten the well-being of families, decimate economic productivity, and perpetuate health disparities. The dismal picture of majority women's health makes it abundantly clear that those majority women themselves along with larger section of society do neither have any perception nor any initiative to cater to almost half of their citizens' health and well-being. Although life expectancy is same during the time of birth of both men and women, deeply entrenched patriarchal norms and values of India manifests itself in both the public and private spheres of women's lives in the country, determining the 'life chances' of women resulting in their qualitatively inferior status in every sphere and

indubitably in health. This inferior health status starting with the conception where girls who are regularly killed in the womb continuing with malnutrition, discriminatory family biases of preferential distribution of food and other circumstances culminating in marriages and pregnancies with high mortality rates, particularly during childhood and in their reproductive years. Since health is socially determined and to a considerable extent access to healthcare, is almost fully so. This being so, the 'lived experiences' of women in India are replete with potential risk factors that have implications for their lives and well-being. On top, this new international division of labour inculcated the redistribution of reproductive work that has divided potential gendered allies by conscripting migrant and subaltern classes of women in the service of metropolitan, citizen, and bourgeois women.

This paper, thus, interrogates the globalization of reproductive inequalities and women's right to self-determination over their own bodies by using these technologies focusing on their other distinct social identities by applying intersectionality especially focusing on women of India. Here an attempt is made to demonstrate that what appears to be freedom of ''choice'' for white and rich women seems to translate into further commodification of the body of economically disadvantaged women. The paper addresses the question of what it means to practice intersectionality sociologically as a theoretical and methodological approach to 'unequal exchange in reproduction' with special reference to the thriving 'supermarket of reproductive alternatives' especially in the zenith of Globalization. The possibilities of selling body parts like eggs, or renting organs like wombs, defined new types of social relations, created by the technologies of assisted reproduction. Artificial insemination, In vitro fertilization and ovum transfer, though in actuality only marginally successful, along with surrogacy are widely practiced. Thus, the female body's generative capacity was discovered as a new 'arena of investment' and profit making for scientists, medical engineers and entrepreneurs in the convivial ambiance of globalization and ICTs. This study brings to the fore the issues like did these technologies divide between women in terms of race, social class and developed/developing nations? Did

there exist now another variety of 'division of labour and concomitant inequality' also in reproduction- between poor women who 'sell eggs or rent their uteruses' and affluent women who pay for them through the conduit of gigantic biomedical engineering and pharmaceutical companies, genetic and drug industries and research institutes and hospitals? In particular, did women's use of technologies for assisted conception, and the local and global transactions is a classic testimony of erosion of boundaries even between reproductive body parts in the era of globalization? Does this assisted reproductive arena create new telling burdens on marginalized women's existence further? Have these repositioned women in a new system of inequality more subversive and invisible than ever before? However, what had once been a popular destination for international intended parents no longer became an option in 2016, at which time the Indian government introduced a Bill making contract pregnancy illegal for commercial purposes. Today, Indian surrogacy laws make it illegal for foreign intended parents to complete a surrogacy in India. The only people who can complete a commercial surrogacy in India today are Indian intended parents who have been married for at least five years. In December 2018, after almost two years of debate, an Indian surrogacy law was passed. This paper portrays the situation of the very recent past reality regarding the contract pregnancy and contract mothers. What would reality be as a result of the new legislation can only be analysed after substantial time has passed.

Section II

New and Assisted Reproductive Technologies and Intersectionality

Global fertility industry or transnational surrogacy, whatever the taxonomy may be, is a prime example where intersectional paradigm is the most pertinent one. So, to begin with what does an intersectional approach entail? It is posited on the study of a matrix of power relations. It involves the simultaneous analyses of multiple, intersecting sources of subordination/oppression and is based on the premise that the impact of a particular source of subordination may vary, depending on its combination with other potential sources of

subordination (or of relative privilege) (Denis, 2008: 677) It can be used in both quantitative and qualitative work (McCall "Complexity"), which examines the micro level of lived experiences (Smith, 1987; Shields, 2008), the meso level of organizations (Acker, 2006) or social structures (Risman, 2004), and the macro level (McCall's Complex Inequality), including internationally. What kinds of intersectionalities help to understand women's lives e.g. in terms of reproductive rights of women including the complexities of context notably economic location, place and time? While gender, class and race have become a widely accepted (though sometimes critiqued) triad of socially relevant locations for study (whose meaning is influenced by their very interconnection), they are not the only ones. Also of interests are ethnicity, religion/religious practice, nationality/citizenship, marital status, country of residence generation, class (whether class of origin or current class) languages, age, heterosexuality and able-bodiedness. Intersectionality addresses the most central theoretical and normative concern within feminist scholarship: namely, the acknowledgement of differences among women. The very fact that differences among women has become the leading subject of feminist theories in recent years. For Maria Mies, an increasing convergence of the sexual and international division of labour, a division where the women of the former colonies are mostly producers and women of the developed world mainly consumers is clearly manifest especially in transnational surrogacy and in case of migrant paid domestic workers (Mies, 1986: 114-16; Hochschild, 2000). By addressing the issue of differences among women intersectionality makes perceptible the multiple positioning that constitutes everyday life and the power relations that are central to it. Thus, intersectionality not only promises to address the 'fundamental and pervasive concern' of difference and diversity, but it does so in such a way that it is able to problematize the theoretical hegemony of gender and also provides a platform for feminist theory as a shared enterprise. In the context of this paper, to approach a policy problem (related to reproductive rights, for example) with an intersectional design (in order to ask questions about differences in constructions and experiences of reproductive freedoms according to class, race, national boundaries, sexual orientation and diverse ability) is to declare that reproductive freedom and rights ought to be examined

for their differential, contradictory and contested entitlements and burdens.

An extra-legal market seems to be operating alongside the legal one globally, and women who produce eggs or rent their uteruses may become victims of criminal networks that work at the trans-national level. Poor and uneducated women were paid $250 for every ''donation'' by a company name Global Arts in United Kingdom. In 2004, European Parliament banned commercialization of organs. Moreover, the legislative divide between countries in the world gave birth to forms of ''reproductive tourism'' from the less permissive countries to the more accommodating ones. In some countries sex selection, as well as the selection of other characteristics, are not permitted – but affluent couples fly overseas where they can shop for these services. If some have argued that NRTs have brought 'new freedoms' in the form of opportunities for some women – for instance, to prevent unwanted pregnancy and births through contraception and abortion; to some extent, the prevention of birth of undesired children through prenatal diagnosis technologies; and the possibility of motherhood for infertile women/couples and single and lesbian women through artificial insemination or IVF etc. Concomitantly, they have also brought 'new dependencies', on technologies and at a heavy price, not only financially, but also in terms of adverse effects on women's physical and mental health. While for some women use of these technologies has meant a shift from being 'objects' and 'victims' to 'knowing subjects' and 'agents' of control over their own bodies, for others they have brought more outside control and expropriation.

Considering the divisions between women who profit from NRTs and those who are exploited by them, medicalization of women's bodies and the adverse effects of these technologies are unquestionably attested. Since not all women have the same interests regarding NRTs, coming from different socio-economic and cultural circumstances, the increasingly global hegemony of enterprise culture, the rise of fundamentalism, increasing disparities characterizing various forms of domestic and international inequalities, a woman's right to choose can be seen to be in crisis. This crisis is perhaps nowhere sharper

than in relation to the transactions in reproductive body parts and reproductive services made possible through the globalization of NRTs on the one hand and information and communication technologies (including the Internet) on the other. Previous feminist analyses have shown that under patriarchy woman has always been an object, but in the new reproductive technologies she is no longer one whole object but a series of objects which can be isolated, examined, recombined, sold, hired or simply thrown away, like ova which are not used for experimentation or fertilization. Combined with the scientific method of analysis and synthesis has made the woman less than a human person and her vivisection into a mass of reproductive matter. At bottom, As Mies reminds us so aptly that "What is left is an assembly of parts. The bourgeois individual has eliminated itself (1988: 11). Thus, ARTs and contract pregnancies are the additions to the long list of services that are offered in medical tourism and fertility industry portrays this as a win-win situation for the intended parents as well as the contractual mothers, with the clinics and the providers being the nucleus of the arrangement.

Section: III

Contract Pregnancy in the 'Supermarket of Reproductive Alternatives'

Briefly, Globalization is marked in particular by transnational capital and trade liberalization. Neoliberal economic policies facilitate the globalization of technologies (through the import of high-tech equipment) and ideas (through the global electronic media, including satellite television), also made possible by faster modes of transport of goods, persons (through aviation) and knowledge (through the Internet). The global development of capitalism is nothing new, but what characterizes its most recent phase is the 'cultural convergence' of cultures and lifestyles around the world in the societies it impacts. Although, the market is the primary motor of globalization, its implications are not limited to the commercial arena alone. In the field of biological reproduction, globalization – understood as the rapid growth of global capitalism has brought in its wake an extension of

consumer culture creating 'new regimes of consumption'. Not only have women's whole bodies been thrown onto the world market for trafficking, the human body and its parts (organs, tissues, cells) have been turned into commodities that are exchanged and traded. Initially confined to solid organs such as kidneys, livers and hearts, and with the development and expanded use of IVF technology, the last decade of the 20th century saw this extended to reproductive body parts, such as sperm, ova and embryos, which have become discrete entities – commodities that can be donated or traded. These can be done by individuals themselves as well as infertility specialists, IVF brokers, etc., for profit. There is an unregulated trade in body parts and fertility tourism within and across countries; in particular, increasing access to the Internet has contributed immensely to the trade's further proliferation. Several centers all over the world, mainly in the US and Europe, but also in India, have profited from the 'fertility business', including the commercial transactions in reproductive body parts. Globalization involves an interaction between economic and cultural factors whereby changes in production and consumption factors can be seen as producing new shared identities. High-tech reproductive technologies are available in many developing countries, too. Since globalization and new technologies make possible a beyond border, an experience of stateless citizenship the very personal matter of giving birth to babies or pregnancy and the sanctification of biological motherhood has been trampled by transnational contract pregnancy to an enormous extent. The birth of babies, through contract pregnancy arrangements has graduated to "a public issue from a personal trouble" with all fanfare. The difference with this outsourcing is that it is emotionally mediated as childbirth and having children is a highly emotional aspect of human lives and thus in the era of this super-capitalism the personal is not only public, it is a global issue. The difference is elsewhere. Here a customized baby is ordered by the affluent intended parents like commodities in the global supermarket of reproductive alternatives but in case of natural birth there hardly exists even a remote possibility of this variety.

The purpose here is not be condemnatory about the intended parents or intended mothers but "purpose is to explain how such a

consumer-driven commodity chain comes to exist, being shaped, while simultaneously shaping individual's experiences of infertility, feeling of loss and potential for recovery" (Rudrappa, 2013: 129). Karla Momberger a graduate student at Columbia law school, relates her story: 'I began my feminist/activist career trying to escape the confines of my body, and that now I take refuge in the solid reality of me-ness that my body brings. . . . I donated ova to pay for law school. That's what I did. I am the mythical $50,000 woman. My finishing law school and becoming a lawyer depended, quite literally, on my body and how much it is worth' (2000: 1-2, 32). Also, specialized agencies mediate between infertile women and potential 'egg donors' (primarily college girls recruited through ads on college notice boards and the Internet) to choose from, with photos and complete profiles regarding IQ and other characteristics. However, attempts to set up commercial transnational contract pregnancy bureaus have been largely unsuccessful in most Western European countries and UK, due to restrictive legislation, where also the sale of human gametes is banned by law. Since July 2003, Baby Donors, an Amsterdam-based company, claiming to be the first in Europe, has been advertising its services on its website, operationalized in September 2003. It offers to act as an intermediary for the sale of tailor-made, personalized sperm insemination and egg donor packages through the Internet. It seeks entrepreneurs from around the world for franchising or joint venture partners at a license fee of €5000. The global manifestations of ARTs are varied. Consumers of ARTs as reproductive aid range from infertile couples to couples who want children with special characteristics to same sex couples and women beyond their reproductive ages. Though the playing ground of ARTs remains uneven it is the developed capitalist countries who remain the consummate consumer, and the global South continues to be the source of raw materials and suppliers of service. Interestingly enough, India, where most of the medical facilities for majority ordinary Indians wallow in utter miserable conditions, the presence of skilled intermediaries and cutting edge technologies, cheaply accessible ample wombs for assisted reproduction has made India world's capital of transnational gestational and/or traditional surrogacy.

Section IV

Transnational Contract Pregnancy and Contract Mothers-Workers of India: Through the Lens of Intersectionality

> *All kinds of U.S. jobs are being outsourced to India, from telemarketing to computer programming. Now you can add one more service to that list: child-bearing. Yes you heard right. Some childless couples in Europe and U.S. are hiring Indian women as surrogate mothers* (World Vision Report, 2009).

> *Women of the South ... are increasingly reduced to numbers, targets, wombs, tubes and other reproductive parts by the population controllers* (Mies and Shiva, 1993).

A Surrogate Mother Contract was an agreement between the intended parent(s) and a surrogate mother and her partner/spouse, if any. These contracts can be compensated or uncompensated and are intended to detail the parties' rights, obligations, intentions and expectations in connection with their arrangement. The contract addresses subjects such as parental rights, custody issues, location of delivery, future contact between the parties, and insurance (both health and life). In addition, the contract covers issues such as control over medical decisions during the pregnancy, payment of medical bills, liability for medical complications, availability of medical history and personal medical information on the gestational carrier, and intended parents' presence during doctor's visits and at the delivery. Financial considerations such as the surrogate mother's compensation and expenses, including lost wages, legal fees, child care and maternity clothes are also addressed in the contract. The surrogacy contract is one of the most important pieces of every surrogacy process. The contract guides the entire surrogacy journey, clearly outlining each party's rights, roles and responsibilities before, during and after the pregnancy (https://surrogate.com/intended-parents/surrogacy-laws-and-legal-information/understanding-surrogacy-contracts/ visited November 14, 2016. However, essentially in case of contracts in English it meant little to the barely literate majority surrogates. Either it was their husband or family members and most of the time third party medium took care of it. In actual reality, as mentioned "the surrogacy

contracts, ideally created to protect the rights of all parties, are undoubtedly skewed towards protecting the interests and rights of the intended parents, rather than the surrogate" (Nayak 2013: 16). Seema (name changed), a contract pregnant worker /surrogate told that only thing she knew about this contract she will not have to sleep with anyone, and that the seed will be transferred into her with an injection. She had to keep the child inside her, rest for the whole time, have medicines on time, and give up the child (Pande, 2010: 977). The translated contract was a critical part of the disciplinary process. It restated the transitory role and disposability of the women, not just as workers but also as mothers. Works on globalization and women's work has analyzed how women workers of the global South are made to feel disposable and has noted that this is an integral part of the workings of global capitalism (Chang 2000; Ehrenreich and Hochschild 2003; Wright 2006).

The larger context in which this variety of Pregnancy is practiced is fundamentally propelled by commerce within the globalized economy. It has also become an essential component of the flourishing larger fertility industry. This is hardly a revelation that commercial surrogacy has assumed transnational industrial proportion and India emerged as the global destination for not only ART practices like in-vitro fertilization (IVF), but also for traditional and gestational surrogacy arrangements. In fact, India is well-positioned to lead the world in making especially commercial gestational surrogacy a viable industry: labour is cheap, doctors are well-qualified, no problem of English being spoken as all the intermediaries know or are well-versed in English, adoptions are closed, and the government has worked hard to establish an infrastructure for medical tourism. Under Indian Council of Medical Research (ICMR) 2005 guidelines, there was no legal bar for the use of Assisted Reproductive Technology (ART) by a single or an unmarried woman, and the child born would have legal rights on the woman or man concerned. Thereafter, partly due to pressure from campaigns because of absence of law on contract pregnancy /surrogacy, the draft ART Bills of 2008, 2010 and 2013, stated to be revised based on the recommendations of the Ministry of Law and Justice, which have consistently proposed that ART in

India would be available to all persons including single persons and foreign couples. The Ministry of Home Affairs (MHA), according to the guidelines of July 9, 2012, restricted surrogacy to foreign nationals; i.e. a man and a woman married for at least two years would be required to take a medical visa for surrogacy in India. Even though surrogacy is an administrative concern, it was decided and declared that till the enactment of a law on the ART Bill, 2013, the guidelines issued by the MHA will prevail. (http://www.thehindu.com/opinion/op-ed/ending-discrimination-in-surrogacy-laws/article5970609.ece, visited on July 4, 2014). Further, women in India cannot act as contractual mothers /surrogates for more than three successful births, including that of their own children, is one of the landmark provision part of the proposed draft Assisted Reproductive Technologies (ART) Bill, which the government plans to bring to the Cabinet before introducing in Parliament for passage (PTI news reported in The Hindu August 5, 2013). This in a sense is 180 degree turn around for the anti-natal Indian state to turn pro-natal in case of ARTs and NRTs. But in all these there is one clear convergence that it was the Indian woman who has been the target of both anti-natal population control campaigns and pro-natal pro-technology programs. Further interesting is that how the use of ARTs like surrogacy is congruent with the anti-natal dialogue and hard-line population control programmes in India? Some have termed it "revised eugenic scripts".

The negative eugenics has aimed the lower income groups and minorities with voluntary or coerced sterilization whereas the rhetoric of so-called "individual choices" tactically highlight ARTs as options for upper class and of course, white couples desperate to have the reproduction of a baby under their privatized surveillance. Not unexpectedly, these current forms of eugenics are matching to and probably product of neoliberal ideologies and policies (Pande, 2014: 27-32). Hartmann accurately explains the association between concepts of "waste and "burden" with negative eugenics and the concept of "consumer choice" as central to positive eugenics and the endorsement of ARTs and NRTs (2006). This revised eugenics scripts used to be writ large in the policies of government of India.

It is ironic that the Government expenditure is decreasing on public health facilities and state -run hospitals where poor women access are mostly in dismal conditions barring a few and also rather confounding that the country which has the highest absolute number of maternal deaths and 51 doctors for every 100,000 people, there many Indian scientists and doctors are investing in NRTs and ARTs. That is to say, the history of reproductive politics in India is not only a saga of state's surveillance to serve state's interest and control of women's fertile bodies it is also a tale of history of contradictions (Pande, 2014: 35).

India's contractual pregnancy explosion began when in 2004 Radha Patel gestated and delivered twins for her UK based daughter at Dr Nayna Patel's Akanksha Ferility Clinic in Anand, Gujarat (Ruparelia, 2007). This small town established its reputation as the contract pregnancy outsourcing centre of the world. Due to the nonexistence of any national registry no authentic and reliable information can be given on the number of such clinics in India but information from ICMR and National Commission for Women (NCW) provided an approximate number of 3000 clinics that were in operation (Smerdon, 2008; Sama, 2009a). Contract mothers are recruited through different procedures. For example, Dr Rama Devi's hospital in Mumbai sent infertile couples pictures of their contract mothers/ surrogates and accept special request for "Muslim eggs" and "Hindu surrogates" and recruits surrogacy workers from among her employees' families and acquaintances (Schulz: 2008). Multinational corporate hospital like Planet hospital and corporate five-star hospital like Rotunda medical Center in Mumbai recruited contract mothers/surrogates through newspaper advertisement and were less personal compared to Dr Patel's Akanksha Ferility Clinic. The Rotunda offered a DHL-Cryo-Ship program for couples to send frozen gametes and embryos to India for implantation. They were supposed to start a Skype Surrogate Connect video-Conference programme so the parents will have a clear notion of how well the pregnancy is going and how well the surrogate is looked after (Medical Tourism Corporation 2009). Furthermore, there was no fixed fee for surrogacy in India, but the costs were significantly less.

The entire surrogacy process in the U.S. costs between $40,000 and $150,000. Surrogate workers/contractual mothers received 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 contractual mothers was high, but applicant pools are deep. Some 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 contract mother/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 contract mothers /surrogate workers received about $3000 for a successful delivery, but the going rate in Delhi was $10,600 (Wade, 2009). Every major city in India such as Mumbai, Delhi, Chennai, Bengaluru, Kolkata now are partners in surrogacy trade and proffer gestational surrogacy to those who can afford to pay the price (Wade, 2009).

The International press usually reinforces connections between poverty and contract mothers'/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 earned as surrogate 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). Contract pregnancy/ 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 Contract mothers/surrogates to pay for family medical expenses. Anita, a bank worker, became a contract mother/surrogate for a Korean-American couple, because her son has a heart condition and needed an expensive operation (Subramanian: 2007). The last global recession also has had an impact on the fertility industry. Dr Patel has noticed an increase in middle-class women turning to contract pregnancy/ Surrogacy work as their husbands lost jobs (Chandran, 2009). This is how the global press presents surrogate workers' stories. The rhetorical focus here is on opportunity, choice and fair exchange, not unequal exchange, commodification of women's body, body parts or impact on health and risks or the contractual nature of work which foster conditions of vulnerability, instability, marginality and temporariness. Rudy Rupak, President of Planet Hospital, said the clients' 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). Colour and caste also play a central role in a contractual mothers-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 colour. 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 stable ….The skin colour should not be too dark, and the appearance should be "pleasant" (Schultz 2008: 3).

In Sama's analysis of thirty-three contract pregnancy/ surrogacy related advertisements about forty percent specified that intended parents were looking for surrogates that were "fair, good-looking, and beautiful" (2006: 74). But it must be kept in mind that these criteria are for gestational and not traditional contract pregnancy /surrogates. The surrogate is not genetically related to the foetus. So, worries about skin colour 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. This is distinctly a characteristic mark of neo-racial and neo-colonial attitudes where patriarchy and super capitalism, i.e. Globalization intersect and hence a new typology of a mother-worker combination are created by adding babies to the shopping cart and making reproduction a commodity.

In the Website of Medical Tourism Corporation of India it was clearly stated: What are the screening criteria for surrogate? How is a surrogate chosen in India? Medical Tourism's network of hospitals in India has very meticulous and stringent criteria for choosing a surrogate. The surrogates are between 21-35 years of age. They are married with previous normal deliveries and healthy babies.

Detailed medical history, surgical history, personal history, and family history is looked into. History of blood transfusion and addiction is also taken. It is made sure that the surrogate has an uneventful obstetric history (no repeated miscarriages, no ante-natal, intra-natal and post-natal complications during previous pregnancies). The surrogate and her partner are screened for infectious diseases like sexually transmitted diseases, Hepatitis B, Hepatitis C, HIV, VDRL. Thalassemia screening is also done. Detailed pelvic sonography is done and other tests for uterine receptivity are performed to ensure maximum chances of success. A detailed financial and legal agreement is then drawn up between the surrogate and the commissioning couple." (http://www.medicaltourismco.com/low-cost-surrogacy-in - visited on December 23, 2014)

Choice is a real complicated and probably most contentious word in case of contract pregnancy/commercial surrogacy. Amrita Pande tell us that "Ironically, while supporters of surrogacy emphasize the element of choice (i.e., that is the woman has the right to choose what to do with her body) most of the surrogates' narratives indirectly downplay choice as part of their decision, as if to say", 'it was not only in my hands, so I cannot be held responsible, and should not be stigmatized' (Pande, 2014: 134). One of Pande's contract mother surrogate said that she knows that surrogacy is unethical but it is absolutely necessary for survival or to fill the empty stomach. It is obvious that as surrogates become conduits to give birth to children, their autonomy, choice, freedom are all redefined and reconstructed within the framework of negotiation, discipline, control and surveillance; thus ultimately making their bodies 'docile bodies'. In other words, a contract mothers/ surrogates are not at all free to interpret her pregnancy or her life during this period. It is well-nigh impossible for the surrogates to defy the decisions of the intended parents reiterate their subordinate status and lack of power to take decisions freely. With or without the written contract the surrogate is almost totally subservient to the clinic and the intended parents. This is indisputably clear when the staying arrangements of the surrogates are taken into consideration.

Portrayals about contractual mothers /surrogate workers staying arrangements during their pregnancy are clearly indicative of

the fact that they are perceived as temporary workers. I will present some research findings here: 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 programme, 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 to 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). Madge's work on a private medical clinic in Gujarat tells us that

> The surrogates were placed in a surrogate hostel during the nine months of pregnancy. The hostel at the clinic was a two-story bungalow, which, originally, was the house of Dr Nita. There were eight rooms with iron beds and the belongings of the women were scattered around. The only source of entertainment for the women was television, one on each floor. Initially these surrogates found the idea of being

away from family fascinating and a break from their daily routine. They chatted and laughed with each other. But slowly their 'controlled' life in the hostel due to their 'delicate pregnancies' ('soft', 'delicate', and 'fragile' were terms often used by the clinic staff and some surrogates also) rankled and took a toll on them. The women were not allowed to step out of the house and their only trips for nine months were to the clinic and back. Though family members could visit on Sundays, the women missed their homes and children. I witnessed some of the women weeping uncontrollably for their families (Madge, 2013: 16).

Surrogacy/Contract pregnant mother workers' hostels, therefore, are contested spaces and the power hierarchy of the medical establishment, and intended parents pose restriction for surrogates' real autonomy. For example, one surrogate received a mobile phone from intended parents and had to deal with the inquiries about her health thus turning the advantage of having a mobile phone into a means of surveillance. The surrogate said:

Madam calls me every day, and asks about my health telling me What to eat and not. Like yesterday, she told me to eat lots of green vegetables, as it would be good for my health. Anyways, I follow what the doctor asks me to do (Sama interview, surrogate Rita).

At Contract pregnant mother workers'/surrogacy hostel at Garv, Tina, a surrogate describes the daily routine in the following way:

Everything works like clockwork. We wake up at 8 am, have tea take our medicines and injections and go back to sleep. Then wake up at noon, bathe and eat lunch. We basically rest. That's what is required for us. We are allowed visitors but not for the night. In evening we pray. Then the English tutor comes and teaches us how to speak in English. We will be learning how to use a computer next (Quoted in Pande, 2014: 64).

The obedience to the clinic and to the intended parents is a clear case of power inequity in the contract pregnancy/surrogacy arrangement and life in surrogacy hostel can be added to the catalogue of "total Institutions" which Erving Goffman did not have the fortune to experience. In a real sense, the Contract pregnant mother workers /surrogate mothers had very few rights in India and are often stigmatized. Unlike pregnancy of a married woman which is often a matter of

celebration, a surrogate pregnancy is veiled in secrecy and hence strict surveillance and exploitation are structurally embedded in Indian surrogacy arrangement. Also pregnancy in surrogacy is treated like an ailment as the pregnant women needed to be separated from the rest of the world. This certainly reminds of child-birth practices up to early 20th century in several countries in terms of inclusion-exclusion dichotomy.

In a way there is nothing "traditional" about potential baby making in the 'Cyberprocreation era'. The internet increased the availability of and the market for human embryos and surrogacy services to a larger audience than ever envisioned (Reich and Swink 2011: 242f.). In this free market, some "women's bodies are now converted into the industrial process of eggs, uterus, with an infant as its final product, its packaging decided before its delivery through genetic editing, all of it controlled by factory floor managers of the assisted repro tech" (Virani 2016: 167). The birth of babies, through surrogacy arrangements successfully graduated thus to "a public issue from a personal trouble" with all fanfare to recollect C. Wright Mills' famous coinage. This huge industry of transnational contract pregnancy/surrogacy has been realizable by real life national boundaries of a globalized world along with a partner in ICTs. The intended infertile couple, mediated through Agencies and fertility clinics, engaged in transnational reproductive commerce, meet its service provider the Indian surrogate woman. Consequentially, it successfully reinforces neo-colonial power hierarchies where the globalized North, the developed world maintains its hegemony over South, the so-called developing world.

A study done in Kolkata India (carried out between 2013-2016) with thirty seven surrogates from different sectors revealed that surrogates are paid not only based on supply side situation but also based on customized features of individual surrogates on demand, e.g. fairness of the skin, educational qualification and overall economic and cultural background. The matters of surrogates' services are priced according to their physical and other attributes as the market determines the wage of baby production like production of any other commodity. Here it was amply evident that the choice of contract

mother workers /surrogate is determined by a host of factors where intersectional perspective indubitably dominates. A few surrogates told that physical look was the most important criterion for the intended parents and for the doctor the ability to carry the full term of pregnancy otherwise it was loss of future business possibilities for the doctor and the Clinic. A former surrogate explained in Kolkata that those women who go on their own cannot answer properly to the queries and do not also know how to lie properly which is a requirement of the trade. She laughed and said "she can be mother of one child in one place and in another mother of two. Who can really verify?" (Surrogate respondent, Bhadra 2016). A contract pregnant worker told that only thing known to her that she has to give up the baby and listened to all the directions given to her without fail and then she will be paid once the job is done. In 1985 Margaret Atwood wrote in The Handmaid's Tale about women kept in reproductive slavery, fed, given lodging to have sex with the masters of the house as the labelled infertile wife watched. Whatever rationale or ersatz story of empowerment may be portrayed but the surrogates mostly live in heaving spaces living between the lines of other's procreational lives. For their paid- for pregnancy they are cut up, their uterus is part of the IVF package […] They are given the remaining rental money, sent off on their way; before which the milk filling their post pregnancy breasts is abruptly medically halted with drugs. Some are also told to bind their breasts (Virani 2016: 264). Both Pande and Hochschild report based on their researches that surrogacy was a compulsion for the women who become surrogates, a job which pays more than some other jobs otherwise the conditions are worse in the this reproductive business. It does not take much to recognize that there are no born surrogates. Some women undergo a process of mortification of self at least temporarily to become surrogate during their temporary stay in surrogacy hostels like within a disciplinary regime. Hochschild aptly comments that "In Akanksha, Dr Patel organized surrogacy much as she might have the manufacturing of clothes or shoes" (Hochschild 2009: 30). And Dr Patel does this like a professional safeguarding quality of the product by monitoring surrogates' diet and sexual contact, and assuring a smooth, emotion-free exchange

of baby for money. So, for every dollar that goes to the surrogates, observers estimate, three go to the clinic (Hochschild 2009: 30f). Thus, the one and only focal point of the surrogacy arrangement is to have a baby successfully, for which, the surrogate is nothing but a medium.

"On January 29, 2014, 26 year old Yuma Sherpa, died in the aftermath of a surgical procedure to harvest eggs from her body, as part of the egg donation programme of a private clinic based in Lajpat Nagar, New Delhi" (Peoples Democracy, January 11, 2015). Many surrogates have expressed feelings about the neglect of the surrogates' health by the clinics, by the doctors and even by the intended parents after the birth. This disregard is of course the hall-mark of the business that decides the transactions in this industry. It is kind of startling that some researchers forget that surrogacy is unregulated whereas garment industry is regulated in India. And also are conveniently silent on the other side of the spectrum like "India's first known case of ovarian hyper-stimulation syndrome complained only of stomach pain and nausea, and died twenty to thirty six hours later in 2010. She was seventeen years old, a minor and donated three or four times to the same fertility clinic before she died and the owner"- doctor is a successful name and still practicing in spite of the charge sheet given in 2010' (Virani 2016: 182f.). Or, Premila Vaghela, 30 years old, of Ahmedabad had opted to become a surrogate mother and deliver child of a US-based couple to supplement her family income and brighten the future of her own two kids, died due to unexplained complications. But she completed her job— the child was delivered and is in the NICU recuperating from early birth. These instances can be cited in large numbers which attest that the healthcare needs of a surrogate are measured only in terms of giving birth to a child. Once she has delivered the coveted child, she is on her own.

> The general attitude of the couples and the doctors is of carelessness with respect to their health. I am not saying this only for myself, but happens with other surrogates also. Everywhere the attitude is similar. The couples treat the surrogates only as a means of having a child. The health of the surrogate is the least of their concerns (Surrogate Savita Sama interview quoted in Nayak 2013: 9).

Concluding Comments: A Mother-Worker

> *Commercial surrogacy in India as a new kind of labour—gendered, exploitative, and stigmatized labour, but labour nonetheless* (Pande 2008, 2009b).
>
> *"Surrogacy preys on poor women. We cannot pretend that women in India suddenly have choice and autonomy where their reproduction is concerned* "(Economic Times, November 8, 2015).

In actuality, through contract pregnancy/surrogacy is a vital part of the disciplinary process of manufacturing a perfect mother-worker. This "disciplinary project not only emphasizes a perfect-worker model but also demands perfect-mother qualities from the surrogates. A good surrogate loves the product of her transient labour as her own. Good mothering qualities are required not just in conjunction with the good worker qualities but independently as well. A surrogate has to be a good mother to her own child before she can be a mother-worker for someone else's baby (Pande, 2010: 980). The reality is crystal clear: With or without the written contract the surrogate is almost totally subservient to the clinic and the intended parents. This relates to a situation where there is a lack of predictability and security as the job and contract both are result of a flexibilization and informalization of the new labour process of the neoliberal entourage. Researches show that job of a surrogate was mainly a compulsion for the women who become surrogates, a job which pays more than some other jobs in the short term, otherwise the conditions are worse in this business of reproduction than many businesses. The contract mothers/ surrogates perform an invisible "emotional labour". Since structural adjustment crises of the 1980s the informal sector has grown three to four times faster than formal sector employment. Surrogates are part of that informal economy which has been a perennial and enduring companion of the formal capitalist economy. Thus, to conclude with Hochschild:

> Filipina nannies and Indian surrogate mothers are behind the "front stage" of global free market – the jet-setting briefcase-carrying businessmen forging deals in fancy hotels – to a lonelier "back stage". The hidden part of the emotional labour of "back stage women" reflects the enormous costs of life in a total free market (Hochschild 2009: 21).

[Names of all surrogates are changed]

Note

1. When the term globality is explicitly employed, it may be defined as the intensification of more-or-less worldwide connectivity and increasingly reflexive global consciousness. Overall, the condition of globality is accentuated greatly by the compression of the world (Beck 2000; Robertson 1992).

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