ACCESS AND EQUITY IN INTERNATIONAL SURROGACY POST 1990s: IMPLICATIONS ON SOUTH ASIA

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DECLARATION

I declare that the dissertation entitled "**Access and Equity in International Surrogacy Post 1990s: Implications on South Asia**" submitted by me for the award of the degree of **Master of Philosophy** of Jawaharlal Nehru University is my own work. The dissertation has not been submitted for any other degree of this University or any other university.

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CERTIFICATE

We recommend that this dissertation be placed before the examiners for evaluation.

PROF. AMITA BATRA
Chairperson, SAS

PROF. AMITA BATRA
Supervisor

This Dissertation is dedicated to

My Nanajee,

Maa and Paa.

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List of Abbreviations

ARTs	Assisted Reproductive Technologies
GDP	Gross Domestic Product
ICMR	Indian Council fro Medical Research
ICMART	International Committee Monitoring Assisted Reproductive Technologies
ISAR	Indian Society for Assisted Reproduction
IVF	In Vitro Fertilization
NARI	National ART Registry of India
OBO	Our Bodies Ourselves
WHO	World Health Organization
WOREC	Women Rehabilitation Centre
WTO	World Trade Organization

CHAPTER 1

INTRODUCTION

Globalization though claimed to be a phenomenon existing since historical times in the form of trade across borders; its contemporary form is much varied from what it used to be. The contemporary form of globalization with the advancement in science and technology has led to compression between space and time. Although, economics is understood to be the main driving force behind the process of globalization, the attempt of the research is to understand how the economics is inter twined with the social, political and legal forces helping in the increasing incidents of the cross border surrogacy.

The question of human rights is taken as a shield while both criticizing as well as supporting the practice of surrogacy in the form of being altruistic or commercial, traditional or gestational. Article 16 of The Universal Declaration of Human Rights says that ‘Men and women of full age ... have the right to marry and form a family.’ Further Article 27 goes on to say that ‘Everyone has the right ... to share in scientific advances and its benefits’. By this reasoning alone one can argue the right of an individual to avail surrogacy services so that they could complete their family by using the technologies available in the market. Though there are impertinent ethical issues at stake when one views surrogacy at large. The commodification of human beings (baby and surrogate), the idea of ownership, even if it is just for 9 months, raises the question of accessibility and availability of services for few over others.

The bourgeoning reproductive tourism industry along with mounting acceptance among societies has propelled the growth of the industry considerably. This is further accentuated by the economic needs of the women who entered into the practice of surrogacy. Exploring the dimensions of expanding jurisprudence around the cross border surrogacy, Mathew and Sapsed have raised ethical questions regarding the exploitation, commodification and coercion, especially where there are substantial power differentials between the intended parents and the women who are paid for delivering the child.

Understanding surrogacy as a work in the global world, which can be either commercial or altruistic, attempt is to engage with the idea of how state determines the nature of these transactions on one hand and how the process is nurtured in the context of the social and economic background of a country. Having a broader view of these developments, a narrow approach would be adopted to see how the global perceptions affect the local perceptions and vice versa. This approach is adopted predominantly in the pursuit of engaging at two fronts i.e. the global and the local, to make sense of a relational understanding of the practice of surrogacy in different countries.

1.1.The Problem of Infertility and the Technological Solutions in the form of ARTs:

"Over thousands of years that humans have been able to reproduce, it has been only the last fifty years or so in the industrialized world, with its nutrient-depleted foods, genetically engineered agriculture, chemical processing, drugs, radiation and pollution, that we are now observing massive impacts on our ability to bear offspring, particularly in affluent Western societies."[1]

The Oxford Dictionary defines Reproduction as the action or process of forming or creating or bringing into existence again. The credit of making Reproduction the center of our social analysis goes to the feminist studies and the medical anthropology. The problem of infertility has being in existence since decades and the earlier solutions were to adopt some of the home remedies or get help by sister or a maid as stated in the biblical stories. The advancements in medical technology have opened avenues to cure the problem of infertility. Jackson in his book, covers everything related to it in what he calls it as a plan C i.e. Medically Assisted Reproductive Technology as a solution to infertility.

Assisted Reproductive Technology in simple terms implies manipulation of egg and sperm in treating infertility. As stated in Mosby Medical Dictionary, it includes administration of drugs to induce ovulation, fertilization, gamete intra fallopian transfer, and zygote intra fallopian transfer and cryopreservation gametes. As this

[1] Jason Jackson N.D, 2009, *Making Babies: The Definitive Guide to Improving Your Fertility and Reproductive Health"*, Zesus Publications.

provides a solution to the problem of infertility it has emerged as an upcoming industry in the global world.

World Health Organization defines infertility by using a reference of one year of childlessness (women with no live birth). It classifies the conditions into two categories: primary infertility and secondary infertility. While the former refers to the absence of conception despite cohabitation and exposure to pregnancy, the latter refers to the failure to conceive following a previous pregnancy despite cohabitation and exposure to pregnancy. In 2001 a meeting was convened on "Medical, Ethical and Social Aspects of Assisted Reproduction" to examine a region and country specific study of infertility and its issues. Its main objectives were to review and assess developments in ARTs along with identifying its unresolved issues and to further provide research on it.

The Progress in Reproductive Health [2]published the World Health Organization report stating the overview of how high rates of infertility persisted especially in developing regions and in response to it private clinics were being set up. "There are over 186 million couples in developing countries alone (excluding China) who are affected by infertility". From 1990 to 2004 the Demographic and Health surveys were conducted in collaboration with WHO stated that, out of every four couples, one couple was affected by the problem of infertility in the developing countries. It also specified a brief outline of the different situations that prevailed in India, Latin America, Middle East and Sub Saharan region.

It further clarified that ARTs are associated with wider societal issues and this had the impact on its usage as well as its availability. For e.g. in Latin America there was dominance of public health and since this was provided by private clinics the poor were deprived of it. While on the other hand, in the Middle East region though the use of ARTs was permitted but in a restricted way. There was partial acceptance as it was compulsory to use only the husband's sperms and therefore use of outside gametes was banned. The usage of this technology was liberal in sub Saharan region of Africa owing to high prevalence of the problem of infertility. Expressing the situation in

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[2]Patricia A. Butler Progress (2003) "*Assisted Reproduction in developing countries – is facing up to the issues"*, Progress in Reproductive Health Research No.63. It is a quarterly newsletter which is issued (since 1978) by the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, department of reproductive Health and Research, World Health Organization, 1211 Geneva 27, Switzerland.

India it is stated that, not having a child was considered a stigma, hence parents would go to any extend to have one.

In 2012, a study was published by the WHO about the burden of infertility and informed that the levels on 2010 remained at the same levels as that of 1990 among the women of 190 countries[3]. The World Fertility Survey (2012) also quantified that among all the regions, South Asia had among the highest number of people with problem of infertility. Within South Asia it reported that, Bangladesh had the highest rates of infertility[4]. Particularly for India, a survey was conducted which revealed that couples nowadays have substantial faith in assisted reproductive technological advancements like IVF.

The fertility rates started declining post 2000, as has been recorded that there was 17% decrease since 2000. More than 60 % of the couples observed, had attempted to acquire solutions from Internet and friends. The study simultaneously observed that around 64% of the couples, even in 21st century believed in the will of god and thereby delayed their treatments. There is a consensus among fertility experts that, the public at large is not aware about the complications associated with infertility. This lack of awareness has resulted in a state whereby the couples adopt alternative therapies and religious rituals to satisfy their quest for conception. Consequently, crucial age and time is squandered away. And ultimately women are pressurized, thus attaching a stigma to her inability to conceive without finding out the real problems associated to it.

The study by the International Institute for Population Sciences (IIPS)[5], Mumbai (2010), affirmed that childlessness among Indian couples has risen by 50 per cent in the period of twenty years from 1981 to 2001. By analyzing the data from the annual census conducted along with the information provided by the National Family Health Surveys, found that in the age group of 35 to 49 years, while 4 per cent of married/ separated women in 1981 had never had a child, this figure rose up by two per cent in 2001.

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[3] http://www.who.int/reproductivehealth/topics/infertility/burden/en/

[4] http://www.fvvo.be/monographs/biomedical-infertility-care-in-poor-resource-countries-barriers-access-and-ethics/invisible-women-in-bangladesh-stakeholders-views-on-infertility-services/

[5] The IIPS serves as a regional Institute for Training and Research in Population Studies for the ESCAP region.

Infertility entails within itself private agony and a social stigma and thus creates a generous demand for ARTs .We can look at development of these technologies from the lens of emergence of tissue economy wherein risks are manufactured to sell a kind of medical insurance. The leading role is undertaken by the he International Committee Monitoring Assisted Reproductive Technologies (ICMART) on a global level for the development, collection and dissemination of data on assisted reproductive technology (ART). It information is provided to health professionals, authorities and to the public on availability, effectiveness and safety with regard to use of ARTs. In cooperation with the World Health Organization (WHO) the glossary has been framed and facilitates data on ART through a set of definitions that are agreed-upon. Thus it provides a theoretical framework to further develop international terminology and data for ART.

1.2.The Context of Reproductive Tourism in the Globalized World:

In the globalized world, health care industry has undergone a rapid expansion in the past decade. Earlier the trend was movement from developing or less developed countries to developed countries for availing the specialized health care services, which were not available elsewhere. However, now it has been enlarged to incorporate travel to the developing countries as well. This phenomenon is also increasingly being promoted by the developing economies as an opportunity to export these services and generate foreign revenue. The expansion of Medical services are being incorporated in the economic strategy by the developing countries that have started interlinking it with their trade policies.

With the emergence of the globalized world, the sense of recognizing each other has developed among all nations. In medical terms, this has led to the development of new industry called medical travelling. Some of concepts framed to define this new industry with different dimensions are “medical travel”, “healing holidays”, “medical migration” and many more. TRAM[6] in its 2006 report, identified that medical tourism

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[6] Tourism Research & Marketing is an independent consultancy with a reputation for excellence and a consistent professional approach to solving our clients' problems. Established in London in 1980, additional offices were opened in the Netherlands 1994, Barcelona in 2002 and Austria in 2010 to benefit from the growing opportunities in European tourism.

is expanding in many countries with double digit growth, may grow up to a level of 40 million trips i.e. 4% of the volume of all global tourism by 2010. This inter linkage is supported by the General Agreement on Trade in Services (1995) of the World Trade Organization in which these services were linked into the overall trade in services. The movements across international borders by patients who want to undertake ARTs have been incorporated as one of the sub categories.

ART is a complex phenomenon associated with a larger capitalized framework of medical tourism, which is a multibillion-dollar profit, oriented industry and has situated itself in a significant position. ARTs are an extensive arrangement of technologies aiming at facilitating and preventing by intervening in the process of reproduction. In this process of reproduction a specific focus is to understand surrogacy, which means when a woman agrees to carry a child for another woman with the intention of relinquishing the child at birth. There are two types of surrogacy: genetic (the surrogate is genetically related to the child) and gestational (the surrogate carries the fetus but is not genetically related to it). In terms of surrogacy arrangements, there are altruistic (no payment) and commercial (payment) arrangements.

Knoppers and LeBris (1991) were the first to introduce the concept, and named it as 'Procreative Tourism' in a law article. In this they compared the regulatory structures and principles that governed ARTs during that time. In this path the attempt was then made by Inhorn whereby she conducted an empirical research to describe travel for infertility treatments in Egypt (1994). Eventually, this started being recognized as a new phenomenon involving cross border movements to avail the solutions for infertility offered by ARTs. And subsequently scholars started exploring the way communities endure this phenomenon and in the process either work through, break apart or transcend different ways of healing and remaking their worlds.

Inhorn has described the concept of 'Reproductive Tourism' as a process of search for ARTs and human gametes (eggs, sperm, embryos) across national and international borders (2011). This transnational surrogacy in simple terms then means that it allows intended parents to buy the egg cell in say, India implant the embryo in the womb in Iran and bring up the baby in America. She has tried to conceptualize this

reproductive tourism within global reproscapes drawing the idea of scapes from Arjun Appadurai[7].

Inhorn added one scape of medical anthropological interest to Appadurai's list i.e., the 'bioscape' defined as movement of biological substances and body parts. Thus defined 'global reproscapes', as a process that involved the exchange of actors, technologies, money, media, ideas, and human gametes, in complex manners across geographical landscapes. For this movement to take place she gives reasons which may be due to shortage or constraint in their own country in form of religious sanctions, legal hurdles, social stigmas due to lack of privacy, insurance, technology and competence.

The practice of ARTs is largely undertaken in all countries in one or the other forms. Though there are no accurate figures about how many clinics are working in each individual country leave alone the number of patients they attend. Chhabria in her report highlights the study conducted by World Trade Organization (WTO) in five countries, i.e., Thailand, Malaysia, Jordan, Singapore and India about the medical travel expenditure that was growing at the rate of more than 20 per cent every year (2005).

Though there are no accurate figures about what numbers of clinics are working in each individual country leave alone the number of patients it attends. Nevertheless mounting reports by organizations such as the International Consumer Support for Infertility (ICSI), ESHRE and many more have suggested that there is a rising relevance of ART's in present day world. An international umbrella organization for infertility consumers, the International Consumer Support for Infertility (ICSI) listed four African groups (Nigeria, Kenya, Uganda and Zimbabwe), an Indian group and South American group suggested that ARTs is progressively relevant today in the developing world.

Talking about development of ARTs ESHRE in its report[8] (20112) detailed that around five million babies have been born using ART; since 1978 with an average

[7] Appadurai has characterized globalization as the movement of people (ethnoscapes), technology (technoscapes), money (financescapes), images (mediascapes) and ideas (ideoscapes). He talks about this taking place in varying degrees and attributes this to the idea of localizing.

[8] http://www.eshre.eu/Press-Room/Press-releases/Press-releases-ESHRE-2012/5-million-babies.aspx

27% of treatment cycles resulting in the birth of a baby. The majority among these resulted from use of traditional IVF or intracytoplasmic sperm injection (ICSI) techniques in which fertilization is achieved by injecting a single sperm in the egg. [9]

Additionally, two surveys were conducted, first in the year 1997 and second in the year 2003 to trace the changes that took place regarding surrogacy and maternal involvement in adoptive procedures. [10]Forty countries were selected ranging from America, Germany, France, Russia, Mexico, India, Spain, Norway, Singapore and so on. It was found put that since religion was an integral part of lives of citizens as well as their country's structures some countries with strong Roman Catholic or Greek orthodox philosophy, out rightly rejected the idea of reproductive technologies, consequently surrogacy didn't stand a chance in those places. Countries of Middle East, Saudi Arabia, Iran, Egypt, Yemen and Jordan having strong Muslim faith did not allow for the practice of surrogacy. While countries like India and Russia are unable to enforce their philosophies due to social and political instabilities have seen a rise in surrogacy practices.

While describing the prevalence of surrogacy around the world it briefly talked about almost all the states. In Europe the scenario is mixed. In countries like Norway, Sweden and France it is forbidden while it is illegal in Germany, Italy and Poland. Italian couples engage in contracts in other countries that are then approved by a special committee. This however does not happen in the UK. In the same lines as that of UK, Belgium, Greece, Ireland and the Czech Republic surrogacy is not regulated by law. Similarly in Finland, surrogate mothers are available but the practice in not regulated by any laws. Much harder stance is adopted by Estonia who has banned and even declared to execute both couples.

Outside Europe, surrogacy in the USA, it is widespread in some states while illegal in some. In Canada for some years, surrogacy was allowed but since 2004 its commercial practice is banned. And countries like Russia, India and Ukraine followed the commercial path and have almost formed itself into an industry.

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[9] Malhotra, N., Shah, D., Pai, R., Pai, H. D., & Bankar, M. (2013) "*Assisted reproductive technology in India: A three-year retrospective data analysis*" Journal of Human Reproductive Sciences, *6*(4), 235–240. DoI: 10.4103/0974-1208.126286

[10] Mathew D & Sapsed S 2014 "Surrogacy: an International Phenomenon" E-leader Milan 2014

The dominant western discourses on surrogacy revolve around the ethical moral dimensions. Its debate is about whether surrogacy is good or bad. Surrogacy is understood to be an arrangement wherein there is use of technologies to help conceive a child between the intended parents and the surrogates through clinics. In the process of gestating a child, surrogate is not directly linked to the child and therefore is increasingly being commercialized in the market space.

The idea of providing child birthing as a service has been both accepted and rejected. The supporters argue that it liberates the women from her traditional roles and makes her independent to decide for herself. American researcher Ragone states that surrogacy "allow(s) women to transcend the limitations of their family roles and to achieve a certain degree of independence and personal fulfillment" (1998). She goes on to the extent of explaining how surrogacy can eliminate class and race differences while this is really debatable that it has eliminated the class differences or further escalated it.

The feminists' arguments, like that of Kutte Jonsson, also describe surrogacy to be associated with words like liberation, emancipation, freedom and so on. Most of the stories of surrogacy narrated by the supporters, clinics and newspapers suggest how helpful the practice of surrogacy is and how happy families are created through it. The overshadowing of the practice, which is emerging as an industry, will be explained in the later section.

The activists have been divided on the issue of surrogacy since the issue surfaced in 1980's with the Baby M case. The feminists who believed in the liberal ideology approached it in a much positive way by highlighting the right of a woman over her body as well as the right to enter into contracts. The Marxist feminists compared surrogacy to the concept of alienated labour, as a form of generating profits and reproducing sexism. While the socialists and radical feminist have opposed the practice of surrogacy as it involves the commodification of women.

1.3.Situating the Global South:

Advancement in reproductive technologies along with ease of travel and direct payment in form of money have helped the couples with a range of possibilities to use inter-country surrogacy as an option to have families (Ramskold and Posner 2013).

While drawing a world picture of growing surrogacy industry, Sapsed has given the World Bank data, which predicted that Indian surrogacy alone would be a US$2.5 billion industry by the year 2020.

The advancements in technological procedure along with significantly lower costs, and English-speaking providers with supply of women interested in acting as surrogates provides a 'business climate' that encourages the outsourcing of labour. There is lack of regulations and regulatory structures to bind the industry, which thus acts as a major contributive factor. India enjoys vis-à-vis developed countries the cost advantage because of which the people from other countries are attracted.

The study done by SAMA Resource Group on Women and Health in 2008 shows that an IVF cycle in India costs $2,000 (approximately Rs.90, 000) in contrast to the US costs around $20,000 (approximately Rs.9, 00, 000). A surrogacy arrangement, including IVF, costs about $11,000 (approximately Rs. 5, 00, 000) in India, while in the US, surrogacy alone, excluding ART charges, costs $15,000 (approximately Rs. 6, 75, 000). In the UK, an IVF cycle costs about £7,000 (approximately Rs. 5, 00, 000) and surrogacy costs about £10,000 (approximately Rs. 7, 00, 000). While in the US, up to 50 per cent of the cost of ART with a surrogate arrangement goes to the surrogate, in India most of the money is appropriated by sperm banks, clinics, etc.

Tattara outline the push and pull factors that make cross border reproductive travel possible: "Medical tourists are pulled mainly because of lower costs, availability of latest medical technologies and a growing compliance with international quality standards, as well as the fact that foreigners are less likely to face language barriers in India. Whereas the cost of treatment in other developed nations, especially in the US, UK, is very high, India can provide quality healthcare at very low cost due to the availability of relatively cheaper but quality manpower, low-priced drugs and other infrastructure"(Tattara 2010).

Analysis of this situation would make it clear that the surrogates from poor background, in the limited employment opportunities, system of lax rules and regulations are compelled to be a part of this from the developing world. Being a surrogate may be then the only means of employment for the poor illiterate women of developing or under developed world. Moreover it is observed that there is a shift in the focus from the rights of mother and child of the underdeveloped countries while

they still persist for the women of the developed countries. And thus, it becomes important to question both the nature and the deployment of technologies in the context of distinctions in terms of Accessibility and Equity for the North and South.

It's in the emergence of the international surrogacy that one finds the scenario where there are exchanges between the developed and underdeveloped countries; there are also global structures that symbolize and reinforce inequalities. The accessibility of these services then becomes an area of great interest to look at distinctions that exist between the Global North and South and within South. SAMA, Resource Group for Women and health has stated in its 2010 publication about the research they conducted in three states of India and has brought to the focus the rapid proliferation that is taking place from metropolitan cities to smaller towns and cities.

It was found out by the study that the couples from South Asia, Southeast Asia, the Middle East, Australia, Europe, the USA, Canada and Africa accessed ART services (including egg donation and surrogacy) from the providers in Tamil Nadu and Uttar Pradesh. Among the developing countries as stated earlier in the WTO report, most of the countries of South like Thailand, Singapore, Indonesia and India are becoming global hubs for cross border reproductive travel.

In the Baby Manji Yamada's case, commercial surrogacy in India was identified as "reaching industry proportions". Surrogacy is considered legitimate as no Indian laws ban it, rather the recognition provided by the Supreme Court along with the ICMR guidelines published in 2005 and the Visa regulations issued in 2012 provide evidence of its increasing recognition in the market. Nevertheless no Indian law permits surrogacy either. And if India passes the Assisted Reproductive technology bill 2010, it will be one of the first Global South countries to legalize surrogacy. Other South Asian countries i.e. Pakistan, Bhutan, Nepal, Bangladesh, Afghanistan, Sri Lanka and Maldives have no legal laws regarding surrogacy.

Though surrogacy is being practiced in some form or the other in all countries but due to the religious and social structures has not been legalized. The situation in India is quite opposed to all South Asian countries as it has legalized and at the same time is progressively being defined as one of the most favored destination. The estimates provided by the Indian Council of Medical Research (ICMR) state that in 2002 there were roughly 3,000 ART clinics operating in India.

The Confederation of Indian Industry (CII) and McKinsey Consultants published a joint report, which specified that in 2004, around 150,000 foreigners visited India for treatments; additionally these numbers are rising by 15 per cent each year. Similarly Giuseppe Tattara had mentioned in his work that, 'India is the second Asian provider for medical tourism with an inflow of 4, 50,000 tourists in 2007'(Tattara 2010). Plus it was also estimated by the Business Insider in 2013 that surrogacy industry in India is worth $400 million/year.

With this background of booming surrogacy industry in India, its reach has now been extended to its neighboring South Asian country Nepal too. The workshop organized by the Women Rehabilitation Center (WOREC), Our Bodies Ourselves (OBO) global partner in Nepal along with SAMA resource group on cross border reproductive health care, where issues were discussed about the growing surrogacy arrangements in Nepal and the concerns of women acting as gestational mothers. In the workshop they advocated for framing public policies to protect gestational mothers.

The travel by foreigners to Nepal is indicated by the study published by SAMA in 2010, Pinky Singh Rana who is associated with Safe Motherhood Network and SAATHI Nepal. While talking about emergence of ART's in Nepal has discussed that Nepali women prefer crossing the border because of easy accessibility and higher success rates in India. In this scenario then among the South Asian Countries, India is the only one which is promoting this industry more than any other South Asian country which then becomes an area of study. One can look at it from the point of view of how India is serving the patients of South Asian countries who are seeking reproductive services. And here again the question of who have access to these services while crossing the borders within South Asia and across other developing countries arises.

With the globalization of ART services and surrogacy as an option to reproduce a range of stakeholders are involved in this process of reproduction. From the doctors to surrogates one finds an inter relation between the couple who avail these services and the surrogates involved in the process of reproduction. This range of stakeholders further spread across space when International Surrogacy is practiced. Focusing on the space across the globalized world, it is important to understand the differences,

which exist in the settings of the developed and developing world, which are classified as Global North and South.

The process of movement from the global north to global south has multiple intersections, which makes us question the status of accessibility and equity, and also when one looks at the south –south scenario. The term coined by Ginsburg and Rapp 'stratified reproduction', had emerged which means there exists an unequal power equation. In this reproduction for some categories of people are encouraged or empowered to reproduce, while in others is devalued. Here one finds that the surrogacy services provided by the Indian women help in the reproduction for foreign couples while these services are not available for the Indian nationals at the same time.

The priorities of the state then in relation to health care have shifted from protecting the public good to promoting the interests of industry, thus creating the conditions for health care to be profit-making industry. Thus these technologies bring back age-old questions and concerns regarding women's right over their bodies, as well as debates around ownership, exchange and renting of body parts. With the stark economic inequalities characterizing the global relations, with free flow of capital, goods and services and people, the practice possess the potential to be immoral and abusive. The issue of accessibility to these technologies then remains in question for the majority of women in the Global South.

Apart from the divisions, which are evident in the practices of international surrogacy, another intriguing issue is emerging regarding the movement of people and most importantly surrogates across the borders. It is known that from times immemorial people in search of livelihood have walked miles and with the integration of economies people have crossed borders to secure their earnings. The General Agreement on Trade in Services in its Mode 4 talks about movement of people apart from the other three modes of providing services. In this background the nature of movement of surrogates across borders becomes an area of study as it has been reported that these movements are looked at in the broader subject of trafficking.

Though the women of developing and under developing countries voluntarily opt for surrogacy, the studies lack in explaining the motivations. In the context of South Asian countries, with India sharing borders with almost all its neighbors, the

movements of surrogates across these borders is important to understand the nature of these movements. While it has been stated that Nepali women cross borders to act as surrogates in Indian clinics, there is no data available regarding other south Asian countries women coming to India to act as surrogates. But at the same time as women from Nepal crosses border in search of employment as surrogates how much the nature of this movement is voluntary is yet to be studied. Along with these women, the other women from other part of the region travel to India are yet to be explored along with its nature of movement.

Though surrogacy is legalized in one of the South Asian country, India, it has been found to exist in all other countries in some form or another. And the most emerging country now is Nepal. This draws attention to the region to be studied in the area of providing cross border reproductive care and how it's being shaped up. While in Nepal efforts are being made by working groups like WOREC to get a bill passed on the similar lines as that of India's bill that's pending, and Sri Lanka too is directing efforts to recognize it, no South Asian country seems to have a legal framework. Then how do Indian industry and the upcoming Nepali industry support the demand of surrogacy in South Asia and broadly in the world is the area of study.

Surrogacy has emerged on international scale as a part of medical tourism and trade in services. In this backdrop India has being defined as an attractive destination and Nepal industry as an extension to India's industry. While this being practiced in all South Asian countries there are no legalized framework existent in any of these countries though it has been legalized as a commercial practice in India as the bill is still pending in the parliament. With this scenario of lax rules, easy access of cheap labor and most importantly low cost questions regarding the inequalities existent in this process comes to fore.

At the global level one understands it as a reproductive service being available across borders creating a more equal world. But ironically in the process of this reproduction global inequalities are taking a distinct shape. On one hand from intended parent's point of view the question of accessibility of whether the services are being provided as need based or market based. And on the other hand from the surrogate's point of view the question of equity is looked at along with the rights and protections for them. In contrast to the global north, the global south is contextualized in a very different

scenario and within south too one finds differential treatments. In this context then, South Asia as a region becomes an important area of study. And apart from this, study would also focus on the aspect of easy movement across borders within South Asia and how this has facilitated the surrogacy market. In this, particular attention would be sketched regarding the movements of surrogates across India and Nepal border as the industry in Nepal is understood to be an extension of India's industry.

- **Access and Equity issues between Global North and South**:

These developments have to be understood in context of the disparities that exist between the north and the south. As has been indicated there are uneven distribution of assisted conception in the patterns of reproductive tourism across the globe. Travel by couples to places where these services are considerably less expensive like in India, Guatemala, Russia and Ukraine from the U.S, U.K, South Africa, Europe has become a common phenomenon in the last two decades. The contradictions strongly portray the injustices that explain the disparities between the North and the South. There are different cultural and social impacts in which we develop different personal and collective identities.

In these transitions we also recognize the differential power relations embedded in reproductive tourism. There are multiple social and spatial boundaries that people cross say ethnic, racial, economic, religious, and national.. The myriad structural and cultural constraints in India reflect many of the disparities in terms of gender, race, class, nation and place.

A research study conducted by Pande, shows how India's arrangement allows for the existence of global surrogacy industry. While explaining the structure of India's commercial surrogacy industry, stated that "The Indian structure is closest to the liberal market model of surrogacy in California where surrogacy births are primarily managed by private, commercial agencies that screen, match, and regulate agreements according to their own criteria and without state interference" (2009). In her

dissertation while identifying these multiple sites of domination she stated that defiance to one set of forces often involves reification of other forms of domination.

While portraying this international division of reproductive labour where poor women of the Global South reproduce babies for richer women, often from the Global North she has described commercial surrogacy as a form of labor. Moving beyond the Euro-American setting she has tried to explain the larger view of the cultural reaction to these technologies. She held that her work has deconstructed the image of the "victim" which is talked in context for the bodies of "Third World" women. The everyday resistances of surrogates may not challenge the fundamentally exploitative structures operating in International surrogacy. Nonetheless, they do highlight a perpetual process of compromising and manipulating at the local level. They aggravate a reconsideration of existing norms surrounding surrogacy. It also raises concerns about our understanding of new forms of women's labour, responses to new technologies and thereby the resistances.

- **Equations within Global South:**

Understanding reproductive tourism occurring along north–south pathways it is equally important to emphasize this phenomenon within the global south. While North American, Australian, and European clients are served by the clinics of major cities like Mumbai, Delhi and Gujarat, a growing number of IVF/surrogacy clinics in other cities throughout the country cater to regional clientele from Bangladesh and Pakistan, as well as clients from within India, from regions where ART infrastructure remains immature. This is illustrated by Inhorn in her study where she found that many infertile South Asians seek ART services elsewhere, unable to obtain affordable, high-quality services in their own country (2012). These examples of south–south transnational reproduction provides additional case studies through which we can contemplate about the complexities of stratified markets of reproductive tourism.

By understanding these stratified markets, the term tourism was criticized for misrepresenting patients' difficult experiences in seeking treatment across borders. Drawing from the term reproductive exile coined by Roberto Matorras in 2005,

Inhorn and Patrizio particularized it by citing the subjective sense of being “forced out” of a country’s ART sector because of increasing attention on western market (2009).

In the context of South Asian countries economic exile has been inter twined with the reproductive exile where Dubai is treated as a global hub for them. Inhorn(2012) in year 2007 has done an ethnographic survey in one the largest private clinic named Conceive, the gynecology and fertility center where the main patient population was constituted of South Asians. And for them they never used the term holiday or tourism to describe their trip as one of the patients described it as more of a gimmick.

Almost most of them complained about the poor service quality provided back home. They recognized the disparity of the services being provided for reproducing a child for a brown couple in comparison to a white couple. Thus adding to the stories of Indian and Pakistani’s that have traveled to Dubai in their journeys for conception is described as arduous, expensive and very stressing. It’s not therefore just the desire for procuring a child but also at times due to the pressures provided by social setting.

- **Surrogates of Global South:**

The actors involved in International Surrogacy bring in with itself new international order, which could be understood through the lens of what Maria Mies has talked about and linked it to the history of colonialism that connects the world into asymmetrical and hierarchal relationship. Drawing her analysis from Marx she described modern capitalist systems as predatory, identified its close relation to housewifisation and calls it capitalist patriarchy. Further using Wallenstein’s World System Theory, Mies argues that “with the rise of capitalism, as a world system, based on large scale conquest and colonial plunder and emergence of world market it becomes possible to externalize or exterritorialize those whom the new patriarchs wanted to exploit. The colonies were no longer seen as the part of economy or society; they were lying outside as ‘civilized society’.” (1998:75)

An out and out vertical exploitative relationship that characterized the old international division of labor, Mies argued that the new division of labor was significantly different as it directed to a disguised exploitation of erstwhile colonies.

Applying this logic to the relationship of women from different regions she defined the Third World women as the 'cheapest, most docile and most manipulable workers who helped lower production costs as far as possible' (1998:114). And the women in the rich countries were described as 'consumers', which further embraces the women of urban middle class of Asia, Africa and Latin America.

Building on this theoretical framework of hers, the trend in reproductive tourism especially in regard to commercial gestational surrogacy market could be understood. She viewed these technologies as a means of instituting power over nature that only added to the ways of perpetuating humiliation and exploitation. On this same line of thought Carrie Shelver of POWA (People Opposing Women Abuse) said 'people of the global north are exploiting women of global south .In these countries women are still viewed primarily as bearers of children and therefore international couples are taking advantage of that'.

Way back in 1992 R.P Ravindra talked about the NRT having the ability to alter the very soul of human activity. He focused on effect of sex selection and the effects of the forthcoming issues regarding surrogacy. He quoted Andrea Dwarkin notion of restructuring of society into 'reproductive brothel model'. He stated in this context of its impact on third world for countries like India where these technologies were most likely to be used, abused and misused.

Understanding the specific conditions within India reference is made to an ethnographic study done by Amrita Pande in a clinic in India involving the narratives of women involved in this new form of reproductive travel – the transnational clients and the surrogates themselves. By drawing words such as 'gift', 'sisterhood' and 'mission' as used in north both the parties downplay the economic aspect of exchange. But in real terms they both attach different meanings to it and in turn highlight the inequalities constructed on class, race and nationalities. She describes the strange setting of India in which surrogacy is burgeoning in a legal vacuum along with immense disparity between the buyers and sellers of surrogacy.

Her fieldwork was conducted between 2006 and 2008 in 'New Hope Maternity Clinic' (a pseudonym for the clinic as given by her). One of the prime marketing

points of this clinic is surrogates are kept in the surrogacy hostels under continuous surveillance by the medical staff throughout their pregnancy for their food, medicines and daily activities. Arlie Hodschild had mentioned in her study of Akansha clinic that the clinic itself asked them to think of their wombs as carriers while in this clinic they were asked to think of their wombs as gifts of god and thus not to indulge in material aspect of it (2000).

In the narratives penned down by Pande, all the surrogates attached with this service, a symbol of gift to help the mother in need, instead of gift giving to the needy couple. To quote her "The altruistic nature of Indian surrogates seems to be reflected in their selfless love for their children, rather than in their ability to give gifts to the intended mother"(2010). Also to negate the contractual nature, they used the concept of sisterhood to recognize their relation with the intended mother. Since they themselves minimized the value of providing a gift to intended parents', substantial class, racial and national differences are noted. This makes the gift-giving metaphor ineffective as a cultural tool. Thus the accounts of the intended mothers too accentuate the structural relational inequities involved in the practice of international surrogacy.

- **Movements of surrogates within and across borders**:

Along with these structural inequalities there is another dimension attached to this that underlines the experience of mobility and immobility, movement and stillness between the surrogates and the intended parents. In nuanced ways the studies of Pande and Hodschild in Gujarat and Hyderabad reflect on how surrogates are restricted in their hostels and thus subjugated to rules. In the maternity homes, surrogates are confined, and this could be understood as a form of "spatial imprisonment". Thus as Harvey rightly points out, a place is defined by space and time that is a social construct and for these women the clinics had constructed their living place. In this case thus the reproduction and the globalization of reproductive reflect and reinforce global structures of inequalities.

And while focusing on these inequalities there is a new form of trafficking arising out of the issues of mobility and immobility. Though Commercial surrogacy may not

technically fall within the definition of Human Trafficking as lay down by the United Nations Protocol but it said to increases the cases of trafficking for surrogacy. It is very important to look at this because the movements of women to act as surrogates or ova donors in some cases may be voluntary but may also involve trafficking of women. A case in 2001 was reported by Indian Express, pointing out to the helplessness of a poor girl who felt used and abused for a mere Rs.5, 00, 000. Similarly in 2011 it was reported by the media that a police investigation in Thailand involved 14 Vietnamese women out of them 7 were pregnant who were trafficked for a Taiwanese company to act as surrogates. Veerendra Mishra had said issue was overlooked, as it was not much in news at that time.

This is further been stated by the Hague Convention Report who have worked on child Adoption and child abduction and with the rise in international surrogacy made a preliminary report. This report specifically points on to this aspect by looking at the incidences, which occurred in Poland, Ukraine and many other places. This aspect then becomes further interesting when one looks from a South Asian perspective where the boundaries are so porous with the never-ending illegal movement of people from one country to another.

In this present scenario international surrogacy then adds various interconnections which need to be studied and it is in this context attempt is to further move on like to do an exploratory research after complete theoretical understanding. As this concept can be only studied contextually as different countries symbolizes surrogacy differently.

1.4.The Scope of the Study:

The credit of making Reproduction the center of our social analysis goes to the feminist studies and the medical anthropology. The problem of infertility has emerged some decade's back and the earlier solutions were home remedies or help by sister or maid as stated in the biblical stories. The advancements in medical technology have opened avenues to cure the problem of infertility. Medically Assisted Reproductive

Technology as a solution to infertility has massively developed in the last three decades.

As this provides a solution to the problem of infertility it has emerged as an upcoming industry in the global world too. Surrogacy in this context means arrangement of carrying of a pregnancy for intended parents. There are two main types of surrogacy, gestational surrogacy and traditional surrogacy. In gestational surrogacy, the pregnancy results from the transfer of an embryo created by in vitro fertilization (IVF), in a manner so the resulting child is genetically unrelated to the surrogate. International surrogacy is defined as surrogacy arrangement; regardless of how it is organized, involving an overseas country.

Post 1990's the movements across borders have been more open and in the emergence of globalized world, cross border reproductive care services have increased substantially than ever before. While movements for seeking high class technological health care services were towards the global north, a shift was noticed in regard to cross border reproductive services where movements took place towards global south.

While the specific areas in Global south have promoted the idea of surrogacy there are many regions that have banned it completely or have no laws formulated on it. While India among the South Asian countries has legalized it since 2002, no other south Asian country has legalized it. Some prevalence of making surrogacy available to international trends is seen to be rising in Nepal and also at the same time Nepali women themselves cross borders to act as surrogates.

Being less regulated and more secretive international surrogacy involves within itself many nuances, which are to be examined. In this context the numbers play major role which are difficult to ascertain as there are no accurate figures available about the number of patients crossing borders to avail these services and the number of women themselves crossing borders to act as surrogates. A significant gap exists when one looks at it from the experience of patients i.e. the intended parents. Here the rationale is to grade the differences of patients of the North – South and within South. It is in this context the intended parent's viewpoint would help one understand who can and who cannot avail these services. Along with this the question of accessibility would also focus on the ways experienced in the process of availing surrogate's services.

The global divide exists in every exchange between the global North and South; it also follows the same trajectory for the reproductive services. And it is the surrogate's viewpoints that will help us understand this distinction. The motivations, which drive them to be, so are different and the aim of the study is to bring this difference on surface. Apart from the different motivations the study would help further on establishing a relationship if so exists regarding the background of the surrogates. In this context on the basis of class, caste and religion the surrogates of Global North belong to will be compared to that of Global South. This inter relationship would aim to clearly portray the differences that exist in the discussion of the North – South divide. Here the viewpoints of women of South Asian countries acting as surrogates in Indian clinics would be considered as voices of global south.

A considerable gap also exists in the available literature regarding the practice of surrogacy in absence of any legal framework. In South Asia, none of the countries have laws guiding this practice. Even in India though guidelines are provided by ICMR, the bill is pending despite 15 long years of efforts. Nepal too is in the process of drafting a bill on the same lines as that of India. And in the rest of the South Asian countries no efforts can be seen despite the existence of ART'S clinics in all the countries though not the practice of surrogacy in particular. The judiciary plays an eminent role while giving judgments in surrogacy related cases and the scope of the study would be to understand the outlines being framed by these courts.

Finally, the scope of the study lies in the way movements of surrogates takes place. Within their sphere how their mobility is restricted due to internal and external reasons. And when one looks at the transnational nature of how surrogates are moved across boundaries. Thus an attempt would be made to discover if this has led to increase in involuntary movement of women around South Asian borders to act as surrogates and here movements across India Nepal border would be analyzed because of the porous borders that exist. Most studies focus on the movement of the intended parents therefore this would primarily focus on movement of surrogates that needs much attention.

1.5.Research objectives:

Though there are no accurate statistics available on how many patients are travelling across borders for availing Cross Border Reproductive Care, it is clearly evident that the market for surrogacy is growing. There exists a range of potential benefits and negative effects in the practice of International Surrogacy. It is in this background then one can find the power equation that is graded between the global north and south and within south itself. So the objectives of this study are as follows:

- To theorize the rise of Cross Border Reproductive Care with emphasis on surrogacy as one of its major form and exploring the context for South Asia as a region.
- To study the movement across borders by the intended parents of Global North vis-à-vis Global South and within Global South.
- To analyze the differences that exists on the question of accessibility for the patients of the Global North and Global South. To situate the South – South movement of patients for availing these services and the reasons behind it
- Examining surrogates motivations behind taking up Surrogacy as an option for earning money. Analyzing the differences that exist behind the motivations of the surrogates of the global north and south.
- Contextualizing surrogates background within the Global North- South and South-South. In this regard particularly looking at life worlds of surrogates of South Asian origin.
- Assessing the emerging legal frameworks emerging in South Asian countries and comparing it to the global world.
- To study the movements across borders by surrogates for Surrogacy. Whether it's voluntary or involuntary focusing on movements across South Asian borders.
- Examining if these movements, in anyway, can lead to increase in number of cases of trafficking across the globe and particularly in South Asia.

1.6.Research Questions:

Given the expansion of Cross Border Reproductive Services, how differences exist on the question of availability and accessibility of ART services to intended parents from Global North, Global South and particularly from South Asia:

- How can one categorize the movements of patients of North and South across borders? Can it be called as reproductive tourism or reproductive exile for the patients of South Asian countries?
- For what reasons do women take up surrogacy as an option to earn money? Is there any distinction in the motivation of the women of global south than to the global north? What are the motivations for the women of South Asian countries?
- What legal frameworks are being evolved in South Asian countries? Do they address the current needs of the public at large?
- In what ways can the movements of surrogates be examined within and across borders? Is it voluntary or involuntary? Will the practice of International Surrogacy in any way lead to cases of trafficking within South Asia?

1.7.Hypothesis:

- Access and equity with respect to reproductive services is not necessarily need based for patients of South Asian countries.
- Poverty rather than altruism is the main motivation for the women of South Asia to become surrogates. On the other hand altruism is a motivation for the women of Global North to become surrogates.
- Not being illegal as a commercial practice makes India an attractive destination for surrogacy services. Nepal's surrogacy industry emerges as an extension of India's industry on account of restrictions recently imposed.
- Movements across borders have been more involuntary rather than voluntary for women in South Asia. In this background surrogates' movement within and across borders of India and Nepal have led to question the nature of these movements.

1.8.Research Methodology:

Rising globalization has called for a perspective anchored from the world's point of view. This then becomes an important juncture to start thinking about any idea and

then going further deep into the local contexts. The study would primarily be an exploratory study, which would adopt inductive as well as deductive method to give a view on the situation. This method is adopted to understand the global as well as the local.

International incidents have helped in framing the arguments as not one particular country's position give the entire depiction of the complexities associated with the practice of surrogacy at the local levels. Therefore an attempt is made to comprehend the global along with the local and what affects they have on each other.

Within South Asia, India has been described as a hub for international surrogacy but with its increasing restrictions in regard to who can have access to these services have opened the doors for this industry in Nepal. Therefore the focus has been predominantly on these two countries in South Asia. The other countries of the region are also talked about, though due to absence of clear facts available not much could be analyzed about them.

Subsequently when we talk of the world, one is forced to look at divisions that exist inevitably between the North and the South. In this scenario then a comparison between the content and context that exists becomes an important area of study. The inequalities prevailing in this practice has thus formed the base of the current study.

The primary data for giving the figures regarding problem of infertility and the number of clinics, doctors, and associated actors would be taken from Government's individual ministries associated with it. Apart from Government reports, the reports produced by NGO'S at both International and National level will provide a great insight into the ground realities that exist.

The secondary data would constitute various books, journals and most importantly the contemporary resource i.e. newspapers across countries would provide the study its minute details.

Along with these data, efforts would be directed to visit the clinics and have a direct interview with the patients and surrogates or focus group discussions if possible. All the actors from intended parents to the doctors, nurses as well as members of surrogate's family would help enhancing the understanding of contextual situations that exist.

1.9. Chapter's summarization:

While explaining the concept of cross border reproductive care in the context of globalization in this chapter along with the conceptual nature of the services being provided across borders, the following chapter on **Accessibility and Availability in international surrogacy: Emerging South Asian Industry and its implications** would illustrate the experiences of patients crossing borders to avail reproductive services esp. surrogacy. In this background then distinctions would be charted out in ways how experiences differ between the patients of the global north and South and patients within South. Here, the movements would be traced esp. for countries within South Asia and how these can fit in with in the question of accessibility.

The third chapter would particularly focus on surrogates i.e. **Economic and social equity for the surrogates of the Global North and South**: **Situating the surrogates of South Asia.** The economy of surrogacy surrounds around the surrogates and therefore it is important to understand the way surrogates understand its economics. The chapter aims to explore the nature of being surrogate as a kind of work. What are the motivations that drive the way to take up surrogacy as a means to earn money? Are these motivations different for the surrogates of the global north and south? Apart from the differential payment system the idea is to examine the background of the surrogates involved. Consequently, the aim is to understand the inter relation between class, caste and religion. The aim of the chapter is to examine the socio-cultural backgrounds of the surrogates in both global north and south.

In the end effort would be to understand the legal frameworks that exist around the globe which ultimately structure the movements across borders. The fourth chapter thus titled **Legal frameworks of the Global North and South: Evolving legal framework for surrogates in South Asia,** observing the above two aspects, the study would look at the legal aspects of surrogacy being practiced all over the world. Being banned and restricted, it becomes an important area to look into the legal status of the surrogates and the emergence of this new industry in the legal framework. Cross Border Reproductive Care itself speaks for the movements of actors involved in International surrogacy. In this chapter the idea is to look at the nature of the movements involved by the patients and surrogates within and across borders. Is it willful or forced? In this context the endeavor is to examine if it involves trafficking

of surrogates in any form because South Asia already being vulnerable to this issue will these movements in any case lead to a rise in number of trafficking cases.

Finally in the conclusion effort would be to converge on how these differences exist in the experiences of patients as well as surrogates could be bridged. Governmental efforts as well as role of INGO's and NGO's would be written and how can it be further molded to make their lives better.

CHAPTER 2

AVAILABILITY AND ACCESSIBILITY IN INTERNATIONAL SURROGACY: EMERGING SOUTH ASIAN INDUSTRY AND ITS IMPLICATIONS

The question of availability and accessibility in surrogacy services is addressed by what resources are available and who have access to these services. While surrogacy as a practice was long established, its present form as a commercial practice has attracted a lot of attention. With some countries banning, restricting or prohibiting while others promoting its commercial nature. In this context, we see a rise in surrogacy industry in Global North, furthermore its rapid surge in the Global South. In South Asia, India is said to have a business climate for the surrogacy services, which is turning out to be a multibillion-dollar industry.

While this industry is advancing its transnational nature and attracting intended parents from all over the world it becomes important to understand who ultimately gets access to these resources and who have limited access to these resources. The effort is then to look at how one can categorize the movements of intended parents. Do any differentials exist when one looks at the intended parents from the North vis-à-vis South? Apart from this, the aim is to look at how this affects the resources i.e. the public health system of one's own country, in the process of globalizing of these services. In the end, the analysis would be made about how the prevalence of international surrogacy has impacted the lives of the nationals of South Asians in general and Indians in particular as it is a thriving industry in India.

2.1.Emergence of Surrogacy Services in Developing / Low Resourced Countries, particularly South Asia:

The "trade in pregnancy" emerged in the 1970s in the USA[11]. The first advertisement for need of a woman who was willing to deliver a child for the infertile couples was made known in an American newspaper. While it was taking place in a very small scale it was Lawyer Noel Keane who built up an agency to help the infertile couples to complete their families. The practice spread over the period of time that was

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[11] Ekis Ekman defined trade in pregnancy as renting of woman's womb to act as a surrogate. Though surrogacy existed since historical times, the publishing of an advertisement in the newspaper highlighted its commercial nature.

described as traditional form of surrogacy as the child was genetically linked to the father. The first custody battle occurred in Keane clinic itself where a mother who was inseminated with the father's sperm refused to give up the child. The debate started on the most sensitive issues around "Mother versus Father, egg versus sperm, lower class versus upper class, and blood versus contract"(Ibid). This stirred a debate all over the USA. The judge finally decided to give the custody of the child to the intended parents, as they were economically better off. This was the well-known case called the Baby M case, which raised further questions of defining the boundaries of the surrogacy contracts.

Another major development in the 1990s surfaced known as 'embryo transplantation' through which gestational surrogacy could be practiced. As another woman's egg would be implanted in her uterus, the woman who would act as a surrogate would not be genetically linked to the child. While traditional surrogacy was limited to the Western world, the gestational surrogacy industry attracted a lot more attention in the developing world. It was this shift in describing pregnancy as a service and not motherhood that led to its expansion.

The concept of 'procreative tourism' was introduced by Knoppers and LeBris(1991). Likewise Inhorn's empirical research in Egypt described travel for infertility treatment and for the newly introduced technologies (1994). Eventually, it started being recognized as a new phenomenon of the transnational movements for assisted reproduction treatment. Subsequently, scholars started exploring the ways communities endure this phenomenon and in the process either work through, break apart or transcend different ways of healing and remaking their worlds. The number of individuals who cross borders to avail surrogacy services cannot be ascertained although the phenomenon seems to be on the rise. The uses of Internet and increasing advertisements are evidence to say that foreign couples are crossing borders with their movement being supported by collaboration with foreign companies and clinics.

Inhorn has described the concept of 'Reproductive tourism' as a process of search for assisted reproductive technologies (ARTs) and human gametes (eggs, sperm, embryos) across national and international borders. Drawing the idea of scapes from Appadurai, she has conceptualized this reproductive tourism within global reproscapes. One scape of medical anthropological interest must be added to

Appadurai’s list namely, the ‘bioscape’ that was to be defined as movement of biological substances and body parts. Thus this defines 'global reproscapes', as a process, which involves the circulation of actors, technologies, money, media, ideas, and human gametes across geographical landscapes. For this movement to take place she gives reasons that may be due to shortage or constraint in their own country in form of religious sanctions, legal hurdles and social stigmas due to lack of privacy, no insurance, low technology and competence.

In most of the countries access to assisted reproductive technologies is not publically funded. The International Federation of Fertility societies particularly points out in the survey conducted that half of the countries have no compensation when it comes to third party assisted reproduction by the side of Government national health plans or through a private health insurance. The states for either religious or ethical reasons prohibit some or the other form of assisted reproduction. So legal restrictions imposed in one’s home countries are one of the principal reasons for crossing borders to get the treatment. Also long waiting periods because of lack of surrogate mothers have pushed the citizens to UK and Israel to avail surrogacy services outside their homeland. In UK, it was stated there was a waiting list of three years.

Between 2004 -2008 the number of gestational surrogacies has increased by 89%.[12] The reasons attributed to the increase in demand for treatments along with problem of infertility are the increasing “demographic changes” such as delay in age of marriage leading to further delay in child bearing and other factors like obesity or sexually transmitted infections. This demand is sometimes not fulfilled in one's own country that leads to the increasing trade in services. Inhorn states that out of the 191 members of World Health Organization only 48 have IVF facilities (2009). Among these countries also, we see a wide range of restrictions. These numerous restrictions and legal regulations along with a need to maintain privacy accelerate the movements across borders. The movement is then attracted towards the regions which makes these services available at low costs and hence we see a greater movement to the global south in countries like India, Thailand and so on.

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[12] Council for Responsible Genetics (2010) “*Surrogacy In America*” [Online] Available at: <http://www.councilforresponsiblegenetics.org/pagedocuments/kaevej0a1m.pdf> [Accessed 23 December 2014]

2.1.Ancillary Industries:

In the developing countries, the cross border reproductive care is being treated as a new export commodity thereby creating a bigger industry around it. This industry is accompanied by the growth in the pharmaceutical companies, semen banks, cryobanks, collaborations with international clinics, donors and donor networks, health care consultants, surrogacy agents, surrogacy law firms, the media and advertising industry, hospitality industry and tourism industry. Thus apart from the work performed in clinics and hospitals, the other industries also involve much larger gamut of staff thereby creating a new economic dimension as a reflection in ancillary industries.

The doctors and nurses employed in hospital, the agents and brokers involved in the deal, the semen banks and cryobank functionaries are the immediate employers. In the process of addressing the international clients, tourism industry attaches importance to this sector. The hospitality industry revenue is thus increased. The role of consultants and law firms are equally definitive in the growth of this industry since there are no laws guiding the stakeholders. And most critical role is played by the media and advertising industry without which it wouldn't have attracted people from all the places. Within this online advertisements and websites play a major role.

It is obvious that the ART industry comprises of a gamut of stakeholders. With the globalization of surrogacy services, this range is spread across space and time, and includes actors from different countries. However, complete details regarding these collaborations were unavailable and hence it is not possible to estimate their full scope.

India's fertility industry has beheld the progression of agencies that specializes in providing consultancy services to both providers and users of commercial surrogacy. Some of the examples of such industries working in India are mentioned here. Indian Med Guru, a consultancy firm, caters exclusively to international users. Forerunners Healthcare Consultants market itself as a pioneer in medical tourism. Trivector Scientific International promotes itself as 'the most trusted source for all Infertility Management Needs of IVF centers all over India and outside'.

Owing to the mounting demand for commercial surrogacy and absence of a related legal framework, specialized law firms and agencies have come up that deal with contractual agreements and legal issues vis-à-vis surrogacy. Mainly these services are availed by intended parents from abroad. The law firms also offers services to clinics, to ensure compliance with 'standards', so as to prevent legal problems from surfacing.

To quote from the website of Kay Legal, a Mumbai-based law firm which advertises its services as follows:

> "Our record of achievement in the area of surrogacy law has earned us [a] reputation for excellence and an ability to effectively resolve client matters. Our relationships, dedication to quality, unparalleled understanding of the law and devotion to client services at Kay Legal provide us with an ability to achieve outstanding results for our clients. We are a professional firm with a dedicated team committed to provide high quality, personalized surrogacy, representation and related legal services to help couples and individuals create the family that they have always wanted. We have more than 100 successful cases to our credit over the last few years for various IVF Clinics in India. You will receive skilled, experienced, personal legal help at every step...."

It should be noted here that these ancillary industries take up the major share of income. Especially the clinics operating the field along with the middlemen involved does not appropriate the due share of the services provided by the surrogates. In the recent years middlemen have led to chaos in terms of interacting with the surrogates. Cases of exploitation are reported. A personal interaction with Dr. Roma Satwik, highlighted the problems associated with the agents and thus recommended that there should be no involvement of agents. In organ donation no mediation is allowed so why in surrogacy? She advocated that the money should be directly transferred to the surrogate's account. Therefore unnecessary brokerage and agents should be eliminated to make the functioning of the system more transparent. [13]

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[13] While the ones who facilitate the existence of surrogacy industry i.e. surrogates are the ones who should deserve a major share of income but this is not true. This will be explained in the next chapter, as it's not the work, which she is paid for but also attaches with herself her socio-economic background that determines her income. And out the amount she is entitled too, the agents take major share in some cases away.

2.3.India as an attractive Global Destination for Availability of International Surrogacy Services within South Asia:

Describing the drive for couples to India because of low cost, lack of regulations and high quality medical care; the Lancet report gives an estimate of around more than 25,000 children born to the surrogates of India out of which 50% are from the West. The report stated that this practice though legalized in 2002, remains unregulated in the same way as the medical tourism industry.

Major countries like U.S.A, Spain, Belgium, and Cyprus are the hubs for assisted reproduction treatment in developed world. Countries like Jordan, Israel and South Africa exists in the Middle East and Africa region. With in Asia, Thailand, Malaysia, South Korea and India are emerging as major hubs. And as it can be noticed India is the major hub with in the South Asian region as also suggested by the WHO survey regarding the rise of medical tourism to India. Medical Tourism in these countries have evolved due to the favorable state of affairs available such as world class infrastructure, government policies supporting medical travel along with visa facilities, tourist infrastructure and most importantly lower wage costs and relaxed regulatory frameworks.

As explained in the earlier section, India’s fertility industry around surrogacy is growing at mounting pace along with the other industries. Tattara outlined the push and pull factors that make cross border reproductive travel possible: "Medical tourists are pulled mainly because of lower costs, availability of latest medical technologies and a growing compliance with international quality standards, as well as the fact that foreigners are less likely to face language barriers in India. Whereas the cost of treatment in other developed nations, especially in the US, UK, is excessive, India can provide quality healthcare at a very low cost due to the availability of relatively cheaper but quality manpower, low-priced drugs and other related infrastructure"(2010).

In South Asia, surrogacy is legalized in India since 2002. Other South Asian countries i.e. Pakistan, Bhutan, Nepal, Bangladesh, Afghanistan, Sri Lanka and Maldives have not legalized the practice of surrogacy. Though surrogacy is being practiced in some

form or the other in all the countries but due to the religious and social structures it has not been legalized. The situation in India is quite opposed to all south Asian countries as it has legalized and at the same time is progressively being defined as one of the most favored destination for the said reasons.

According to estimates by the Indian Council of Medical Research (ICMR), there were approximately 3,000 ART clinics in India in 2002. The Confederation of Indian Industry (CII) and McKinsey Consultants published a joint report, which specified that in 2004, around 150,000 foreigners visited India for treatments; additionally these numbers are rising by 15 per cent each year. Similarly Giuseppe Tattara had mentioned in his work that, 'India is the second Asian provider for medical tourism with an inflow of 4, 50,000 tourists in 2007'(2010). Plus it was also estimated by the Business Insider in 2013 that surrogacy industry in India is worth $400 million/year.

The Law Commission of India (2009:11) in its report stated that the entire infertility treatment was around 25,000 crore (Kohli 2011) of which surrogacy accounts for 2000 crore. And it was estimated by the Business Insider in 2013 that surrogacy industry in India is worth $400 million/year.

With this background of thriving surrogacy industry in India its reach is now been extended to its neighboring South Asian country Nepal. Nepal is a classic example in the emergence of International Surrogacy as it has allowed foreigners to avail the surrogacy services but has no guidelines for its own citizens. The workshop organized by the Women Rehabilitation Centre (WOREC), Our Bodies Ourselves (OBO) global partner in Nepal along with SAMA resource group on cross border reproductive health care where issues were discussed about the growing surrogacy arrangements in Nepal and the concerns of women acting as gestational mothers.

In the workshop they advocated for framing public policies to protect gestational mothers. One of the leading newspapers has stated that the cabinet has allowed foreigners to avail surrogacy services and it was reported by one of the private clinics that as many as twenty Israelis had surrogate babies including other foreigners.[14]

Surrogacy in Pakistan has not been accorded any legal status may it be for Pakistan's own nationals or foreigners. The first court case of surrogacy was reported in

[14] http://nepalitimes.com/article/nation/wombs-tolet-surrogacy-nepal,1991

Pakistan, where a married couple while living in abroad decided to make a surrogacy arrangement[15]. To make that happen the man named Farooq, married a lady Farzana and started the IVF process. After a few days of delivery the court decided to hand over the child to Farzana. In the move to get the child back, Farooq again filed the case against Farzana and appealed to the court that since he was wealthier he could take care of the child better.

Here, if we remember in Baby M case court decided to hand over the intended parents who had entered in contract, as they were wealthier, a completely opposite judgment was given by Pakistani High court. While stating that surrogacy has no legal status in Pakistan, the child would stay in Farzana's custody, the woman who acted as surrogate. After making another appeal against the court earlier judgment, since he denied any married relationship with Farzana, he again lost, as it was reiterated by the court that surrogacy had null and void status in Pakistan. (PLD 2013 Lahore 254). Thus, it is very clear that a child born out of surrogacy arrangement would not be recognized and no legislative framework exists to guide these arrangements.

While in Bangladesh, clinics providing assisted reproductive technologies are flourishing, though there are no clear surveys available to say that surrogacy practice is thriving. In Sri Lanka too, Dr. Milhan Batcha states that there are increasing demands for assisted reproductive technologies while both the egg donations and surrogacy arrangements have their limitations.[16] In Bhutan, no prevalence of assisted reproductive technologies clinics can be traced. Likewise for Afghanistan and Maldives.

A 'business climate' [17]that stimulates the subcontracting of labor, lack of binding industry regulation and famous tourists destinations, act as contributive factors for thriving of surrogacy industry. India enjoys vis-à-vis developed countries the cost advantage because of which the people from other countries are attracted. The study done by SAMA Resource Group on Women and Health in 2008 shows that an IVF

[15] The further details regarding the case have been discussed in the chapter on Legal Frameworks. For detailed reference, Khan Sharmeen 2014 "Surrogacy in Pakistan: Legal Perspectives" http://www.siut.org/bioethics/Sharmeen%20article%20final.pdf

[16] Attygalle, the Island. June 1, 2013. http://www.island.lk/index.php?page_cat=article-details&page=article-details&code_title=80322

[17] According to the law dictionary, business climate is defined as an environment of a given community that is relevant to the operation of a business; usually includes tax rates, attitudes of government towards business and availability.

cycle in India costs $2,000 (approximately Rs.90, 000) in contrast to the US costs around $20,000 (approximately Rs.9, 00, 000). A surrogacy arrangement, including IVF, costs about $11,000 (approximately Rs. 5, 00, 000) in India, while in the US, surrogacy alone, excluding ART charges, costs $15,000 (approximately Rs. 6, 75, 000). In the UK, an IVF cycle costs about £7,000 (approximately Rs. 5, 00, 000) and surrogacy costs about £10,000 (approximately Rs. 7, 00, 000). While in the US, up to 50 per cent of the cost of ART with a surrogate arrangement goes to the surrogate, in India most of the money is appropriated by sperm banks, clinics, etc.

"Since the advent of legalized commercial surrogacy and egg donation in India in 2002, a number of clinics in Gujarat, Delhi and Mumbai now specialize in providing commercial surrogacy and ova donation services oriented primarily towards foreign clients from the United States, Britain and elsewhere, including expatriate Indian couples."(Whittaker, 2011) In its study SAMA noted that out the sample clinics were located in thirteen districts, where users from districts located in at least nine other states visited the clinics. Thus we can say that this demand is not limited to where the clinic is situated rather crosses its geographical boundaries to provide and receive services across districts states and countries. Further more the providers in Uttar Pradesh and Tamil Nadu catered to the demands of couples from South Asia, Southeast Asia, the Middle East, Australia, Canada, Europe, the USA, and Africa. Another interesting fact was provided by the clinics operating in Allahabad, Meerut, and Agra that their foreign patients were primarily of Indian origin, with family associations in these cities and towns.

It is in this framework of globalized medical tourism that a new enlargement in the ART industry has surfaced. This means that there is an evolving trend of setting up of joint collaborations of the Indian clinics with that of clinics situated in other parts of the globe. This has helped in developing ties with international clients and further boosts the trust and confidence in the services being provided. For example, Planet Hospital (PH), a medical tourism agency headquartered in California, has an exclusive surrogacy arrangement with Dr Gautam Allahbadia, the Director of Mumbai-based Rotunda—The Centre for Human Reproduction. PH's client base is primarily American, including those of Indian origin, and also includes Europeans.

Typically acting as brokers between the 'clients' and the clinics, the agencies are forming base in the countries, reassuring the former about the reliability and specialized credentials of foreign health care suppliers placed in India, and synchronizing all aspects of the treatment, including specific requirements. Also to develop in house capabilities, ART clinics within India also enter into collaborations among themselves for conducting ART procedures. For example, technical assistance is provided by a clinician from Agra, Uttar Pradesh to other IVF clinics (referred to as collaborative centers) in other smaller towns, such as Bareilly and Gorakhpur in Uttar Pradesh, and Ludhiana and Ambala in Punjab, as well as to clinics in neighboring Nepal (Kathmandu) and Bangladesh (Dhaka). Similarly, a provider from Meerut was also a consultant at ART clinics in other towns in Uttar Pradesh (Bareilly, Meerut, and Allahabad) and in Punjab (Jalandhar).

2.4.Implications on Health Care Resources: Challenge of availability and accessibility of Surrogacy Services for the Internationals and Nationals:

The trade in health services is said to have opened huge opportunities for low income countries by providing job options and by further linking it to tourism, hotel and service businesses; encouraging private sector and most importantly adding foreign exchange to country's economy. But these advancements come with the plethora of negative effects, most glaringly on the public health system of the home country. While much classified, technologically sophisticated hospitals in the private sector serve the international clients, the less advanced services are available for the nationals of their own country or for the ones who cannot afford these advance services constituting the majority of the population. This in the process creates the two-tired structure in health systems affecting the treatments meted out to the international vis-à-vis own nationals.[18] . Therefore the WTO trade negotiations, which desired to create equality for trade in services has created differing effects on the public health system of developed vis-à-vis developing countries.

Considerably the grey picture that surrounds the practice of surrogacy has made countries ban the practice altogether from some of the US states to China, France,

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[18] Many scholars have criticized the growth of private clinics in developing countries like India who have the majority of population having no access to basic health care needs. And post 1990s the crossing of borders have led to increasing movements of international patients for other medical services which are provided at a lower cost.

Germany, Italy, Spain, and Turkey so on. Some impose partial bans such as countries like Israel, Canada and Greece while others let the practice prevail subjecting it to regulations like UK, Argentina and South Africa where there ethics committees are formed to evaluate surrogacy arrangements.

While the Industry exists under strict control of states such as in USA and California, Israel is a typical case of allowing the practice with the state itself playing the role of regulator. And finally the countries in which this industry thrives with no regulations, like India and Finland. Model followed in India is close to the California's liberal market model where major role is played by the private sector and agencies (Pande 2009).

The cross border reproductive care becomes an important area of study to look at how trade is affecting the countries own national health system, how its own nationals are treated and finally how the women who act as surrogates to facilitate this thriving business are perceived[19]. In the assisted reproduction treatment particularly where surrogacy is being practiced in Global South countries major fears surround over the question of access and equity both from the intended parents and surrogates point of view.

It is a major challenge to strike a balance between the rights of the individuals who cross national borders with the rights of the individuals who belong to that country and also the ones who are providing the services to meet the demand of both sections of individuals. The increasing movement of people across borders is clearly possible due to the available personal resources which one owes. Healthcare was earlier associated with the provision of specialized services which were not available in all countries and thus movement towards the technologically advanced countries was taken. But in the last two decades trade in medical services is being recognized as a new export commodity with a prospect to generate revenues and investment, which is expected to grow to US $100 billion by 2020 (Deloitte 2008).

Attributing technologies as a dominant force behind market led development; Qadeer has highlighted the role of reproductive technologies in benefiting the patient along

[19] Andrea Whittaker while analyzing the rising industry of the cross border reproductive care has highlighted the effects of how the global forces influence the local. Her work has been further expanded to make the sense the rising surrogacy industry within developing countries.

with earnings of profits. While the motives differ according to the social and legal structures in society, the impact of technology is not understood till it has created some negative situations on ground reality. She has pointed out to the grave deep-grounded realities surrounding the accessibility of ART services, which is prevalent in the market to those who can mobilize resources while on the other hand the poor who depend more on the public sector fail to get access to even simple services.

"India with a strong tertiary sector estimates 100-150 annual surrogate births with the tripling of fertility facilities, while infertility estimates remain at 8 to 10 percent, most of it being secondary and preventable"(Qadeer 2010). While it is understood that these services though easily affordable by the rich class of people, the demand is increasingly being made by the professionals and middle class are twisting the priorities towards creating more hi tech infrastructure in the market led by private sector while the public sector infrastructure still lacks the basic infrastructure to cure the problem of infertility itself. She states "Matching the needs of the rich for children to the economic needs of those whose basic needs are unmet, these markets use reforms to encourage financing of hi-tech ART services, knowledge and technology transfer, profits for professionals"(ibid).

Repeated studies in the area of impact of medical tourism have focused and analyzed on how the rising sector is challenging the distribution of health resources among the international and national patients and also among the public and private health systems. This raises the concerns especially in regard to developing countries and low resourced countries, where there exists a majority of population who cannot take care of their basic needs and amenities.

In the conference held in Canada, it was pointed out that in lieu to serve the international patients there is shift in public resources in India whereby the public health system fails to deliver primary health care to its own citizens.[20] It's been argued that the resources are being weaned away from the needy for the services of the affluent. One cannot accept the setting up of the luxury hospitals as a positive

[20] The discussions held during the conference were written by Runnels Vivien, Turner Leigh (2011) "*Bioethics and transnational medical travel: India, "medical tourism", and the globalization of healthcare*", Indian Journal of Medical Ethics, Vol. VIII No 1 January-March 2011.

outcome of liberalization when the same process is leaving health support system in doldrums.

The complex and dynamic relationship between India's health systems adaption to the new global environment is deserving of social science scrutiny. Several papers consider the implications of increasing medical tourism in India for national healthcare systems, either from the perspective of India or patients' country of origin. The potential accentuation of problems and inequalities within the Indian healthcare system as a result of medical tourism has been raised in several commentary and review papers.

Vijaya draws on a small number of interviews with nurses to highlight how the medical tourism market may take away resources that otherwise would benefit the public health system in India. So what can be drawn out that there is a health care divide. There are two India's: the country which provides high quality medical care to middle class Indians and medical tourist and the country in which majority of Indians live who don't have access to quality care (Vijaya RM 2010).

The role of state plays a pivotal role in making the universal health care for the whole nation. In the background of the role played by state, Qadeer that despite being a welfare state India chose substantial privatization of medical services has pointed it out. In contrast to it countries like South Africa and Brazil committed 4-6 per cent of their GDP for the welfare of the marginalized. India today comes under the category of most privatized health care services. Among this category Pakistan too finds its place along with Laos, Myanmar etc. Evidences show that privatization of health care services have never helped the marginalized, instead it further enhances marginalization. [21]

The increasing neo-liberal, market approach for providing health services to majority has been repeatedly questioned because in most of the cases it has failed to do so. Increasing privatization of healthcare led to reductions in public expenditure on health and that this disproportionately impacts on vulnerable groups. Rao illustrates that with globalization, there has been response to the international policy such as the

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[21] During the very short meeting with Dr. Sheila Mehra, she focused on how the issue of commercial surrogacy was a deeply classes issue. She said that there was a need to address why the ART services have not been part of the public health system.

Programme of Action, which promotes reproductive rights and health, stemming from the International Conference on Population and Development (ICPD). But these transmissions of neoliberal ideas can at the same time corrode the prospect of such gains through the collapse of the Indian public health system[22].

Petchesky states this in regard to reproductive health services where the "free market" approach has raised concerns of it being accessible to the minority that has personal resources and not to the majority, which needs it. The question here then arises about the problem of infertility existing in the respective resource countries and how far are the reproductive services being made available to address their needs.

2.5.Reproductive tourism or Reproductive Exile for infertile South Asian:

The travel across borders for accessing reproductive services is predominantly associated with tourism as it is a part of medical tourism and this is the starting point of contention. The question here arises, is it associated with tourism or is it linked with expulsion. Literature around it increasingly focuses on how the travel is more of a trouble than pleasure for the patients of the global south who under their social or personal obligations cross borders. This is broadly then defined as reproductive exile as stated by Maria Inhorn.

The practice of transnational surrogacy has gained popularity in India in the last decade while the practice is as old since the birth of the first child through IVF. It's been reported how couples from UK, Japan, and Australia have travelled to USA to hire surrogates because it was either banned or restricted in their own country. While world-class arrangements have been made to treat the foreign national as they add to the economy, it has been pointed that these technologies remain inaccessible to their own infertile nationals in low resource countries. [23]Despite WHO's call for setting up innovative approaches to solve the infertility issue in these low resource countries by use of low cost technology, it has been noted that efforts of developing countries have been more on creating a global trade in assisted reproductive care rather than for their own local populations. (Whittaker 2009)

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[22] Rao S (2005) '*Financing and Delivery of Health Services in India*', New Delhi: Ministry of Health and Family Welfare, Government of India.

[23] Inhorn, Marcia (2009), "Right to assisted reproductive technology: overcoming infertility in low-resource countries", *International Journal of Gynecology and Obstetrics* Vol:106:74-172.

While avenues are set open for availability of reproductive services to all the clients its accessibility can be defined more in terms of who can pay for it. The costs of IVF are compared to be 50%higher than the gross national income in countries like China, India, Malaysia and Indonesia [24].

In this context it can be stated that it is more of a money led industry where services are provided to those who can pay for it and not for all those standing in the queue in need for these services. While developing countries in the process of establishing themselves, as global hubs to enhance the medical tourism in their individual countries have not realized that there own nationals may be struggling for access to these services. This has been profoundly highlighted by Inhorn in her study of South Asian couples travel to Dubai. In the process of focusing on Western demand for reproductive services the locals are "forced out" of their home country. "In comparison with their infertile Western counterparts, local Indian couples may receive less individualized and privatized medical attention and poorer-quality care, leading to lower success rates, at cost that are made higher by the influx of more affluent Western ART consumers" (Inhorn 2009).

Reproductive exile was the term first used by Roberta Matorrars (2005), which was further described as forced travel by infertile patients and the problems thereby faced by them. Access to safe, effective, affordable and legal infertility care are major reasons for which patients are forced to leave their own home country in which "their choice to use ARTs to produce a child is voluntary, but their travel abroad is not". (Inhorn 2011)

While exile for reproductive services is increasing world wide, it is said to have additional meanings for South Asians i.e. for Indian, Pakistani, Bangladeshi and Sri Lankan workers who apart from not having access to reproductive services don't even have access to stable jobs for survival. (Inhorn 2011) Linking the economic exile with reproductive exile, Inhorn in her 2007 study has highlighted the migration of both Indian and Pakistani couples to the Arab Gulf for economic reasons plus in need of saving money for ART services.

[24] Bolvin J,Bunting L,Collins JA,et al, (2007), "International estimates of infertility prevalence and treatment seeking :potential need and demand for infertility medical care" , Human Reproduction, Vol: 22,12-1506.

Defining Arab Gulf as a “global hub for South Asians” two reasons have been explored by Inhorn in her study. First being, the historical ties with Arab Gulf and second being the availability of high tech information as well as health care services. Emerging as a global destination for medical tourism way back in 2010, UAE allowed the clinics to preserve and freeze embryos through its Cabinet resolution no.36 of 2009.[25] This resolution also permitted the private clinics to practice IVF treatments. Preceding this resolution only government clinics were allowed to undertake this treatment.

Way back in 2007 there were nine private and two government IVF clinics. The study was conducted in one of the private clinics of UAE called Conceive, the Gynecology and Fertility Centre which directed by Indian born and Bristish educated Dr. Pankaj Shrivastav who has employed a multi national and multi sectarian clinical staff, from Middle Eastern countries to South Asian countries as well as from major religions. Needs of the local Emirati couples, expatriate community living in the UAE and many reproductive tourists coming from Middle East, South Asia, Africa and Europe are catered to in this clinic.

Spanning over six months the study involved itself with 125 patient-couples from exactly fifty countries in which majority were Indians followed by Lebanese, Emiratis, British, Pakistanis, Sudanese, Filipinos and Palestinians in rank order. Out of them thirty-three couples studied were from India belonging to Hindu, Muslim and Christian community. There were six Pakistani couples and one couple from Sri Lanka.

For South Asians travel to UAE in search of employment is a self-imposed economic exile, however the travel for reproductive tourism can be well described by the term as involuntary reproductive exile. The reason to travel to Dubai for ART services was excessively attributed to the untrustworthy medical care by Indians as well as Pakistanis. Pakistanis also crossed borders in absolute faith in order to avoid the stigma that is attached to IVF in a Muslim country. Even the Indians present there were totally secretive about their treatment in Conceive.

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[25] https://www.uaelawblog.com/ivf-law-uae/

Much of the travel is associated with tourism that means a much happier term but for the South Asian patients the term tourism is problematic as it was stressful as well costly to fulfill their need of a child. “As one of the male patient at Conceive put it, “ Reproductive tourism” sounds like a gimmick.” And for them they never used the term holiday or tourism to describe their trip. Almost most of them complained about the poor service quality provided back home.

They recognized the disparity of the services being provided for reproducing a child for brown couple in contrast to a white couple. Thus the stories of Indian and Pakistani who have traveled to Dubai in their quests for conception described their journey as arduous, expensive and very stressing. It’s not then the desire for procuring a child but more of the pressures that are imposed by social setting.

The story of Beena and Atul focuses on how the home country India could not fully diagnose their problem and their travel first to Mumbai was exhaustive as well as expensive. Apart from huge waiting time the doctors just gave them two to three minutes and it was felt that they were being experimented upon. Mahmoud and Fatima who have been residing in UAE for last six years and their arduous journey to and fro to India and then back to UAE is something which highlights how a quest to have one’s own child makes them cross borders and undergo surgeries which narrate another not so happy story.

It was at Conceive that they underwent an IVF cycle but in complete secrecy from their family and relatives as it attracted negative sentiments within the Indian Muslim community. The story of Omar and Aneela dates back to a journey undergone to and fro from Pakistan to UAE. It was after thirteen years that there only hope was to undergo an IVF cycle but due to religious restrictions and high cost they underwent an IVF cycle at Conceive. In his conversation, he stated that most Government hospitals in Pakistan did not have IVF treatments while the private clinics extended their services to the Pakistanis who worked overseas and were earning well to undergo such high cost treatment back home.

Thus the major themes as highlighted by the narratives of South Asian couples surround the fears of poor quality health care along with high cost involved and the need to maintain secrecy because of the social circumstances for religious or other reasons as the reasons for crossing borders and travelling abroad.

2.6.Defining parenthood:

While the demand was mainly from the heterosexual couples till quite some time but in the last decade of twentieth century, greater demand has been raised from the side of the single parents and homosexuals. One of the earliest cases that have been stated in the newspaper is that of Svenska Dagbladet, which mentioned that, the Swedish gay couple hired American women who would just take money to cover her expenses to bear a child for them. Countries like UK have allowed the use of surrogacy for single parents and homosexuals but restrict its commercial nature[26]. Though being a money based market oriented industry still some countries restrict the surrogacy services to heterosexual couples. Though recently the rights of the homosexuals have been recognized their desire to have a child of their own is being restricted. Thailand with no regulations and laws because of the recent scandals has attracted the focus of authorities making surrogacy difficult and in very specific circumstances.

Countries like Russia and Ukraine completely bans gestational surrogacy for the homosexuals. The same can also be stated in the context of India where the latest guidelines have banned the right of foreign single parents and homosexuals to avail surrogacy services. [27] Typical case of Israel were the law restricts access of surrogacy and adoption to gay men and also to the Palestine women residents of East Jerusalem who are married to non citizens especially a man from the West Bank. (Hagel and Mansbach 2015)

Because of the advocating stringent rules in India where the commissioning parents are suppose to be married for two years and also get a letter to be recognized by their home country the entry of child as legal citizen, Nepal is emerging as a new favorite destination for the gay couples round the globe. Another new center, Mexico primarily focusing on the gay market with less than half the price of US has surfaced in recent years.[28]

2.7.Need for Availability and Accessibility:

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[26] http://www.stonewall.org.uk/at_home/parenting/3558.asp
[27] http://world.time.com/2013/02/15/why-people-are-angry-about-indias-new-surrogacy-laws/
[28] http://www.theguardian.com/world/2014/sep/25/tales-of-missing-money-stolen-eggs-surrogacy-mexico

It has been noted that these restrictions inevitably leads to illegally of crossing borders by infertile couples turning them to "criminal". (Whittaker, 2011) It can be concluded that because of the social, cultural, religious restrictions in one's own country leads to crossing borders to avail surrogacy services. This chapter borrows much from the legal frameworks adopted across the world, which would be detailed further in the fourth chapter. Here the aim was to look at how differentials exist when one looks at the question of accessibility for the intended parents of North vis-à-vis South. And how this further reinforces the differentials in terms of availability of world-class services and infrastructure for the few in relation to many.

Though one cannot deny that the one who pays, gets the services, the increasing gap between the incomes of the rich and poor need to be addressed. Much can be resolved if efforts are made to make the industry public oriented available in the public sector. Argument is not to deny or ban the services altogether but to bring it up in public hospitals with more effort for equal availability. The need of the hour is then to make the services according to need and not just for the one who can pay for it.

Along with the availability, the effort should be made to make sure that the world-class infrastructure such constructed should not take away resources that could satisfy the needs of the nationals. ICMR Guidelines provides solution to this which state that the profits earned by cross border health services should be used to subsidize the public health systems for accessibility of poor local populations[29]. Such suggestions if implemented would address the need for accessibility and availability for all and not just a few.

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[29] Indian Council of Medical Research, Ministry of Health and Family Welfare ,Government of India , "National Guidelines for Accreditation, Supervision and Regulation of ART clinics in India, New Delhi.

Chapter 3

ECONOMIC AND SOCIAL EQUITY FOR THE SURROGATES OF THE GLOBAL NORTH AND SOUTH: SITUATING THE SURROGATES OF SOUTH ASIA

The understanding of commercial surrogacy in the last two decades has to be interlinked with the rising global world. With great interconnectedness, commercial surrogacy as has been learnt in the earlier chapter has emerged as a transnational phenomenon, where in it is being treated as a new export commodity being part of larger phenomenon of reproductive tourism. In the process of transnational surrogacy new citizens are created for which neo-liberal ideology is adopted by the clinics which is argued by Krolokke and Pant as a concept of "repropreneurs"[30]

> "As a model for action based on *economic entrepreneurship* (emphasis added) in which the reproductive citizen is transformed from the passive citizen of the welfare states or the poor citizen of neo-India into an active "repropreneur"- the mobile reproductive client/consumer/assistant'worker of a global economy in reproductive services."

The neo-liberal ideology describes an individual as a rational, choice-making, and responsible individual that fits well into the discourse of surrogacy for the infertile couple as well as the surrogates. While the infertile couples take the direct personal responsibility to make a choice to get a solution for their problem of not being able to conceive a child. A surrogate on the other hand, is said to be defined as an individual having a right over her body to decide for herself.

This is the dominant argument made on the notions of 'choice' and 'autonomy' which to describe in Raymond's words, is advocating "reproductive liberalism" as the right of the surrogate over her body to choose and make decisions. The clinics market on the language of the argument on autonomy. To state an example here, Dr. Patel of Akansha clinic reports that the process profits all the parties concerned. While

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[30]Krolokke H Charlotte and Pant Saumya, 2012, " 'I only need her uterus': Neo-liberal Discourses on Transnational Surrogacy" Nordic Journal of Feminist and Gender Research, Vol. 20, No. 4, 233-248.

intended parents realize one's right to parenthood, surrogates fulfill their economic needs.

3.1.Surrogacy as a Work and Surrogates at the core of the work:

Work is defined as any physical or mental act, surrogacy as a work involves both. While a surrogate physically delivers a child for the intended parent at the same time mentally she is involved in the act. The extreme profiteering of the surrogacy industry as a multibillion one is due the availability of the women providing materials and labor (Spar 2006). The economics of surrogacy surrounds around the surrogates and therefore it is important to understand how surrogates understand the economics of this practice.

This chapter in the above context explores the dimensions of a woman's motivations to participate in the process of surrogacy. While analyzing the motivations attempt would be see the differentials, if they exist, between the motivations behind a woman's decision to act as surrogate in Global South in comparison to the Global North. In this regard then the aim would be to specifically locate the position of the surrogates in South Asia.

Surrogacy as sexual and reproductive labor has been under controversy has and been both accepted and rejected. The feminist's view of challenging the patriarchal notion of biological division of labor has been further pushed by surrogacy being adopted as a form of work and not a private affair. Firestone acclaimed the potential of reproductive technologies to challenge the domestication of women's sexual and reproductive labor by providing them liberation and autonomy. This autonomy is not only is financial but also enhances her role as a decision maker (1971).

The self-dependence and voice the surrogates enjoy in home after earning their own money. While most of the Indian women depend on their husbands and spend according to his wishes. Being surrogates gives then financial independence and they become self sufficient and decision makers though their husbands still try to deny this independence. Such instance is highlighted in Pande work where Parvati spent on her own well-being even when her husband didn't want her to do so. Also what is interesting that these women who in most cases had to work at some one else's homes to earn money, now felt better off at these clinics being pampered and cared for.

It’s argued that if individuals can contract as well as reproduce then why not reproduce under contracts. It is trade of woman’s labour and not the woman herself (Spar, 2005:294). Whereas a critical analysis of this romanticized interpretation of surrogacy as an arrangement needs attention. In contrast to giving autonomy commercial surrogacy as is argued by Berkhout, is said to undermine a women’s self respect which is critical to her autonomy (2008). Similarly Goodman advocated for a comparison of commercial surrogacy to slavery and baby selling in a free market (2008). In the similar vein, Ekis Ekman treats surrogacy as another form of prostitution (2014).

Also there is always a need to assure that the women are not being coerced or bullied by the brokers or her extended family. And this is what is a point of debate that who will decide that the woman who is offering her services is doing out of will or is being forced to do it. One of the implications of being a surrogate in the Third World village is that she may be called a prostitute or she may see herself as one because of the social stigma attached to it. It’s still not seen as a reputable job in Third World countries.

> “There have been cases of trafficking. There have been cases of default. If a child is stillborn or disabled, or if there is a miscarriage, or if an inadequate embroyo has to be aborted, does the unsaleable outcome invalidate the contract? The surrogate was promised payment in exchange for a healthy child. She may be denied her money if her workmanship is poor.”

3.2.Wage Differentials between Surrogates of the North and the South:

Usually a highly skilled worker is paid more than a comparatively less skilled worker. In the context of work involved in being a surrogate who does not involve any differentiation between skilled and unskilled labor defines this notion of differential payment. Still the feminist’s discussions mostly focus on the exploitation involved in surrogacy due to differentiation in the amount of compensation paid to surrogates globally.

Spar has argued that given the national and transnational inequalities in a market, the practice has turned coercive influencing the surrogates' decision to participate in the arrangement (2006). Along with this, by compensating, one is objectifying women's reproductive capacity, in effect giving away control over her body. On the other hand if surrogates are not compensated for the physical and emotional service performed for the others is also problematic.

This compensation is also context specific and the level of exploitation in compensation is also context specific as stated in the comparative study of Israel and the US. Israel addresses the issue of compensation in a multi pronged way as the list of compensation is as follows: "Among other things, reimbursement for the inability to work, household and childrearing expenses in case of bed rest, life insurance and compensation for any medical procedures the surrogate mother must undergo" (Hagel and Mansbach 2015: 13).

Nevertheless the debate in Israel surrounds on the need for additional compensation beyond the list. The need is to compensate the surrogate during medical evaluations, and not after the detection of child's heartbeat as discussed by the feminists. Issues are also raised in contest of little compensation in case of miscarriage or failed treatments. Thus the advocates argue for a more equitable process where the state should define a minimum payment including the emotional and psychological stress of surrogacy.

Arguments are made on the other hand for the need of surrogacy to be altruistic, as that would motivate the surrogates to recognize their act as a contribution and not just a service. This would defy the economic transactional nature of the arrangement, and make surrogates empowered throughout the process of gifting a life. [31]

The study of the surrogacy arrangements occurring in EU member states shows that in France the surrogates' not just belong to France but also to Belgium, UK and non-EU countries like US, Canada, India, Russia and Ukraine. United Kingdom too reported surrogates from India, US and Ukraine. While on the other hand Belgium and The

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[31] During a small conversation with two doctors present in a book release, there were two contrasting viewpoints stated. While one of the doctor stated that surrogacy services should not be exploited in a poor country, while the other doctor stated that it empowers a woman by making her financially independent. In maximum number of cases, we encounter the financial compensation what the surrogates makes them empowered.

Netherlands with less number of births compared to France and UK had surrogates belonging to their own countries. [32]

In each of the European countries, surrogacy was commissioned on a non-commercial basis, the costs to obtain a surrogate child by the intended parents varied widely. Costs were said to be highest in France around 70000. In Greece it ranged from 14000 – 50000. This costs covered the expenses relating to childbirth including the cost of IVF, agency fees, transportation and legal expenses. In Greece a surrogate is also compensated for the loss of earnings and in UK too a certain amount of compensation could be considered for some cases. Every country has some criteria for the surrogates ante natal care during pregnancy. Surrogate mothers do receive psychological support in Belgium.

The compensation to the surrogates in the US ranges from an average $35,000 to $ 1,20,000, which is much higher in comparison to other nations. Though the market pressures that require the industry to expand drive this. This would lead to the women from the lower socioeconomic status to obscure the potential risks involved in the practice. This issue is not just in case of United States but also in all the states where surrogacy industry is guided by market forces. The main risk thus is the extraordinarily high payment to the surrogates.

Though one may argue the differential payment system as exploitative the author has tried to highlight that the rewards change with the localities.

> "Remuneration for a surrogate in India lies between US$4000 and US$10000. In the United States an equivalent surrogate would charge in the neighborhood of US$32000 to US$37000. The difference could be in the ratio of 1:10. In India an educated woman in industry or agriculture would earn less than US$2 a day. In the United States an uneducated woman paid at the federal minimum wage would earn US$7.25 an hour. The difference, assuming the woman puts in an eight-hour day, is

[32] This data has been taken from the study, which states that there were limitations in collection of data. There were only some clinics that reported back. And also in most cases official data are not recorded and thus there are no national figures. However UK figures are said to be somewhat accurate, as parents are required to obtain a parental order (PO) to get legal responsibility. Its been said that during the period 1995 to 2007 some 33 to 50 POs are granted each year.

> not far off 1:30. The disparities are neither fair nor unfair. They are what they are. That is how the market system works. That is how the agreed upon game is played".

While this is in question because there is a need to adjust the local price upward to ensure the purchasing power strategy and thereby not become a destination just to exploit the cheap surrogates available in low developing countries like India, Thailand or for that matter Nepal. He suggests that as the street vendors adjust the prices and uprate it to somewhat a level that a tourist would pay at home similarly what Humbryrd suggests should be adopted.

Humbyrd advises to set up a broad national category to fix a price to be paid to Indian surrogates when she is reproducing for Americans. "Nominal wages may be less to surrogate mothers in developing countries compared to their counterparts in developed countries, but the real wages should be equivalent"(Humbyrd, 2009: 117). This would thus mean that the person could buy an equivalent basket of commodities in different countries to which the buyers and sellers belong. This thus would be in line with the fair trade principles. [33]

3.3.The knowledge of Decision making among Surrogates: Choice or Necessity:

The most problematic issue among the formal mechanism of arranging a surrogacy arrangement is that of informed consent. Whereas one must not ignore the fact that it's the clinics that address the needs of intended parents and the surrogates, in which the needs of the former are preferred over the latter. This priority is accorded only because the former gives a wholesome amount to the clinic on which there profits are based. In this scenario then there are chances that there must be incomplete or inaccurate information would be transferred in some cases. Apart from this situations gets complicated when the surrogates are not educated enough to read through the contracts. And the wish to earn money drives them to take up this risky venture without knowing the consequences.

The dominant Western ethical argument criticizes the language of "choice" in transnational surrogacy, which outshines the limited "choice", the surrogate's

[33] Reisman David (2014) "Trade in Health: Economics, Ethics and Public Policy" Edward Elgar Publishing, Cheltenham, UK.

exercises. While portraying the Third world woman as empowered to have control over their bodies and decisions, surrogates are depicted as helping the First world woman. However the choices don't occur in a social-cultural vacuum. Stressing the amount earned by a Indian surrogates around $5000 ans $7000 who would otherwise earn about $300 a year, the Lancet report raise the question of these financially vulnerable women being exploited by the system. Along with the financial desperation, no other job alternatives also adds to the vulnerabilities to the surrogates position. [34]

In words of Damelio and Sorenson, while a woman's options to earn expands by contracting out heir wombs, it does not validate their choice or what they would prefer to do because they realize the price is too high for refusal. In the globalizing world, structures of inequalities are reinforced in the process of transnational surrogacy. It is thus their unfortunate situations as expressed by surrogates themselves as 'majboori' or 'compulsion' highlighted in Pande study. (Pande 2009)

> "In other words, reading the 'Third World' surrogate's experience as empowerment simply on the grounds of choice/decisional autonomy, and romanticizing her subject status on the basis of this without going into the problematics of consent, leaves out any scope for addressing the oppressive socio-political conditions (both local and global) in which she takes up or lives out her identity and sense of agency as a surrogate. In other words, if the surrogates status as a subject is romanticized, then theoretically it becomes difficult to talk about the larger social world she inhabits with its constraints of poverty, social ostracism, lack of access to certain basic necessities as children's education (especially for the girl-child), and so on."

Emerging as a new industry, activists in Nepal are increasingly raising concerns for the Nepali women who could be forced by middlemen or their relatives to carry babies for foreigners. Serious concerns highlighted by Renu Adikari of WOREC

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[34] Priya Shetty, World Report (www.thelancet.com)Vol 380 November 10, 2012.

(Women's Rehabilitation Centre) in case of no laws on surrogacy, which can result in forcing women against their wishes and also cases of trafficking. Story of twenty seven year old Nargis (pseudonym) portrays the compulsions, which forces a woman to work as a surrogate. After being left by her husband with whom she stayed in Mumbai she had no money to survive. Her own mother suggested her to rent her womb and she came in touch with a middleman.

For first six weeks she stayed in Mumbai and in her fourth month she crossed border to enter Nepal where she was suppose to stay with other surrogates in a hotel because of the restrictions in India. After delivering the child in Kathmandu she went back to Mumbai but stated that she would do it again so that she could send her own child to school. It was reported in the same article that agents looked for women aged between 25-30 in Mumbai's slums, and for every successful birth in Nepal are awarded with $1000. Similarly story narrated by Radha highlights the way woman are forced to act as surrogates for foreign parents in Nepal.

3.4.Temporary Survival Strategy with Differential Treatments:

Though a global debate regarding the commercial nature of surrogacy is criticizing against the use of women's womb as a product to be bought and sold, it is particularly intriguing for the women of developing low resource countries women to act as surrogates. It is widely known to be more of an "adaptive preference" rather than a free autonomous decision (Donchin 2010). Described as "bioavailable" population of women, Cohen states the reasons of poverty and patriarchal set up for women of developing countries to agree upon to act as surrogates (2005).

Ethnographic study (2006 to 2011) conducted by Amrita Pande in the entire Global South describes the global trend of international surrogacy in the concept of "stratified motherhood" the term coined by Shelleen Colen to describe power relation between West Indian nannies and their female employers. However, this term is increasingly being used for describing the power relations existing in the process of assisted reproduction technologies, particularly surrogacy. In a much broader contest France Winddance Twine conceptualizes all reproductive functions of women to be stratified along the power defferntials, she defines surrogacy as "stratified contract labor".

The changes to the Indian guidelines which are yet to be passed as law does not address the rights and concerns of the surrogates and only further perpetuates the trend of “stratified motherhood” where the historically advantaged women of upper class race enjoy the right to reproduce at the expense of the women of disadvantaged class or race (Pande 2014). The surrogates as Reisman claims are treated as business asset and it is this status that reflects their lower status of being from the Third World. Emphasizing on the debate regarding surrogacy he stated that it was more of debate for equality of respect along with the right of being a parent. A surrogate empowers ‘unknown other’ who may be a “single homosexual, a same sex partnership, an infertile couple, a postmenopausal woman, would be mother unwilling to undergo the trauma, dangers and stretch marks of childbirth”.

Notwithstanding the arguments of use and control of Third World women by the First world in transnational surrogacy, Banerjee has argued that these stereotype categorization of woman is among the first reasons to distort the perceptions of Third world woman as passive and inherently powerless victims. Chandra Mohanty, according to whom the idea of categorization is surrounded around hegemonic constraints to serve colonialist agendas, further helps reify the object status of Third world women in contrast to powerful first world women. This Mohanty describes as enforcement of “Third World difference” (Banerjee 2010: 110). The survey conducted in the years 1970 and 2003 raise 5 major questions regarding the ethical implications in International surrogacy especially in the context of countries like Russia, China and India have given particular attention to the large wealth and power differentials that exist between the intended parents and the surrogates. (Sapsed 2014)

The analysis of these Western dominant discourses in the contest of transnational surrogacy as a debate between the power and activity on one hand v/s the powerlessness and passivity and exploitation on the other hand reflects a major gap in understanding. Banerjee who believes that the power dichotomy of having or not having power is itself flawed explores this area. With the help of Mohanty’s arguments, she states that the understanding of “power over” [35]does not help one solve the issue of injustice. As it would clearly mean to turn the tables and let the

[35] As stated by Banerjee, “power-over” is one of the dominant stand to understand power as a form of domination.

other have power over the same thing. This does not address the core issue of justice at hand. This only opens another door for oppression and exploitation.

Drawing a feminist pragmatist framework from the works of Follet, Banerjee has highlighted the need of understanding individual not as a separate entity from others but in relation to the whole. Stating the gaps that exist in the popular understanding of transnational surrogacy from a reproductive liberalism framework or exploitation paradigm, she attempts to apply the pragmatist logical-ontological framework to focus on the relations rather than on entities. According to Banerjee, reproductive liberalism fails to account fro the social context in which an individual exists and only addresses the issue in a non-relational notion of individuality, the exploitation paradigm focuses on the passivity and victimization of women and fails to pay attention to the actual realities of the situation.

This provides an alternative understanding of the surrogate's situation that emerges in a particular "geographical-political-economic situation" (Banerjee 2010:113) By taking the complexities that exist in everyday experiences of power, the strength of ontology of relations is to understand individual as relational individual and not a particularistic. Banerjee using Follettian language illuminates how our experiences of empowerment and disempowerment arise because of these relations. While understanding power as an ability to act, Follet has defined genuine power as power-with and pseudo power as power over. (Ibid)

This relational understanding of individuals as well as power can thus be understood in the existence of the practice of transnational surrogacy. At the first place what clearly comes out to ones understanding is the differentials that exists in terms of economic resources between the Third world women in contrast to First world women. The First World commissioning parents, as Dr.Patel states are just ordinary middle class couples who are not able to access the surrogacy services in their own country due to social or legal problems.

Banerjee states that it's only by the virtue of their relations with the transnational surrogates of Third world, that they exercise the power to choose as a real "consumer choice" (Ragone 2000). This choice is evident when one comes across the services

those are available for the international couples. For example, Dr. Rama Clinics in Hyderabad advertises that the microscopes are from Japan and the test tubes are from United States and so on and only the surrogates are from India.

On the other hand, surrogacy seems to restructure the lives of the Third World women who act as surrogates. It has been widely acknowledged that the poor women are in maximum cases confined to low paid jobs with unsafe environment and no security. For them, being pregnant and gaining money is more of an act of earning money rather than exploitation. As Sofia Vohra, a surrogate for a U.S couple stated that crushing glasses for 15 hours a day was exploitation in comparison to becoming pregnant, as quoted in Haworth study (Banerjee 2010).

Increasing reports and diverse interviews suggest that surrogacy helps poor woman from a particular group which faces disadvantages in terms of class, caste, education, less paid job opportunities and so on. The point remains, nevertheless that the power with-with which the surrogates experience have to be looked into from the fact that this exists in the larger picture of asymmetric power relations or a "power-over" situation. Moving away from the dominant perception of confining herself according to her gendered role of acting as a womb carrier while being financially independent, she suffers from a deep sense of alienation maternal fetal conflict.

Alienation is then experienced in two ways. Frist, from the child whom they carry during the term and second, from the society they live in. Discussing the first case, it has being noted that in the context of transnational surrogacy, new hierarchies are created in terms of color. In Bhatia's interview of an intended parent named Susan Morrison, power differential in the relationship between her and surrogate is exposed due to the awareness of the fact that the surrogate was from a poor background and also indicates the sense of racial differences that exists in the mind of the intended parents " it would not have been in her [the Indian surrogate's] interest to keep the babies because she could not afford to –and in any case they were going to be white kids and it would have looked a bit funny"(Banerjee 2010: 118).

Finally it is important to understanding the fact that undertaking surrogacy is a temporary survival strategy. It is not sufficient to raise someone's, neither economic

nor social status. Given in the Indian context it is apparent, how a surrogate hides the fact from the relatives as well as society they live in. The society does not consider it as a work; it is looked upon as some kind of stigma or taboo. It is not capable of addressing in the Indian context the larger class, caste and gender hierarchies.

It is thus important to understand the possibility of being a victim even when one is exercising her choice or at least appear to do so. Adding a level of richness to our analysis of the phenomenon of transnational surrogacy for the surrogates who over the period of time have denied reducing themselves to a mere passive being, in contrast to the First World women, still is a victim. And even though the First World women are dependent upon a surrogate do not experience the same level of victimhood as faced by a Third World surrogate.

Though she feels that she is a victim but she experiences and compares the experiences she had while she delivered her own child. As a surrogate, the surrogates feel practical advantages and luxuries, which they never felt during their own deliveries. While these smaller benefits of being treated in a much luxurious ways as surrogates, which they had never experienced during their own child's delivery, the larger picture cannot be ignored. Paradoxically, while being pampered for their healthy being, the same surrogates also pointed to the fact that there was a lot of control by the clinics for the ultimate well being of the child. It's only for the baby who belongs to the higher class that is of importance to both the clinics and the commissioning parents, which is of a major concern and not the surrogate themselves.

> "As lower –class women giving birth to lower –class babies, their own pregnancies are treated as everyday occurrences that don't even deserve any prenatal or postnatal care and attention. As surrogates, however, they become wombs for "precious" middle class and international babies. Their bodies become temporarily worthy of care because they are using their bodies to produce babies for rich (er), couples, often times from the Global North."(Amrita)

Anthropologist Rayna Rapp brings into focus the contradictions that existed in two contrasting situations for the same women who did not have access to sterile clinics and C-sections for her own deliveries but were being provided with best facilities for acting as a surrogates pictured the much sought after reproductive hierarchy. "The fertility, bodies and reproductive decisions of lower class women get revalued only in so far as these women serve as human incubators for their richer sisters."

The survey which was conducted by Pande over thirty surrogates reflected the fact that out of those only two had normal deliveries and rest had to undergo a caesarian section. Defining these babies as "precious babies" the clinic prefers it this way against the wishes of the surrogates too at times. In her study, she mentions an incident where a surrogate named Ramya who delivered twins to the parents from US talked about the use and abuse of the women's bodies for the sake of the affluent.

Giving a solution to this relational analysis, Baneerjee used Follettian texts from Creative Experience "We do not want either side to sacrifice its interests for we want nothing lost, we want all the interests for we want nothing lost, we want all the interests to be reunited". She submits that integration is not submission, domination or compromise. Thus providing a starting point for further analysis "relation", Baneerjee calls for innovative ways to create more power to decrease the power-over.

3.5.Surrogates Exploitation being Specific to Local Context:

The intention of this section is to sketch the profile of surrogates from different countries; who the surrogates are? What's their socio-economic condition and what are their employment or unemployment statuses? For this purpose three countries are taken into consideration; the USA, Israel and India. Three of these states with high participation in ARTs have deployed different methods for regulating these practices.

The comparative study for the US and Israel observed that both the country's had a framework for allowing the fertility treatment. On one hand Israel supports the use of fertility services by legalizing as well as funding it, the USA on the other hand adopts a laissez faire approach. While India's case would be discussed further.

In the US, the economic forces drive the industry as this is highlighted by the way surrogates are chosen. They reflect the dynamics of market as location of surrogates is

from the socially and economically marginalized communities. The economic incentives promote the women who willingly accept the risk associated in serving as a surrogate. While in some other states where the third party and physician are responsible, they check the emotional strength of the surrogates to avoid the risk of litigation later. But these structures too don't look at the emotional or physical well being of the surrogates. "The market based pressures driving medical professionals to efficiently secure a surrogate substantively increase the risk of the surrogates exploitation."(Hagel and Mansbach 2015: 10)

In contrary to the US, Israel has developed a regulated structure to check the medical and psychological well being of both intended parents and the surrogates and which they place in front of the surrogacy committee to get started with the process. The committee understanding its role has established specific requirements to protect the surrogate mother. They state " surrogates must be between 22 to 38 years of age, single[36], with at least one child and not more than four. Additionally, the surrogate cannot be related to either intended parent."(Ibid: 10) However, with the increasing pressure from the Israeli Women network, provision has being included in the case where the intended parents are not able to find a single woman, a married woman could act as a surrogate. [37]

Lipkin and Samama in their report stated 70 percent of the surrogates had a high school diploma and approximately for 80 percent surrogates declared economic incentives as a motivation to participate in the practice.[38] Even though the committee considers married women in case of non-availability of single mothers, the requirement of single mothers is itself considered exploitative. Hagel and Mansbach stated that by limiting it to single mothers it is in a way targeting the most marginalized section in the society who are financially and emotionally at a disadvantage who do not have a support as opposed to the intended parents who are always a couple. So during her pregnancy she lacks emotional and psychological

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[36] The requirement of a single status woman was because of religious reasons as it was considered wrong for a married woman to be fertilized with a sperm of a man who was not her husband.
[37] Almagor Lotan, O (2012) "Egg Donations in Israel" Knesset Report [In Hebrew]
[38] Lipkin, N and E, Samama (2010) "Surrogacy in Israel: Status Report 2010 and Proposal for Legislative amendment" http://www.isha.org.il/upload/file/surrogacy_Eng00% 5B1%5D.pdf

support that further intensifies her exploitation. In 2014, however a bill passed by the Israeli Cabinet has risen the age of women to act as surrogates from 36 to 38 and would only offer services for up to two children.

Since Independence, Indian state undertook strong measures to stabilize the growth of population through family planning being the first state in the world to do so. The state adopted targets and gave financial incentives to promote sterilization. The reproductive technologies is vastly gender asymmetrical and along with that class asymmetrical too as in the case of modern contraceptives were adopted by the State to stabilize fertility rates. This State again surfaces itself in the assisted reproduction and actively promotes Indian women to produce babies to enhance their family income. While women act as surrogates according to the conditions determined by the state, the country is increasingly being defined as a global destination for surrogacy adding to the economy of the country.

In her study, Pande explored life of the women who were acting as surrogates who were mostly in the age group of 20 to 45 years. They were all married, from the neighboring village except two. 14 houses wives, 2 worked at home and others at school or farms or stores. They were mostly illiterate or maximum educated to the high school level, with an average of having only the beginning of middle school level education. The median family income of women were about INR 2500 per month which according to the definition of poverty line as given by Planning Commission of India put these families in the bracket of below poverty line. Financial desperation or medical emergencies were the most common reasons stated by the surrogates during their term of pregnancy to participate. And the money earned a source of pride or indicator of their productivity.

The bill has redefined the profile for the surrogates. The age has been reduced from forty-five as in 2008 draft to thirty-five in the present draft 2010. The number of successful childbirths permitted to surrogates is however increased from three to five. While accessibility of surrogacy child is explicitly permitted to single women, it neither prohibits nor permits single women to act as surrogates, which has left its interpretation open. The compensation to the surrogates is to be paid in five installments instead of three as stated in 2008 bill. However the majority i.e. 75% would be paid as final installment after the delivery of the child.

The universalistic experiences accounts for the existence of structural inequalities that lead to exploitation of the marginalized populations to whom the reproductive labor is shifted. It is because of this they argue for the complete elimination of the practice. Nonetheless this approach lacks the vision to look into the local forces that act and shape the surrogates immediate well being. This viewpoint then does not help the policy makers to address the issues, which are contest specific in individual countries.

As highlighted by the study the way inequalities are structuring the selection process in both countries i.e. the USA and Israel amplify the exploitation of the surrogates in an exploitative system. The health of the surrogate is only prioritized only to the level that she can bear the child. The long-term health implications are not taken into account. What needs immediate attention is that surrogates globally face the same medical risks as that of pregnant women but her risks are multiplied because of reasons like self injection of hormone treatments to align the surrogates cycle, reactions to stimulations like nausea or headache or sometime ovarian hyper stimulation syndrome (Guidice, Santa and Pool 2007).

And finally all surrogates are subjected to restrictions by the clinics or intended parents in regard to medical or dietary behavior. Also they encounter deep emotional and psychological risks too. These risks though were deeper when traditional form of surrogacy was practiced. But one cannot ignore the level of mental and emotional harm a surrogate faces during and after the end of pregnancy.

The World Health Organization (WHO) reported that in 2008 more than 358,000 women died from complications related to pregnancy or childbirth. Furthermore, an alarming 10 million women suffer from injury, infection or disease as a result of a pregnancy. The risks to life from surrogacy are therefore not insignificant. These risks may even be greater than those experienced in a normal pregnancy due to the higher prevalence of multiple births and caesareans associated with IVF[39].

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[39] The law on what is labelled “artificial insemination” can be found in Danish at https://www.retsinformation.dk/forms/r0710.aspx?id 1⁄4 10319 (accessed February 2012).

3.6.Direct Exploitation by the Clinics and the Middlemen:

Renee Marie Stephano, President of the Medical Tourism Association said, "When couples from wealthy countries are desperate for biological services from vulnerable-and, in all likelihood poor and uneducated-women in India, the opportunity for exploitation, even unintentional, is inevitable."[40]

Priya Shetty report raises serious concerns regarding the practice of surrogacy in the context of profit driven clinics operating in the market and the financially desperate women facilitating the industry (2012). If India passes the bill it will set a global precedent as till now, surrogacy even though legal in some states of the West have not cleared on some of the major aspects. As Shetty states the instance of UK, where there are no restrictions on how many times a woman can act as a surrogate.

It is to be noted that altruism as a form of surrogacy attracts less women willing to be surrogates as stated in the Lancet World Report on Surrogacy. The instance is cited of UK where law allows altruistic surrogacy and therefore there is shortage of women willing to participate in the process.

Surrogacy agreements are not enforceable in UK and also in the USA that means that after the whole process of searching and going through the process of surrogacy, still the parents may not get their baby.

On the other hand, in India one might not encounter such a problem because the surrogacy agreement is legally binding. Cultural and financial reasons are cited as the reasons for not enthusiastic to keep the baby. As has been cited in one of the interviews where an intended parent, knew that the surrogate who was about to deliver their child would not be interested in keeping the child because it would add to her finances which were at already vulnerable position. Another example is specified in the report where a surrogate specifically asked Doctor in the Mumbai clinic that whether it was sure that they would take the baby or not because she could not afford to raise three children.

[40] https://www.globalhealthquest.ca/Articles/surrogacy.html

In her report she indicated Medical director Gillian Lockwood's opinion, who said that if properly regulated and surrogate's health is looked after appropriately then surrogacy can be accepatable. And if the process gets highly regulated there are chances of it going underground which could turn out to be more exploitative.

The Lancet exchanges with the surrogates have stressed that high risks involved in implanting more number of embroyos, exxagerates the already risk factor involved due to the immune mismatch. This was listed in the context of flauting of rules by number of clinics in India. The implanation of number of embroyos increases the risk of multiple birth which affects the organs of surrogates in case of twin pregnancies. Aslo it increases the chances of pre mature delivey which in later stages of life could affect the child's health. She specified the life example of Bobby Bains who told Lancet that surrogacy in India is cheaper precisely because the clinics implant more than the stand in the UK that is more than two embroyos.

The Lancet report emphasized the more sensitive cause of concern that the surrogates face apart from the health risks. Detailing the dearth of autonomy the surrogates experience during their term of pregnancy. Apart from the deitary control, they are made to stay in crowded hostels restricting their movements. Often they are allowed to meet their families, but in most scenarios its constrained.

Gianna Toboni travelled to India to create a documentary on India's commercial surrogacy industry from VICE for HBO named as "Outsourcing Embryos" claimed that the medical tourism industry was now worth $2.3 billion, out of which $500 million was related to surrogacy. Highlighting the business of surrogacy she asserts that in the process of commercialization, it was a under cutting one another and it was a mere bidding process where one was struggling to get the cheapest baby. Costing one sixth of what is charged in United States, in India, Tobaoni found out that an agent was guaranteeing a baby at a cost of $12,000.

On the other hand Dr. Nanya Patel claimed to open the biggest clinic in the world because she believes that surrogacy is beneficial for the women and also one of the best option for them to earn. Interviewing one of the surrogates, Toboni found out that it was a mere necessity as the surrogate named Vasanti told her that since she didn't have a home of her own she could have one through surrogacy. There were also non-profit organizations and brokers who encouraged poor women living in poverty as an

alternative to work of home cleaning or menial labor. Also recruiters are reported to visit slums regularly and among one of the slums named Mahavir slum was known to be working directly for Dr. Nanya Patel.

The documentary noted Dr. Ranjana Kumari of Centre of Social Research comments, whose extensive research pointed out to the fact that none of the surrogates had a copy of their contracts because of which they could not even have any legal recourse in case of under payment or any medical risks.

The darker side of the industry is shown in the documentary, where two VICE correspondents acting as intended parents when met the broker over dinner were shown a baby, which they could take immediately without undergoing the whole process of surrogacy. Toboni explains the situation as a one worst case of human trafficking in world of unregulated commercial surrogacy.[41]

Another survey [42] conducted had mostly women who were acting as surrogates for the couples from the United States and Great Britain. The survey argued that since there were no fixed payments regarding the amount of payment, clinics arbitrarily decided the payments. During pregnancy, the report indicated how surrogate mothers were kept in guarded facilities with limited social interaction. While proponents of the practice argue that the shelters provided by the clinic are to provide a clean and hygienic living space for the surrogates.

It must be noted that the surrogates don't feel the same. The concepts of stillness and movement are starkly pointed out by the survey. The survey clearly pointed out at poverty or their children's education expenses as the major reasons mentioned by the majority of women who were willing to act as surrogates. And in some cases were also pressurized by their husbands. It also mentioned about how the women were not aware of the terms and conditions of the contracts.

[41] Jessica Cussins "*It's a Baby Farm*" Bio political Times, Centre for Genetics and Society. April 23, 2015.

[42] Survey was conducted by Center for Social Research, a women's advocacy group based in New Delhi. Over 200 surrogate mothers in Delhi and Mumbai as well as parents, doctors and other agencies involved.

The story of Nancy, who acted as a surrogate for the gay couple in Mexico, highlights the complications associated with the upcoming new center in Tabasco, a state of Mexico. Nancy was abandoned by the agency and was being charged of asking more money. Just after five days of C-section she boarded the bus to get back home along with the final installment. Issues arising out of fraud agencies stealing eggs as well money of surrogates, subjecting them to psychological abuse and also not screening the women who want to act as surrogates surrounds the upcoming industry because the state legally requires the surrogacy to be altruistic.

3.7.“Classisation” of Donors and Surrogates:

Though a field survey would be able to better report on how surrogates are being classified in the market, an attempt is to highlight how surrogates have started being classified into categories[43]. This phenomenon again is reported all over the world where the practice is in particular “commercialized”.

Richard Westoby from London and his partner Steven from America decided to undertake a journey to America considering an agency and a surrogate from Arizona. The surrogate was equally interested in helping the couple, as she wanted to help people who couldn’t have a child. Though fees are paid, it is important what all they considered before choosing a donor. “It was gestational surrogacy, so we took an egg from another donor. We’re both white, so we wanted a white donor. We’re six foot five and wanted someone between five foot five and five ten. We didn’t want anyone with a BMI over 25 and we wanted someone who had gone to a university. You’ve got 30 different filters and you have medical information, psychological history and the medical history of the donor’s sisters, parents and grandparents. We decided not to choose anyone with breast cancer in the family, as that’s genetic. We also wanted a known donor so that our children can know and have contact with them if they wanted”.

It should be noted here that classification of surrogates is maximum cases done by the middlemen or agencies. These is some cases may involve clinics too. It is important to

[43] The phenomenon of classifying, thereby demanding particular traits is also prominent in cases of egg donation and sperm donation.

understand that this classification is done for consumers, satisfying these desires, which can also be in some cases termed as cloning. This has given a very negative image about the functioning of the commercial surrogacy, which needs immediate intervention from the side of the state. In the context of India, since the remuneration is not fixed, this classification affects the compensation a surrogate receives for delivering.

3.8.Concluding Need for Economic and Social Equity:

This chapter on Equity for the surrogates in the economic and social sphere does not demand for the ban of the practice. As Banerjee says, " Even if surrogacy is condemned ethically and prohibited legally on grounds of exploitation, such practices are likely to continue under cover as long as economic inequalities exist and nations open up their borders to others". Therefore, there is a need for a more nuanced understanding of the ethical paradigm suiting the needs of intricate globalized world. In all cases, regulating compensation is the key to end the exploitation of the surrogate's economic and social vulnerability.

Empowerment cannot be claimed simply on the basis of exercising choice. Introducing a framework to analyze how the interaction between the universal and the local forces what can be stated is that the experience of exploitation is context specific. Given the strength of the neo liberal policies and expanding global markets there should be separation of the medical professionals who conduct surrogates screening and those who attend to the intended parents. This way the needs and motivations of surrogates will be addressed according to the long-term health implications. To just state an example, after delivering the child for the American couple, Kamal Kapoor, the surrogate for some time felt sad but soon relinquished all her rights as she had signed the contract of over $8,000 which she stated was more than twelve times her annual earnings as a garment worker. She wanted to secure her daughter's future for which she underwent this process[44].

Given the entrenchment of this practice and the feasible reach of the actors involved, the complete riddance from this practice in not possible. Even though the practice is

[44] http://www.washingtonpost.com/world/in-india-a-rise-in-surrogate-births-for-west/2013/07/26/920cb5f8-efde-11e2-8c36-0e868255a989_story.html

abolished or banned in some developed countries, it will only exaggerate the exploitation in the low resourced countries or developing countries where this practice is not regulated. (Hagel and Mansbach 2015)

Chapter 4

EVOLVING LEGAL FRAMEWORK WITH REGARD TO INTERNATIONAL SURROGACY: IMPLICATIONS FOR SOUTH ASIA

Surrogacy is becoming an increasingly prevalent phenomenon although precise statistics are hard to estimate. Limitations for no precise statistics are reported by the many studies, such as no official recording of surrogacy arrangements or no legal licensing regime for fertility treatment or being legally prohibited due to which no accurate data can be recorded. Regardless of these limitations, media has played an active role to bring up the stories about surrogacy arrangements some in negative or some in positive way. A simple Internet search connects us to thousands of surrogacy agencies and clinics websites willing to facilitate surrogacy services. Internet coverage is said to be one of the major reasons for the increasing number of intended parents crossing borders to avail services. The options available on Internet help one compare and decide amongst many agencies and choose the best option for them. Their acceptance in life of common people is also routed through popular culture such as movies and television serials.

This has enthralled the attention of the lawmakers as a surge in cases being reported in relation to surrogacy arrangements all over the world. In the recent times, reports are documenting a rise in practice of surrogacy especially arrangements involving crossing of national borders.[45]The cases range from a variety of issues like disputes between intended parents and the surrogates, intended parents rights to legal parentage, to the most primary and common struggle to get the formal recognition for the child's legal status. In countries where surrogacy is prohibited or there are no laws, general rules for attributing legal parentage can be adopted. But some states even refuse to grant legal parentage. For example in Australia in some cases while parental responsibility was granted for taking day to day decisions but legal parentage was denied. [46]

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[45] Hague Conference on Private International Law (2012) A preliminary Report on the Issues Arising from International Surrogacy Arrangements, pp 6-8

[46] E.G. Human Fertilisation and Embryology Authority (2012) Fertility Treatment in 2011: Trends and Figures. Available at: http://www.hfea.gov.uk/104.html. E.G. the English courts may grant a non-parent a 'residence order' under the Children Act 1989 if they satisfy certain requirements. A

The situations get complicated in surrogacy arrangements when one crosses borders and there is a mismatch in rules granting legal parentage. Example has been cited in the study where in countries such as Russia, Ukraine and California, the intended mother is automatically regarded as legal mother, while in most European Member states irrespective of where the child is born, legal motherhood is attributed on the basis of parturition. [47] Similar complications are in the cases for defining fatherhood and also for same sex couples and single parents. This ends up as child being stateless

More than the framing of the legal provisions, there is a need to understand the legal consequences of the existing practice. While most of the studies primarily concern about the child and the surrogates, there is a need to understand the status of these stakeholders from the wider perspective of globalization and exploitation with regard to policies. The prevalence of diverse regulatory frameworks has facilitated the movement of patients to avoid restrictions on certain practices in their home countries. For instance Turkey under its Turkish Penal Code has banned any kind of crossing of borders for third party assistance. Two Australian states, New South Wales and Queensland have in particular banned crossing borders for commercial surrogacy as it is against the state laws, although they allow altruistic surrogacy.

The lack of regulations in developing countries has given further boost to the lucrative international trade in reproductive services. While reproductive services ought to provide help to those who need it, but in the process it gets difficult to curb the malpractices that exist in the process. And in order to get rid of these mal practice and to provide protection to all the stake holders involved, the policy makers struggle hard to strike a balance over the extent to which these services should be available and the threshold which shouldn't be crossed by all the parties involved in the process.

Involving parties from different nations enmeshes layers of complexity in the case of dispute regarding parental rights. The legal institutions struggle hard to strike a balance between the moral and ethical standards v/s biological and social parentage.

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residence order will automatically confer parental responsibility, but not legal parenthood. In a number of recent cases in Australia, 'parental responsibility orders' have been granted to intending parents to attribute them with the ability to make day-to-day decisions concerning the child. However, legal parenthood has not been conferred in these cases: Dudley and Chedi [2011] FamCA 502; Hubert and Juntasa [2011] FamCA 504; Findlay and Punyawong [2011] FamCA 503; and Johnson and Anor & Chompunut [2011] FamCA 505. See further Millbank J (2011) "The New surrogacy Parentage Laws in Australia: Cautious Regulation or '25 brick walls'?", 35(2) Melbourne University Law Review 1-44.

[47] A Comparative Study on the Regime of Surrogacy in EU Member States (2013)

While in most cases the courts offers privilege to the biological bond over social relations, it is increasingly argued that the broad approach towards social relations should be considered in the case of surrogacy.

The Laws and the Laws in Making around the Globe on International Surrogacy:

4.1.Countries that Ban Commercial Surrogacy Completely:

Most religious organizations are against the practice of surrogacy and want it to be declared illegal. Raising concerns over its rising commercial nature, they consider it as violating the sacred institutions of marriage and birth and further against the dignity of the child and the biological mother. Countries like Pakistan though allow IVF treatments to cure the problem of infertility but prohibit the third party assistance associated with surrogacy.

Surrogacy contracts enforcement is varied with states like Indiana, Michigan and Arizona prohibiting surrogacy arrangements while other states have distinguished on the basis of the type of contract arranged. States like Illinois, New Jersey and North Dakota enforce gestational contracts while Kentucky, New York and Texas consider traditional surrogacy contracts unenforceable.

4.2.Countries that allow commercial/altruistic surrogacy for nationals:

The study summarized the surrogacy arrangements occurring in EU member states, where France had the maximum number of children born through surrogates. The United Kingdom too reported around 149 births per year. While on the other hand Belgium and The Netherlands only recorded 2 births per year. [48]The survey observed that in most of the cases the child was handed over, to the intended parents effectively at or shortly after birth. However related conditions are applicable. While in UK, even if child is handed over immediately, a Parental Order is required to be obtained within 6 months to get legal parentage. In Greece consent from the Court has to be attained with the child being registered as the legal child of the Intended parents. In

[48] This data has been taken from the study, which states that there were limitations in collection of data. There were only some clinics that reported back. And also in most cases official data are not recorded and thus there are no national figures. However UK figures are said to be somewhat accurate, as parents are required to obtain a parental order (PO) to get legal responsibility. Its been said that during the period 1995 to 2007 some 33 to 50 POs are granted each year.

Netherland child has to be adopted formally within a year while in France child is handed over within one day. Danish law allows altruistic surrogacy, which is conceived "naturally" with the intended father and does not involve any contract or mediator. [49]

The Families Through Surrogacy [50] showed a 180 percent increase in number of intended parents from the United Kingdom in 12 major overseas clinics. This is due to a long waiting list in their own countries along with the provision that the surrogacy must be altruistic, turning intended parents to foreign markets. Foreign and Commonwealth Office have identified parents heading to the US, India, Ukraine and Georgia. Even though officially it is required that children born out of surrogacy arrangement must seek an official parental order, in many cases it wasn't even applied for. Mr. Everingham said, "Hundreds of UK couples go offshore each year in search of a surrogate to carry their child. Government figures are likely to far underestimate the real numbers, given that many UK citizens don't bother applying for parental orders, believing a UK passport for their child or children is sufficient protection." [51]

Surrogacy as a practice in Israel was legalized in 1996 after a Commission was appointed which stated that either it should be banned or legalized all together rather than allowing a limited practice. As a result to this decision, the Ministry of Health stated in 2010 that more than 30,000 IVF transfer cycles were performed in Israel which is four times of any other western country because of the protonalist culture, where bearing of children is a moral necessity. Reproduction forms the responsibility of the state and thus we see that the National Health Insurance Law of 1994 covers unlimited cycles of IVF. Though it should be noted that strong pronatalist culture propagates a highly regulated practice of surrogacy that establishes a legal relation between the intended parents and the surrogates. Increasing applications per year, from 11 in 1996 to 80-90 per year since 2008. Realizing the economic and social disparities between the intended parents and the surrogates, another committee was formed in 2012 to revise the regulations. Though the regulations recommended by the

[49] In this section, Danish legislation and bioethical discussions on surrogacy are used to define the Scandinavian context. Differences exist of course: Norwegian legislation is the strictest in the Scandinavian countries, while the Danish Parliament is currently debating Danish legislation.

[50] An international not for profit group started by Sam Everingham.

[51] http://www.independent.co.uk/news/uk/home-news/revealed-surrogate-births-hit-record-high-as-couples-flock-abroad-9162834.html

committee was to limit the use to only medical infertility and not structural. And also to disallow to single parents and same sex couples of these services for obvious reasons.

Thailand is the latest entrant to the category for banning surrogacy for the foreigners while allowing the same for its own nationals. Previously the Thai Medical board had published guidelines on surrogacy having no legal sanctity were not binding on the clinics and thus not widely adopted. This led to occurrence of few scandals and the readopting of the guidelines by Thai Medical Board instructing the clinics to follow the guidelines strictly. In the absence of laws, a major trafficking incident occurred in 2011, where a Taiwanese man was forcing immigrant Vietnamese women to act as surrogates. These women claimed that they were either lured for a well paid jobs and two of them claimed they were raped. Among the fifteen found, seven were pregnant. After this Thai police started enforcing the medical board guidelines along with Human Trafficking laws.[52]

Emerging as a destination for the gestational surrogacy, the surrogate baby scandal Thailand shuts its 'wombs on rent' industry [53]. There was an Australian couple that abandoned one of the twins and took the one of them back to Australia. The baby who had been left behind had Down's syndrome because of which the couple left the child abandoned. This drew much of public attention and raised innumerable concerns involved in cross border surrogacy arrangements. Though the woman who gave him birth, Pattaramon Chanbua decided to keep the child with her. Subsequently the child was awarded Australian Citizenship and the mother with a bigger house and a monthly allowance. More serious concerns were raised when in an apartment twelve babies were found with nannies, fathered by a single Japanese man Mitsutoki Shigeta who is still fighting case to get custody of these children.

After it's first draft five years back, Thai Parliament has finally passed a law banning foreigners as well as same sex couples for seeking surrogacy in Thailand. Declaring surrogacy was never legal in Thailand, the military government declared all surrogacy arrangements illegal. Banning commercial surrogacy, the law only allows altruistic

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[52] http://www.sensiblesurrogacy.com/gay-surrogacy/surrogacy-law-thailand/
[53] http://www.bbc.com/news/world-asia-31556597

surrogacy only for Thai married heterosexual couples. Also the surrogate must be atleast 25 years of age, either relative of the husband or wife of the intended parents.

4.3.Countries that allow foreign couples but ban single and same sex couples:

The surrogacy market in Russia was till now quasi-legal. It was mentioned in the order of the Health Ministry as a way to solve the problem of infertility. Svitnev and his colleagues in their study of legal regulation of assisted reproduction treatment in Russia published in reproductive biomedicine online, 2010 (892 – 94) defines Russia as a reproductive paradise. So the legislation which protects the rights of a surrogate mother and genetic parents are say Article 35 of the Basic Law of the Russian Federation for Citizens Health protection states that each adult woman of a child bearing age has a right to artificial fertilization and implantation of the embryo. There is no restriction on number of embryos usually two to three are implanted. Marital status is deemed irrelevant but it is provided that the surrogate woman should at least bear one child of her own. The legislation gives a much more scope for a larger public to go for surrogacy. Apart from the couple even those who are not officially married and single woman can avail surrogacy.

But law still holds reservations regarding the process to be adopted for same sex couples. Art. 51 of the Family Code of the Russian Federation gives respect to the surrogate mother as it is only with her consent that the couples can be registered as parents of the child. Following this one Article 52 of the Family Code of the Russian Federation states that neither of the parties can invoke the question of parentage after registration is complete. In addition, the surrogacy procedure is also regulated by the Order of the Ministry of Health of the Russian Federation, which states requirements of consent from both the parties. There are a number of surrogacy agencies, which assume responsibility for supporting the procedure within the framework of the surrogacy contract concluded between a surrogate mother and biological parents. And the surrogacy contract lists all the obligations of the parties involved, the amount and the order of payments, as well as a number of other points that are important and significant for the parties and are determined on an individual basis in each specific case.

4.4.Countries that allow foreign couples as well as same sex couples:

The Liberal approach towards the practice however maintains that the state and the laws should remain neutral as one has the sovereign right over one's body and mind. In the Buzzanca v. Buzzanca case, different interpretations were adopted by the nine states of USA making surrogacy arrangements complicated. For example taking this same case in the process of co ntracting the surrogate the infertile couple obtained the anonymous egg and sperm to form the embryo to be implanted in the womb of the surrogate. But during the term of pregnancy itself the couple filed a case of divorce saying that there were no children born to the married couple therefore they were not responsible for the surrogate child. The California lower court ruled in favor of Mr. Buzzanca but after an appeal by Mrs. Buzzanca, the appellate court repealed the order. It is because of this case the responsibility of the child born through surrogate was either decided on the basis of best interests of child in states like Michigan and Utah or the surrogate and her husband would be legal parents in states like Arizona, Florida, North Dakota and Virginia.

Surrogacy is conducted as a private affair in the United States as the government is guided by the classical liberal tradition. This tradition believes in minimal government intervention in private affair so that privacy and autonomy could be maintained. The Centre of Disease Control 2013 has reported exponential growth, from 99,620 ART cycles at 383 clinics in 2000 to 147,260 ART cycles completed at 443 fertility clinics. In contrast to Israel, there is no public funding or insurance because of which cost remains the main barrier to access the treatment. Different states have different enforcement policies of the contracts, the state of affairs are not clearly delineated which leads to a state of limbo. This results in assigning parentage as ill-defined enterprise to venture upon. On basis of status and orientation of intended parents, only California has extended enforcement of surrogacy contract to same sex couples.

With the passage of the Gestational Surrogacy Act way back in 2005, the state of Illinois exhibits one of the most surrogacy friendly laws in the world[54]. With the requirement of at least one of the intended parent (egg or sperm donor) the act provides for the establishment of a parent child relationship between his or her intended parents and the child. Following this it allows for the names of the intended

[54] http://www.idph.state.il.us/vitalrecords/surrogacy/Pages/default.htm

parents on the birth certificates of the child and not of the gestational surrogate. With the signing of the certified statements prior to the birth of the child, the state provides the intended parents as well as surrogates with less complicated procedures. By allowing for gestational surrogacy, the state has also mentioned that the intended parents may not be residents of Illinois and may also not require to be married. It does not mention about the arrangements for the LGBT couples, thereby not banning the same for them. [55]

4.5.South Asian countries response to the growing surrogacy services:

While the emergence of surrogacy as a practice can be traced in all the countries of South Asia except for Maldives and Bhutan as discussed in the first chapter. Pakistani court has termed surrogacy as illegal while in Sri Lanka it has been accepted as a practice but with limitations. One fails to find much relevant data on the legal status in these countries. In India it was recognized as a commercial practice since the Supreme Court ruling. And Nepal has started to realize the growing industrial proportions of the practice and thus plans to evolve a framework in the near future. Both India and Nepal have taken up detailed analysis for their existing legal status and future frameworks to be created.

4.6.Evolving Legal Framework for Surrogacy in India:

"Although commercial surrogacy is not illegal in India since 2002,currently there are no laws regulating surrogacy in clinics."(Pande This Birth and That) The unregulated proliferation of ARTs and surrogacy is the result of lack of monitoring mechanism combined with legal intricacies. Whilst the value of entire fertility treatment or ART is around Rs 25000 crore according to the Law Commission of India (2009, 11), Kohli (2011) says that out of this surrogacy accounts for 2000 cr.

The Indian Council of Medical Research (ICMR) made the earliest efforts to draw rules and regulations to guide the practice in India but these are mere guidelines, which fail to regulate the mal practices associated with surrogacy. Recently the Ministry of Health and Family Welfare made efforts towards drafting The Assisted Reproductive Technology (Regulation) bill and rules for the regulation of the growing

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55 The state of Illinois has allowed for a joint adoption for the same sex couples, so it is widely assumed it would allow for the surrogacy arrangement too.

industry. This bill was opened for public view, on which many scholars and activists have argued that the bill fails to address some of the core questions. The Law Commission of India too in its report on commercial surrogacy in 2009 where it is seen to have taken a totally different stand. The commission stands for a complete ban on the commercial practice of surrogacy, although recommends to legalize it for altruistic reasons. It's yet to be seen how these viewpoints gets incorporated in to the bill.

The institutionalized contracts in the US and other locations with agreed upon embryo implantation attempts along with the post birth rights of surrogates backed by judicial laws can be compared to the contracts in India which are limited in scope where surrogates gives away their rights and don't even have their names in the birth certificate as specified in the ICMR guidelines.

The bill drafted clearly defines that the practice of genetic surrogacy wont be allowed. This means a surrogate cannot be the egg donor consequently allowing only gestational surrogacy. As per the bill "A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy"[Clause 34(13)]. Such a clause implies that even when a surrogate's own eggs are viable she has to undergo a complicated procedure of Embryo Transfer.

While stating that the commissioning parents should make sure that the surrogate mother and child are 'appropriately' insured and the surrogate mother is free of any health complications. But the bill at the same time does not elaborate on the nature and kind of insurance or defines the word 'appropriate' means.

A welcome addition has been made in the current bill to be tabled that the commissioning parents would need to get a legal certificate from their own countries declaring that the child born through surrogacy would be a legal citizen of their country. This would be very useful in dealing with the citizenship issues of the child. Although the bill grants Indian citizenship to the child born, it mentions that in case the intended parents are from outside and refuse to take the custody of the child within a month, the local guardian shall be responsible for the child and can even hand over the child to the adoption agency.

The case of Baby Manji:

In 2007, a Japanese couple, Ikufumi and Yuki Yamada visited India to have a child through surrogacy. They went to the Akanksha Fertility clinic in Anand, Gujarat where the process was started using the sperm of the father i.e. Ikufumi whereas the eggs were donated by an anonymous donor. However during the course of the pregnancy the couple got divorced and a month later the child was born to the surrogate mother. The father nonetheless came back to take the child back to Japan as the mother (his wife Yuki Yamada) did not want to raise the child. The contract too stated that if the couple got separated the father would raise the child.

The troubles soon began when the father had to take the baby to Japan and the Japanese Embassy denied the travel documents to Baby Manji as the Japanese civil court does not accept surrogate children. To get the documents Ikufumi decided to adopt the child but that could not be permitted according to Indian laws that deny single man to adopt a baby girl. Finally, he requested for an Indian passport but could not even get that. This was due to the fact that he needed identification for the child i.e. the birth certificate that was not given by the Anand Municipal Corporation over the confusion regarding who was the mother; the surrogate or the egg donor or Yuki Yamada the commissioning parent. Subsequently, after an appeal filed by Ikufumi, the Municipal Council of Anand with only father's name granted birth certificate to Manji.

Since Manji had septicemia and viral infection she had to be shifted to a hospital in Jaipur. Meanwhile Emiko Yamada, Ikufumi's mother came to India to take care of the child and filed a petition in Rajasthan High Court to attain temporary custody of the child. Nevertheless an NGO, Satya filed a habeas corpus petition in Rajasthan High Court asserting that the child was a victim of Child trafficking and in absence of laws to govern surrogacy the custody could not be granted to Yamada.

The case moved to the Supreme Court of India, which permitted temporary custody of the child to the grandmother Emiko. It also issued a notice to the NGO demanding its interest in the matter and also repressed its plea for the custody of Baby Manji. Further the Court requested the Solicitor General of India, Vahnavati to define India's position on Manji's parentage and citizenship.

The Solicitor General held that the decision rested with the Union Government. The Rajasthan regional passport authorities a month later issued as a part of the transit

document, an identity certificate. This was the first such certificate issued which then helped her to get the visa for Japan, with a caveat that it was only valid for Japan without mentioning her nationality as well her mother's name. Almost a year later, the Japanese embassy issued a one-year visa on humanitarian grounds to Manji, giving time to Ikufumi to establish the parent-child relationship only after which she could have been recognized as a Japanese citizen.

The Case of Dan Goldberg's Twins:

As a consequence of the restriction over the access of adoption or surrogacy being restricted for the Israeli Gay couples, Dan Goldberg and his homosexual partner travelled to India to undergo the process of surrogacy. With Dan Goldberg's sperm, a surrogate was fertilized and delivered twins in February 2010. However, the family court refused to issue a standard legal order because of which the child was denied Israeli citizenship. The couple had to wait for two months in a Mumbai hotel along with the twins, Itai and Liron pending the Jerusalem Family court permission to ensue with the paternal test. This test was imperative to acquire entry into the country, as the determination of the fact that the parents are biologically related to the child is the pre requisite for child's naturalization as Israeli citizen. The family courts in earlier instances had issued orders to undertake a DNA testing by the parents of children born abroad so that biological relation could be drawn.

The Judge of the Family Court, Philip Marcus, however, stated that he lacked the jurisdiction to issue the order, as it was the state to examine such cases. In clarifying his decision, he said what if one of the partners (homosexuals) turned out to be pedophile or serial killer. Subsequently an appeal was filed on Goldberg's behalf with the Jerusalem District court where a panel of judges decided to appoint a legal guardian to represent the minors and referred the case back to judge Marcus affirming he had the authority to issue for the paternity test.

Meanwhile the lesbian, gay, bisexual and transgender (LGBT) community rallied to the support of Goldberg and held a protest in front of the Interior Ministry office in Jerusalem. Ultimately, the Israeli consulate granted Israeli passports to the twins.

The Cabinet of Israel has approved a momentous bill even after the members of the Jewish Home Party, which would permit homosexual couples as well as single men

and women to have access to surrogacy services. [56]Israeli restrictions have pressured many same sex couples to cross borders, the prime destination being India and Thailand. However, these destinations are no more feasible as India, last year made surrogacy for same sex couples illegal while Thailand has made the provision of automatically granting citizenship on the basis of the mothers who gave birth. As a consequence of this some same sex couples were stuck with their newborn babies.

Reacting to these incidents, Israel Government has made a statement instructing the homosexuals to avoid travelling to Asian countries for surrogacy and also that soon the government would discontinue providing assistance to parents of babies born abroad. In 2009, the Delhi High Court struck down the colonial legislation of criminalizing homosexuality[57]. However, the Supreme Court of India overruled the High Court and stated that only the legislators could do away with the colonial legislation.

The new Indian Visa Regulations have however, restricted the single parents, gay parents and unmarried partners to travel to India for surrogacy purposes. The regulations issued by the Ministry of Home Affairs, Government of India has detailed that only the duly married man and a woman for at least two years could entail the surrogacy procedure in India. Further, they would travel on Medical visa and not on tourist visa. For the need to assure citizenship for the child, it mentioned the need to get a prior certificate from their own home country recognizing surrogacy as well as the child born henceforth. A limited relaxation was accorded on February 2013 to the cases where surrogacy was already commissioned and children due to be born or had been born in the year 2013. These relaxations were applicable on case-to-case basis by the Ministry of Home Affairs.

The case of Nikolas and Leonard:

The twins Nikolas and Leonard were born to an Indian surrogate in Gujarat in January 2008 for a German couple Jan Balaz and Susan Lohald. However, birth certificates were denied to the twins, upon which, Jan Balaz appealed at Gujarat High Court. High Court declared that since the twins were born to a Indian surrogate, therefore the

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[56] http://www.timesofisrael.com/cabinet-approves-surrogacy-equality-bill-for-gay-couples/ Published on June 1, 2014

[57] Naz Foundation v. Government of NCT of Delhi, 160(2009) DLT 277

children also be granted Indian Citizenship and Indian passport. The Government of India then challenged this decision, stating that since the children were born to a surrogate could not be granted Indian citizenship, rendering the twins stateless. As the German authorities had previously denied visa on the grounds that the German law did not recognize surrogacy. Having no other option the couple had to undertake inter country adoption procedure in India, following which the Indian Government gave exit permits to the twins.

4.7.Implications for South Asia: India Nepal's Unregulated Market and the Need for Laws:

Every case in India had some implications either which resulted in some regulations or changes in draft bill, which is yet to be tabled in the Parliament. However the most intriguing implication has been on the rising surrogacy market in Nepal. Nepal is emerging as a new entrant in the international surrogacy industry as a result of tightening of rules in India regarding foreigners. With no laws or regulations, Nepal's cabinet has lately decided to allow foreigners to avail surrogacy services while senior advocate Sapana Pradhan Malla argues that while foreigners are allowed but there are no provisions for Nepalis. [58] Advocate Sadeep Kharel on the other hand said that surrogacy is illegal for Nepalis. Though clinics have reported the use of services secretly by Nepali parents in Nepal as well as in India.

Recognizing the surfacing of reproductive tourism in Nepal, a workshop was held by Women's Rehabilitation Centre (WOREC).[59] Though the incidence of reproductive tourism is undetermined, it had widely recognized the need to bring together the stakeholders to handle in the rising occurrence of the industry there. During the first session of the workshop the difference between the surrogacy in developed and developing countries was talked about. It was during the second session that the inequalities in terms of access were pointed out starkly between those who have resources vis-à-vis those who don't. This session was in particular important to stress on the unequal distribution of services, where a women with resources had the

[58] Nepali citizens on surrogacy routinely consult senior Advocate and Activist Sapana Pradhan Malla but she has no answer, as there are no laws. http://nepalitimes.com/article/nation/wombs-tolet-surrogacy-nepal, 1991

[59] The workshop was held in collaboration with Our Bodies Ourselves (OBO) group from the United States and the Sama Resource Group on Women and Health from India.

opportunity of “designing” their babies, while on the other hand there were women who lacked even the basic infertility treatments.

This critically brings up the question of ill use of infertility services materializing in many developing countries. Judy Norsigian states “ Some women get unnecessary health care while other women don’t get necessary health care.” (Pg 2) The effort was further made to bring to the surface the profit motive accompanying the rise of industry that often does not result in treating women well. The increasing participation by the private sector has led to the undermining of the public health approach.

The absence of basic preventive fertility care has led to a further rise in infertility rates. SAMA identified this as one of the mounting concerns where there was an urgent need to comprehend the causes of infertility. It emphasized that the cause of this could be poor obstetrics and gynecology (OBGYN) practice, sexually transmitted diseases (STIs), genital tuberculosis, pelvic inflammatory disease, and others such as exposure to toxic substances, environment and work related conditions along with the social determinants of health.

The concerns are also raised over the use of terms lacking sensitivity and inclusiveness. There are even concerns regarding the use of term surrogacy which undermines the role of woman as highlighted by OBOS, and suggested that instead of surrogacy, the term gestational mother could be used. As the term gestational mother would signify the role of the woman as the physical mother. As the term reproductive tourism rejects the seriousness attached to the travel across border and the troubles one faces during the entire process. It’s rather better to use terms like cross border reproductive health care and so on.

SAMA identified that India is the fifth most privatized healthcare sector in the world, with the GDP contribution of over 6.2%.[60] Since there is no standard payment structure for the surrogates and dearth of understanding of informed consent and counseling leads to risky practices in the growing industry of India.

[60] SAMA in the workshop held in Nepal in 2012 provided this data.

For example, Nafisa had never seen the picture of the would-be parents; nevertheless she was selected after the parents saw her photograph. How can one define this relationship?

Amidst the recent earthquake in Nepal, concerns have been raised over the rise of surrogacy industry growing, especially for same sex couples in the country. Commercial surrogacy being banned for foreigners in Thailand as well the Visa regulations provided by Indian authorities barring same sex couples to avail surrogacy options in India, have created Nepal as a safe haven for the growing demand. And it has not just emerged as the safe haven but also have increased the incidence of Indian women crossing borders to deliver the children for the international couples since it's prohibited in India. [61] This trickling of Indian women across open border to act as surrogates have raised concerns regarding the issue of human trafficking in the scenario of lax rules and regulations.

4.8.Need for a legal framework:

The legal framework has been evolved around the globe with numerous restrictions and least regulations leading to unscrupulous rise of the cross border surrogacy arrangements. Regulations though have been framed in some countries though without addressing the core issues. In regard to cross border surrogacy there are three questions that need immediate attention. First in relation with the intended parents profile where some countries allow foreigners while other restrict. And with in this restriction lies another restriction in context of couples v/s single or same sex couples.

Second important question that needs instantaneous global attention is the citizenship of the child born out of the surrogacy arrangements. With countries denying recognition to surrogate child, couples are stranded out of their home country to get necessary papers or permission. This restriction leads to enormous trouble to the intended parents and most seriously leaves the child stateless. Moving to the status of surrogates in the context of cross border surrogacy has raised concerns apart from the exploitation in relation to intended parents which has been dealt in the earlier chapter.

[61] http://scroll.in/article/724362/why-the-nepal-earthquake-has-got-india-and-israel-talking-about-cross-border-surrogacy

This chapter focused on the movements of surrogates across borders. This was evident when Vietnamese women were found in Thailand in a flat out of which around five were pregnant. The issue gets very severe in case of open borders of South Asia. In case of restrictions imposed by Indian authorizes over surrogacy services to be permitted to same sex couples, have led to crossing of women to Nepal to deliver the child for international couples. Even the bill which mentions very explicitly that only Indian women could act as surrogates and no ART clinic or bank would send or an Indian woman abroad to act as surrogate. The situation seems bleak to curb the practice, which in some circumstances could be voluntary or involuntary. And moreover the notion of taking a voluntary decision is surrounded around the situation one faces in their own home country being poor or in need of money for survival or for their children.

CHAPTER 5

CONCLUSION

This study has undertaken to examine and analyze the issues of access and equity in International Surrogacy on the basis of availability of services. Economy is the basis and driving force for all kinds of transactions within the nation and international arenas. It is the major cause of globalization. Due to advent of science and technology, man has been able to satisfy his needs to a great extent, which could not have been envisaged ever before. Commercial or altruistic surrogacy came into existence to realize the dreams of many infertile couples around the world. Debates have erupted worldwide, about the extent to which a human body can be bought or sold or rented or donated over the last few decades. At the beginning one clearly surrounds the arguments against surrogacy as with regard to sex work highlighting the gender-based disparities. One must take into considerations that these disparities do not arise due to social constructions but the implicit biological ability of women to reproduce.

Surrogacy whether altruistic or commercial have in particular raised these concerns further with a growing number of persons crossing borders wishing to obtain services that are either restricted or complicated in their home countries. The national differences in regulation among countries have led to increasing interaction between the purchasers and the providers. The global socioeconomic differences have raised the ethical worries in the geographic spaces. The major challenge then is to view how the global perceptions affect local perceptions and vice versa.

The research work has primarily studied South Asian countries along with other Global South countries to compare and contrast the conditions prevailing in Global North. Due to lack of facts and figures available for individual South Asian countries, focus has been upon India and Nepal. First India and lately Nepal is emerging as globally favored destination to avail reproductive services. As discussed in the preceding chapters, commercial surrogacy has grown exponentially in low resourced countries of Global South due to availability of cheap labour and low cost technology. The argument is not that it has surged in just Global South; instances of its mounting success can be recorded in countries like the USA of the Global North. Nonetheless the argument is that in the Global South its surge has been much more vigorous forming itself into a profit minting industry than in the Global North.

By focusing on the movements across borders, an attempt was made to categorize these movements and what it meant for intended couples from various regions of the world. How these movements impacted the home country where these services were provided was examined in the second chapter. Along with this the questions of availability and accessibility in regard to reproductive services were considered. In the third chapter, the aim was to apprehend the story from the surrogate's point of view and how the industry has placed them. The motivations for commissioning surrogacy for the other and what impact it has on themselves as well as their family and society is looked upon. Poverty is one of the most troubling debates when one talks about surrogacy as it has the potential to influence the women to sell or rent their womb in a situation. Attempt was also made to look at whether there exists any differences between the surrogates of the Global North vis-à-vis Global South.

In the fourth chapter effort was made to understand the prevailing legal frameworks round the globe and how different or similar are the frameworks adopted by South Asian countries. Hereby the chapter deals with the ethical and legal dilemmas which surface as a result of surrogacy regarding adoption, guardianship and citizenship. These issues become critical in case of cross border surrogacy. While concluding this work, the intention is to go backwards i.e. from the legal provisions how solutions can be derived for the prevailing inequalities that exist in the practice of international surrogacy especially in the South Asia. By understanding the current phenomenon existing the South Asia, the objective is to answer the broader questions of accessibility and equity in the context of South Asia as a region.

Though reproduction is a natural phenomenon but infertility has set in particularly in societies due to industrialization and a different lifestyle. Improved medical technology has answers to many problems and surrogacy is deemed to be a perfect solution for the problem of infertility. Administration of drugs to induce ovulation, fertilization, gamete intra fallopian transfer which all imply manipulation of egg and sperm in treating infertility.

The usage and availability of ARTs is associated and affected largely due to social societal issues. In some places the poor are deprived, somewhere partial acceptance is there, somewhere it is prevalent due to high incidence of infertility and somewhere considered as a taboo because infertility is itself is considered as a stigma. The social stigma attached to infertility along with the desire to have their own child, couples indulge in the practice of availing surrogacy services. ICMART has played a pivotal role to provide information on availability, effectiveness, and safety to health professionals as well as to the public. It provides a framework for further international terminology and data development for ART.

Initially the movement was to the developed countries for the specialized health care services but in contemporary times travel to the developing countries is observed. It not only provides foreign revenue but also has become the basis of a new export commodity interlinking it with the trade policies. This new industry within the category of medical tourism is gathering momentum. And as various reports point out the major reason for this travel in the present times and coming years will be for ARTs which have emerged as a multi billion profit oriented industry.

Most religious organizations are against the practice of surrogacy and want it to be declared illegal. They consider it as violating the sacred institutions of marriage and birth and further against the dignity of child and the biological mother. The states prohibit surrogacy for moral and ethical reasons, which then influence the couples to cross the borders to get the surrogacy services from where they are easily available and with less legal complications. Number of gestational surrogacy has increased due to the increase in demand owing to factors like late marriages, obesity or sexually transmitted diseases. When the demand is not fulfilled in ones own country there is enhancement in international trade.

Lawmakers are involved in surrogacy industry due to various disputes between surrogates, intended parents and for child's legal status. Legal complications are enhanced when borders are crossed in surrogacy arrangements. Different countries have differing laws regarding the practice wherein priority is given in some cases to the woman who gave birth or in some cases to the intended parents who are wealthier.

Lack of regulations in developing countries has given further boost to the lucrative international trade in reproductive services. While some countries have completely banned surrogacy others have allowed altruistic surrogacy while some have banned any kind of third party assistance.

Regarding ownership of the child while in some countries parental order is required while in others a consent letter from court. In India a letter from individual country embassy recognizing the surrogate child is required. And if the intended couples deny taking the responsibility it will be the local guardian's responsibility. While claiming ownership there are concerns regarding the situations where child is born with some ailment or disability. This was surfaced in the famous case where an Australian couple disowned the baby with the Down syndrome.

Global attention is indispensable to the issue of citizenship of the child born out of surrogacy arrangements. Recognition to the child is of utmost since it leaves the parents fretting for legal documents thereby making the child stateless. Different states have different enforcement policies for the contracts related to surrogacy. For example Illinois exhibits most surrogacy friendly laws in the world by providing the signed certificate statements prior to the birth of the child thus there are less complexities.

South Asian response to surrogacy services is diverse and varied as mentioned earlier. While in India surrogacy is not illegal but no laws are implemented in clinics regarding the commercial practice of surrogacy. ICMR has made earliest efforts to draw rules to guide the practice in India but these are mere guidelines that fail to regulate the mal practices related to surrogacy. The Law Commission of India stands for a complete ban on the commercial practice of surrogacy although recommends to legalize its altruistic form. Recently the Ministry of Health and Family Welfare made efforts towards drafting a bill for the industry but it has been argued that it does not address some of the core issues.

The contracts in India have a limited scope where a surrogate gives away their rights and don't have their names in the birth certificate as specified in the ICMR guidelines. Even though the bill states that the child and the surrogate mother should be appropriately insured, it fails to specify the kind of insurance and neither defines the word appropriate.

Indian restrictions have given way to growing industry in Nepal, where the workshop was held in 2012 in the wake of reproductive tourism. Here differences between the practice of surrogacy in developed and developing countries were talked about. The inequalities in terms of access were pointed out between those with the resources could make a choice and the other who lacked even basic infertility treatments.

Global South is an attractive destination since it provides the facilities at a very low cost. With the increase of the main industry, complementary industries are created like pharmaceutical companies, semen banks, cryo banks, consultancy firms, surrogacy agents, donors, law firms along with the media and advertising industry, hospitality industry and the tourism industry most importantly. All this has created an economic boom in the main industry and employment in various sectors. Thus the revenue is generated and growth of this industry is seen.

While we observe the booming of the surrogacy industry and it's flourishing in respect of international patients it serve, there is ironically another important aspect where we need to pay attention. That is, the surrogacy industry is facilitated by the labour provided by the surrogates, it would be appropriate that they get a major share of income. Nonetheless they

don't get what they deserve. And to her disadvantage her remuneration depends on her socio economic background.

India is considered as a major hub in the South Asian region, which is indicated in a WHO survey. World-class infrastructure, government policies supporting medical travel along with visa facilities, tourist infrastructure, and relaxed regulatory framework with no language barrier together facilitate the business to flourish. India legalized surrogacy in 2002 while in other neighboring countries some has banned like Pakistan while others such as Sri Lanka provides facilities with some regulations at hand which are still not identified.

Nepal is emerging as a unique case as an offshoot to India's industry though no guidelines or regulations have been framed. Issues were raised at the workshop and discussed specifically health issues relating to surrogacy as well as the rights of the surrogates in the process and the child reproduced therein.

Even though the South Asian region particularly India and Nepal has business climate due to the availability of labour with least regulations, unfortunately the surrogates do not benefit as much as others related to this baby business. There is a need to study and review this aspect.

Since surrogacy is recognized in both India and Nepal, national and international boundaries are crossed to receive or provide these services. In this regard, joint collaborations between Indian clinics as well as international clinics are set up to solicit foreign clients. These reassure the credibility and professional qualifications of foreign health care providers and coordinate all aspects of the treatments. These clinics provide technical assistance to other IVF clinics within India and the neighboring countries like Nepal and Bangladesh.

The trade has opened countless new avenues and opportunities by providing jobs in the process of linking it to tourism, hospitality and consultancy sector. Thus adding further to the foreign exchange to country's economy however these advancements bring in negative effects on the public health systems of the home country. A study should thus also be made of the fact that why the international clients are given sizeable generous treatment while the national clients denied or in some cases not treated right especially in private sector.

This is important to highlight as the industry is predominantly driven by the private sector, where in India there are cases of both providing the services with a differential treatment or denied to the many who don't have access to these services. While in Nepal there is no mention of access to these services for the Nepali citizens themselves, though it is practiced in secrecy. And it is well known that whatever practice is shrouded in secrecy is bound to have elements of misapplication.

The cross border reproductive care becomes an important area to study of how trade is affecting the countries own national health systems. Not only the rights of intended parents should be secured but also the rights of the surrogates need to be secured to. It is challenging to strike a balance between the rights of the individuals who cross national borders with the rights of the individuals who belong to that country and also the ones who are providing the services to meet the demand of both sections of the individuals.

The prospects of the baby business have matured and its turnover is huge and would reach a staggering height of US $100 billion by 2020. India would prove to be a strong provider along with Nepal because of tripling of the surrogacy facilities in both the countries. Consequently there is then a need to analyze the impact of this rising sector, the distribution of the health resources among the international and national borders and between the private and the public health systems. It should be studied that why the national resources are not being provided to the needy though the affluent are only been benefitted. India as well as Nepal's health care systems adaptation to the global environment needs to be scrutinized.

Thus the benefits provided by the growing reproductive industry should be reconsidered in the context of why Indian resources don't benefit the public health system, why high quality medical care is provided to the foreigners and the rich affluent class and why majority of Indian's who don't own resources have no access to quality health care.

India today comes under the category of being described as one of the most privatized health care services provider; this eventually increases the unequal division of resources and thus marginalization. "Free market" approach in India is dividing the resources where the well-off minority takes away a major share while the majority who needs it is left empty handed. There is a need to include the ART services in the public health sector of India and also by the Nepali Government.

The practice of surrogacy has gained momentum in the last two decades with increasing globalization and people have travelled long distances to avail surrogacy services. This potential of trade in services has been appropriately tapped by the developing countries by making massive arrangements to facilitate its progression.

Availability of reproductive services depends on the clients who can pay for it. So it is more of an industry based on the wealth owned. Wealthy western ART consumers receive individualized and privatized medical attention while the local residents are kept away.

The need is to review the increasing gap between the income differentials that exist between the rich and the poor. The complication can be resolved if efforts are made to make the industry public oriented. The need is to make it more explicitly available in public hospitals and thus make it more accessible to all. So this baby business should be more need based which it is currently not. The revenue accumulated from international trade of surrogacy could be used to subsidize the treatments for the less well off and needy. This will address the need for accessibility and availability for all and not just a few.

Access to safe, effective and affordable care led the infertile couples to undertake journeys to cross borders. Movements across borders is termed mostly with tourism attaching with itself a happy pleasurable journey though this may not be the same experience by all who undertake this journey. For the South Asians economic exile out of fewer opportunities in the home country, Inhorn has attached the concept with reproductive exile. The South Asians migrate to gulf countries in pursuit of economic stability and to also to save their wealth for ART services. The Arab Gulf is therefore defined as social hub for South Asians. Moreover, South Asians indulge in reproductive exile to maintain secrecy as in these traditional societies; infertility is still associated with stigma. Many consider it as a gimmick. The disparity in providing services to brown couple in comparison to white couple is distinctive.

In the last decade, demands have been upraised from the side of single parents and homosexuals. In recent times, LGBT rights have been surfaced. While the Supreme Court of the USA recently legalized gay marriages in a landmark judgment, the Supreme Court of India reestablished a ban on gay sex by overruling the Delhi High Court judgment to decriminalize homosexuality. This is just an example to state the contrast about the rights of homosexuals in the global world.

These further have implications when one among these couples wishes to have a child of their own. The restrictions then imposed on the rights of the homosexuals then additionally stimulate the movements across borders. India laid down stringent rules wherein the foreign intended parents are supposed to be married for two years banned the right of foreign homosexuals as well as single parents and they should get a letter from their home country which would admit the entry of the child as a legal citizen. Sometimes these restrictions inevitably lead to illegal crossing of borders by infertile couples turning them into criminals.

Surrogacy is a physical and mental act. It is possible because the surrogates are available and this multi billion business would not have been possible if the surrogate’s labour were not available at the core of it. The whole economics of surrogacy surrounds her. Thus we need to comprehend the real intention behind her taking this decision and what are the differences between the motivations for the woman of the South and North. Specifically we need to focus

on the surrogates of South Asia. Some consider surrogacy as a reproductive labour while others view it as sexual labour. Feminists say that women are provided liberation and autonomy whereby she plays a pivotal role as a decision maker. Most importantly she becomes self-dependent after earning rather than being dependent on her husband.

Though some people treat surrogacy as another form of prostitution and there is a need to observe that women are not coerced or bullied by the brokers or her extended family. And one needs to make sure that she is offering her services voluntarily since this is not still seen as a reputable job in the Third World countries. Another problem is that if the child is stillborn or disabled or if there is a miscarriage then how would the payment be done because the contract is in exchange of a healthy child. May be she would not be given any money for her poor workmanship.

The need is to examine the differences of the wages for the surrogates of the North or the South though both work equally. There are numerous inequalities between the national and the international market, with the compensation seen as objectifying women's reproductive capacity and thereby turning the market into a bullying one.

Also we need to study that the maximum share of the remuneration is given to the surrogates during the act and not after the detection of child's heartbeat, miscarriage or failed treatment because the stress she undergoes is vast and a minimum payment should be provided anyways.

Every country has set a different payment package for the surrogates along with the compensation for the loss of earnings though it is much more in the North. Remuneration for surrogates in India is staggeringly low (1:10 ratio). The disparity thus is too wide and thus a reason to be evaluated. It needs to be emphasized that the women of the Global North should not exploit women of the Global South. Humbyrd suggest setting up a board to categorize a fixed price to surrogates globally. This would mean that the surrogates would get equal compensation working for anyone and anywhere. Whatever the profit margin is to be derived should be attained from other sources.

Another matter of review is that is surrogacy a choice or a necessity? The priority is accorded to the intended parents for the amount they pay, the illiterate women is then at a loss because she cannot read through the contracts and she ventures in this act without thinking because of the need to earn for her children and her family as has been observed in maximum cases.

It has been further reported that these economically deprived women are being exploited because of their need, who would never be able to earn such a amount after working for the

next ten years also. As these women work in the unskilled unorganized sector or as domestic workers or other such jobs. So they are compelled or forced to undertake this risk. Though there is a talk of empowerment and autonomy, it is overshadowed by the constraints of poverty, social ostracism, lack of access to various facilities like education, knowledge of their rights and so on.

Nepal has recently stepped into this baby business and concerns are there that the women could be forced by middlemen or their relatives to carry babies for foreigners. This is largely possible as there are no laws being formulated and the women might be strained into this business as cases of forcing the women and trafficking have been reported globally. As one can recollect where an educated law student was raped and then beaten for refusing to a surrogate for the guesthouse owner where she worked to earn her livelihood while pursuing studies.

The compulsions in maximum number of cases are poverty or her child's education or due to ill health of her husband wherein she is forced to adopt surrogacy. As aptly said " Economic necessity fuels the surrogacy trade". A global debate is being initiated against the commodification of the women's womb wherein they agree upon to act as surrogates because of the patriarchal set up and there adaptive preference and thus the autonomous decision move into the rear.

The laws passed in India do not specify the rights and concerns of the surrogates. They are considered as business assets and their status is considered low. Ironically a surrogate empowers the other who might be single parent or a homosexual or an infertile couple or a postmenopausal woman or a woman who is unwilling to undergo the trauma of childbirth.

It has been pointed out that the Third world women are exploited due to the differentials of the economic resources that the First World Women possess by exercising real consumer choices. The Third World Women act as surrogates in an enticement to earn a huge amount that would restructure their and their families lives in a short span of time. A true representation of the real situation would depict that the payment for which the poor surrogates are willing to undertake the risk are actually at the mercy of the middlemen and clinics for their payment.

Though it would be right for them to get maximum share of the money given by the intended parents nonetheless there has been numerous cases as highlighted before where the middlemen take up the major share. This is not just reported to be taking place in India but also in countries like Mexico. There is an urgent need to erase these middlemen from the

interaction to make the process more transparent. This would then be helpful for the surrogates to get their rightful share.

The interviews invariably provide us with wider picture where it has been witnessed that surrogacy has shown to be obliging the poor woman, nonetheless also makes her feel alienated from child she contracts for and also the society where she lives. The intended parents too makes her feel estranged from themselves due to differences in colour, caste and creed and most importantly the power differential they inherit among themselves. It has been pointed out that there is least interaction between the surrogates and the intended parents. In contrast to this in the West the surrogates have an equal interaction with the intended parents. In India though concerned about the surrogates well being which is because there are carrying their child, there is no personal contact between them.

The need is to review the status of the Third world women as opposed to First world women. The reason is essentially attributed to the large wealth and power differentials that exist between the intended parents and the surrogates, which makes them passive and inherently powerless victims. The imbalances should be fixed by the State in view to settle the issue of injustice faced by the surrogates who are from a particular geographical-political-economic situation. The remuneration should be fixed for that the surrogates would be entitled to without taking into consideration from where they belong to, how they look or what their background is. There is a urgent need to for the Indian and Nepali Governments to regulate the compensation received by surrogates to eliminate any scope of exploitation by any of the stakeholders.

The surrogates of India are given comfort and their diet has been taken care off in the hostels they reside but they never had the privilege to be taken care of while they were reproducing their own babies. It is brought to the surface through studies conducted that there is a wide contrast of conditions for the same woman who did not have access to care during her pregnancy were being considered precious because their wombs carried babies for rich couples from the Global North.

They are also put under several medical and dietary restrictions by the clinics during that period because their ultimate aim is the welfare of the child and not the surrogate themselves. And for the wishes of the global North, bodies of the Global South are used and abused first by the doctors who transplant multiple embryos and after that by going in for caesarian sections to avoid complications one faces during normal deliveries. Therefore the surrogates feel the absence of autonomy during their term where they are kept in hostels with movements being restricted. There are moreover constraints over meeting their family members.

Another issue yet surrounding the well being of surrogates, is the time till the time she delivers. The long-term health implications are not taken into account of and her risks are multiplied due to the extra medical treatment given to her to safeguard the 'precious' child in her womb. This needs to be addressed at the global level to reduce the power over directly placed in the hands of Global North, exercised via the clinics. It's prerequisite to empower the surrogates of the Global South in relation to the Global North. For the Indian surrogates the studies done have highlighted that these women willing accept their subordinate position vis-à-vis the intended parents and live at the ditz diktats of the clinics. There is an urgent need to undertake similar studies for the clinics functioning in Nepal so that the women acting as surrogates there are not exploited. The workshop that was organized in 2012 primarily aimed to make the women aware of their rights and well being while pursuing the act of surrogacy.

Surrogacy in individual countries like USA, Israel, India and many more is been undertaken very actively. Every country has deployed distinctive frameworks to regulate these practices. As has been discussed in chapter two, these methods adopted have their different set of problems accompanying them. May it be completely market driven as in USA or completely state regulated as in Israel have brought to the fore their own set of complications.

There is a particular profile of women who undertake surrogacy, rightly termed as grouping a particular category of women, from the age group 20 – 45 years, married and specifically from an uneducated and poor background. Financial desperation has been stated by nine out of ten cases taken into consideration. But the story does not end here. There is a need to undertake a field survey to recognize how the surrogates are classified in the surrogacy process. The demand for a beautiful or intelligent or tall or from a well off family are some of the criteria stated by the intended parents.

And to satisfy this middlemen takes up the responsibility of classifying surrogates into categories according to which the intended parents gets the chance to choose and pay accordingly. While a beautiful and intelligent would be paid more in contrast to the not so beautiful and uneducated one. Thus serving the needs of a consumerist society. Finally when the 'precious' child is born since laws are not equally clearly formulated in all countries there are discrepancies. First regarding the ownership of the child and then the citizenship. Still the path needs to be walked where longitudinal studies over the period of decades would help we measure the implications of being a surrogate child. As the story is kept a secret in maximum cases this is a difficult path to tread in for.

Coming back to the issues discussed here, regarding ownership where complications arise due to non-acceptance of the contract or not giving the baby the courts seem to settle the issue. While in some cases the contract may not be enforceable, the intended parents may not get the

rights over the child. While when one takes about a country like India, for obvious reasons it is understood by both the clinics and intended parents that due to financial and social constraints the surrogates would not run away with the baby.

International surrogacy is condemned ethically and prohibited legally on the grounds of exploitation but they continue to exist because of economic inequalities between the Global North and Global South. Appropriate compensation with regulations is the key to end the abuse of the surrogate's economic and social vulnerability. The necessities and motivations should be addressed according to the long-term implications on surrogates health and economic well being. A laissez faire approach relinquishes all their rights just to be paid a compensation that is temporary.

Surrogacy has attained international momentum though the exact data is not available. Media has played an active role in dealing with cases round the globe highlighting both positive and negative aspects associated with it. Internet has further provided the impetus to deal with international clients globally. Although the reproductive services ought to provide assist those who need it nonetheless in the process malpractices trickle in. Hence there is a requirement to strike a balance to let the practice of international surrogacy operate in an acceptable backdrop.

India has the fifth most privatized health care sector in the world. Here there is no standard payment structure, dearth of understanding of informed consent with lack of counseling leads to risky practices in the rising industry of India. Nepal has been safe haven for the mounting demands since India has framed strict rules. This has however led to a rise of additional concern with regard to existence of the industry. The Indian women are gradually crossing borders to act as surrogates for the foreigners. The trickling if Indian women across open borders to act as surrogates have heightened concerns regarding the issue of human trafficking. Movements of surrogates across the borders should be under strict surveillance to avoid involuntary movements.

Though legal framework are being worked out so that cross border surrogacy services may be provided, still core issues need immediate attention by the policymakers. In India surrogacy though not being illegal has imposed restrictions in last two years which have led to an emergence of Nepal as a second hub in the South Asian countries. There is a necessity to add all-inclusiveness to the process of international surrogacy.

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