REPROSCAPE IN THE SHADOWS: UNDERSTANDING COMMODIFICATION AND GLOBAL PATHWAYS OF REPRODUCTIVE BODILY FLUIDS

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MASTER OF PHILOSOPHY

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DECLARATION

Date: 26 /07/2016

This is to certify that the dissertation titled **"Reproscape in the Shadows: Understanding Commodification and Global Pathways of Reproductive Bodily Fluids"** submitted by me under the guidance of **Dr. Sunita Reddy** in partial fulfilment for the award of the degree of **Master of Philosophy** is my original work and has not been previously submitted for any other degree of this University or any other University.

Ritika Kar

Place: New Delhi
Date: 26/07/2016

CERTIFICATE

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

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LIST OF ABBREVIATIONS

ART:	Assisted Reproductive Technologies
ASRM:	American Society of Reproductive Medicine
CAGR:	compound annual growth rate
CBRC:	Cross Border Reproductive Care
FIGO:	Federation of International Gynaecology and Obstetrics
GATS:	General Agreement on Trade in Services
HFEA:	Human Fertilization and Embryo Authority
ICMR:	Indian Council of Medical Research
IMF:	International Monetary Fund
IVF:	Invitro fertilization
MOH:	Ministry of Health
MOHFW:	Ministry of Health and Family Welfare
NAMS:	National Academy of Medical Sciences
NHS:	National Health service
OHSS:	Ovarian Hyper stimulation Syndrome
PFS:	Proactive Family Solutions
PGD:	Preimplantation Genetic Diagnosis
PH:	Planet Hospital
SCNT:	Somatic Cell Nuclear Transfer
WHO:	world health organization
WTO:	World Trade Organization

CONTENT

CHAPTER 1

INTRODUCTION

India is the hub for Medical Tourism. Though the term 'tourism' is criticized as the patients are not in a position to do any sightseeing, thereby some have called it as medical 'travel' or 'exile'. The patients not just from neighboring countries but also from Europe, UK, Africa, Middle East and Australia and US are coming to India for various medical services. The reasons for coming to India are many. One of the most important factor is the low costs. It just cost only one tenth of the cost of treatment in India compared to US or UK. Apart from the low cost is the medical expertise, state of art technology, and good infrastructure (Reddy and Qadeer 2015). Couples coming for the fertility treatment is also included under the reproductive tourism. The reasons for the couples to travel for In-vitro fertilization or surrogacy due to the ban in their own country or due to the high cost.

Research suggests that India presents one of the best conditions for the Assisted Reproductive Technologies (ART) industry to flourish; with numerous fertility clinics opening up seeing the demand for ARTs and having no law so far to regulate the industry. The availability of trained staff, and the most important part of the ART industry is the availability of donors and surrogates who are ready to sell their reproductive services. The reasons for them to sell the services are sheer poverty and lack of stable work and livelihood opportunities. The donor gametes and the wombs come with a conditions and a price, which seems to be a lump sum amount for the donors and surrogates and cost wise is the lowest which cannot be matched anywhere in the world.

IVF clinics are mushrooming in almost all the metropolitan cities; they have also been growing in smaller towns too (Sama, 2010). In this period of recession where most of the billboards are empty, ironically there are big advertisements of hospitals and clinics, shows that there cannot be any recession for health sector, which has taken the shape of industry and business. Whilst travelling across New Delhi, one can see huge hoardings, advertising the availability of IVF facilities, infertility treatments at many clinics and hospitals. These hoardings have images of happy couples holding a new born baby, sending out a warm message that with the help of the treatments, others too with fertility problems can fulfil their

dreams of having their own family. The hoardings provide the information about the kind of facilities and medical treatments one can access. However, what these hoardings only shows the positive side of the story. They do not reflect and convey the processes in which the donors and surrogates experience poverty and marginalization and thus offer to be part of the global trade of selling bodies in whole, or part and the reproductive services. Though the IVF industry fulfills the dreams of the infertile couples of having a biological child of their own. Through this research I have attempted to look at the global and local forces, the actors and the industry which facilitates this process specifically looking at the process of egg donation, and how the bodily reproductive parts are commodified? What are the global pathways and forces which facilitates the movement of the gametes across the globe? What are the regulations and the laws in some of the countries which allow or restrict the access to the ART industry, which ultimately results with India becoming one of the most favored destination countries.

While the macro forces of neoliberalism and commodification have helped in the creation and development of the ART industry in India, I have attempted to understand the micro socio-cultural forces in the Indian context which provide this industry with its most coveted raw material- the woman's body and it parts. This crisscrossing of gametes, agents, ideologies, technologies, laws, socio-cultural process has created a unique reproscape in terms of India, as it exists but is kept in the shadows, which also becomes a part of the topic under study (Inhorn,2011). Through this research I intend to throw some light on the processes, agents, forces regulations or the lack of it which creates this unique reproscape in the shadows.

Available Literature

The IVF centers and fertility clinics are part of the Assisted Reproductive Technologies (ART) industry. India has become a preferred destination for accessing ART, attracting a large number of people who do not have access to these technologies in their home country due to various reasons (Reddy & Qadeer, 2010). The ART industry has grown simultaneously, with the growth of the private health care sector in India, and is largely a part of the private sector and further forms a part of global reproductive tourism industry. At the global level too, the advent of the new genetic biotechnologies and privatization have moved hand in hand, and have proliferated across the globe (Sarojini et al, 2011). This global proliferation of the reproductive services under IVF clinics, has led to the formation of a

'*reproscape*' as stated by Marcia C. Inhorn, which entails the movement of gametes, technologies and processes, finances, media, ideas and people (Inhorn, 2011).The coming together of these forces of neoliberalism, commodification and a ready market has created 'global assemblages' of gametes and their donors, the network of brokers and agents, who act as the middlemen between the donors and the buyers- both the ART industry and the commissioning parents, who in doing so are interacting with various global moral and money economies, and through various forms of technical and political systems and processes thereby, tracing a global pathway of reproductive bodily fluids at a global level (Cohen, 2005; Scheper- Hughes,2005). However, this reproscape exists in the shadows as the processes which facilitate this industry remains heavily veiled and unregulated.

Further, the amalgamation of the neoliberal policies, the development of biotechnologies and globalization has created pathways for the commodification of the bodily reproductive fluids namely the egg and the sperm, which forms the raw material for the ART industry (Nancy Scheper Hughes, 2002). Moreover, owing to the neo-liberal market forces along with the growth of global capitalism new regimes of consumption have resulted in the removal of boundaries between those items that are tradable commodities and that which are vital parts of our being and should not be bought or sold- a process which is very apparent in the current markets for human organs, tissues, cells and reproductive body parts. Furthermore, the increased medicalization of the women's bodies in the neoliberal world has also resulted in the ART industry being a heavily gendered industry, with women bearing both the health and socio-economic risks as egg donors, IVF patients and surrogates (Sharp, 2000). The human egg has been reified to become a commodity (Pande, 2014), and an essential part of the ART industry.

With the woman's egg and the uterus becoming the pivot around which the entire transnational fertility industry is based, the forces of globalization along with the neoliberal policies have pulled in the already burdened women from the erstwhile third world nations, to provide for the ever-increasing demand. This is because third world nations like India, remain trapped under international debt and with ever decreasing number of jobs in the organized sector, and the lack of state support, it is the woman who now has to find alternative means of living not just to support herself but also her family, thereby creating counter geographies of globalization- survival circuits and shadow markets, as termed by Saskia Sassen (2002), to the formation of ice-berg economies as Maria Mies(2007) have stated in their works. Women are forced to invent new productive niches in the so-called 'informal' economy (Davis 2006).

These women's bodies are therefore more 'bioavailable' than the others' for them to be exploited (Marcia and Gurtin, 2011). The Indian scenario is marked by these survival circuits and shadow economies, which then becomes one of the most important sources of the gametes, which are indispensable to the ART industry.

It's not just the forces of globalization and neoliberal policies which always propel the movement of people/ gametes across borders seeking ART services, often enough the regulations at the home country are restrictive- on the basis of ethical, religious or socio-cultural reasons. These people who are restricted in their own countries, then indulge in "circumvention tourism" (Cohen, 2012, p.1381). In India it is the lack of regulations which led to the booming of the ART industry, becoming one of the most favored destination country for people seeking the ART services. Though there are numerous of studies now in India on surrogacy but there are hardly any studies done on in the field of egg donation.

In India, the ART services are catered through the private care set-up, which provides its clients with world class facilities at a fraction of the cost (Reddy & Qadeer, 2010). This is possible amongst, other reasons, because of the easy availability of cheap reproductive labour (Pande 2014). While neoliberal forces have created a survival circuits, making it difficult for the women to survive, it is the inherent localized forces such as patriarchy, which makes women submissive and accepting of the fact that, they in order to improve their living conditions of not just herself, but of her family needs to sell or rent out her body parts, as no regulations exists in this country.

Objectives of the Study

Broad objective: to understand the process of commodification and map the global pathways of the bodily reproductive bodily fluids, especially in the case of the human ova, to look at the socio-cultural, ethical and religious basis for regulating the ART industry, and to understand the socio-cultural milieu of the egg donor.

Specific objectives

1. to map the pathways of the global mobility of the reproductive bodily fluids which are guided by the forces of globalization, the resulting commodification and cultural constructs.

2. To look at the socio-cultural, historical, ethical and religious basis of the laws regulations in countries like – Italy, the UK, Germany, Israel which control the access and proliferation of the ART industry, and to look at the draft ART bill in India, not yet a law, and thus the lack of regulation in India.
3. To look at the process of egg retrieval and the socio-cultural profile of the donors in India and the reasons why the women agree to become egg donors.

Research Questions

1. What are the pathways through which bodily fluids and reproductive parts are being used and transferred across the globe?
2. What is the processes of commodification of the gametes?
3. How is the ART industry gendered?
4. What are the ethical and unethical, religious, socio-cultural factors which become the basis of regulations of the ART industry, especially in the case of egg donation?
5. What are the regulations regarding egg donations in India?
6. What is the process of egg retrieval?
7. How does phenotype, caste, class play an important part in the selection of the donors, and are there any cost variations for a certain type of sperm or oocyte?
8. What are the local inherent forces in the Indian society, which lead women to become 'willing' egg donors?
9. What are the processes through which these women are recruited as egg donors?
10. What are the global processes which bring women from the most unprivileged background to become egg donors?

Methodology

This research is primarily a qualitative study based on the secondary review of literature from the perspective of political economy available on medical anthropology, feminist writings and critiques of the commodification and medicalization of the body, a Marxist critique of the neoliberal policies, a comparative analysis of the socio-cultural, ethical and religious basis of laws and regulations in other countries and an analysis of the regulations in India.

Data Collection:

Though initially I intended to do an empirical study by visiting IVF clinics and interacting with the experts from the clinics and the egg donors, but due to time constraints it had to be a review study. The clinics were also not forthcoming to give their consent for the study, despite trying very hard. Only I could manage to get permission from one clinic and could interview the experts in that clinic in South Delhi. Thus the scope of the study was changed and focussed more on the secondary literature and made it into a review study. The data for the study, thus basically retrieved from the secondary sources comprising journal articles, newspaper contents online and offline, and key informant interviews. This research also entails the experiences shared by various women in the group discussions with the women groups in Srinivaspuri (New Delhi) and also draws from the field visit which was a part of the M.Phil course work. This research also includes descriptive analysis of the websites, catering to the industry. The research is based on the review of articles, medical journals, law journals, social science magazines, books, newspaper articles, and the websites pertinent to the research.

Ethical Clearance

One needs to keep in the ethical components while conducting any research. One of the main components of ethical research is 'informed consent', in order to conduct the interviews with the key informants for the mentioned research written consent was obtained from the clinic, and the participants, once they have been informed verbally and in writing about the following issues- scope and purpose of the study, the nature of the information which is required of them. Furthermore. the participants were also informed about the full confidentiality that will be maintained and their ability to remain anonymous in the research and the extent and procedure of the use of the gathered information. The participant were also made aware of the fact that they can opt out of the interview at any point they feel uncomfortable. The researcher also refrained from asking any such question to the participant which incites anxiety and any sort of distress, further the researcher refrained from building any identities than that expressed by the participant in their narrative. The researcher also encouraged the respondents to speak in their own words as much as possible.

Limitations of the Study

Due to the sensitive area of research and surrogacy being under lot of debate and discussion for the past few years and also the recent banning of surrogacy for foreigners brought lot of anxiety among the IVF clinics. Many scholars were approaching the clinics for the

permission to study, especially foreign scholars, off late, the clinics started restricting the permission to do research, as they feared negative media coverage. This made it difficult for me to get permission in many clinics which were approached. Even though after telling them it is purely an academic study, and the names will be confidential, I could not get permission from the IVF clinics except for one. Thus the interviews conducted in this clinic are only indicators of the processes happening and thus cannot be generalized at all.

However, this limitation was covered by doing a review of the available literature on the subject and the objectives of the study were covered. The identification of egg-donors was also tedious work, as one cannot make out who are these women who comes for egg donation, until and unless one visits the clinics and the expert tells who they are. The ethical practice of maintaining anonymity of egg donors was also the hurdle for the clinics to reveal their names. The agents were also not cooperative for giving details even in the condition of maintaining complete anonymity of the respondents.

Chapterisation

This research is divided into five chapters:

Chapter 1 Is the introduction chapter, which puts forward the purpose of the research; the literature review; it details the objectives of the study and the research questions. It further includes methodology and the limitations of the study along with the chapterisation of the research.

Chapter 2 deals with the theoretical analysis of the pathways of the global mobility of the reproductive bodily fluids which are guided by the forces of globalization, the resulting commodification and cultural constructs based on the review of literature. Futher, detailing the process of commodification of the bodily reproductive fluids, process of feminization of poverty and the development of the shadow markets and survival circuits are covered under this chapter. Further this chapter also talks about, how these global processes make some bodies more 'bio-desirable' to source the raw material for the ART industry, and how a form of structural violence which has been seen from the perspective of 'bioviolence'. All these processes are responsible for the movement of the gametes, wombs and people across the borders.

Chapter 3 consists of a comparative and descriptive analysis of the ART regulations in Italy, the UK, Germany, Israel and India. Here, ethical, religious, socio-cultural factors which become the basis of regulation and control of the ART services in Italy, UK, Germany and Israel, which are also responsible for the movement of bodily reproductive fluids in the manner of reverse repro- traffic and the movement of people, via circumvention tourism, which people undertake to escape the laws in their countries. Further, one has discussed and analysed the draft ART bill in India, its features and the modifications suggested by various researchers, for it to have teeth so that it can regulate the Indian ART industry which remains nearly unregulated, and therefore one of the major reasons for it to be the most favoured destination for ART services. The bill hardly talks about the status of the egg donor making her already precarious condition even more difficult.

Chapter 4 deals with the analysis of the process of egg retrieval and what are the processes through which the Indian woman becomes an egg donor, a descriptive analysis of her socio-cultural profile based on the literature available and the websites which advertise and register donors and surrogates on a worldwide level. Further from the analysis of the websites of two leading IVF centres in Delhi, the understanding of the medical professionals towards the egg donors and surrogates. This chapter also deals with the analysis of the process of recruiting a donor, achieving consent and creating the perfect donor.

Chapter 5 consists of the summary of the findings and discussion along with the suggestions.

CHAPTER 2

Globalization and its Interplay with the Transnational Flow of Reproductive Bodily Fluids: A Review

Introduction

With the birth of the first test tube baby in July 1978, the Assisted Reproductive Technologies (ART) industry has progressed by leaps and bounds (Inhorn, 2003). For those unable to conceive, but have the financial means, this ART industry has come as a blessing. These assisted reproductive technologies fall under the third and the fourth group of new reproductive technologies, as divided by Michelle Stanworth (1987). The technologies have been divided into four groups, with the first group compromising of technologies for fertility control which include contraceptives as well as methods of pregnancy termination. With the medicalization of child birth along with the rise of professional medicine, hospital based delivery practices became the norm, replacing home births in most of the first world countries. This shift has been accompanied by the development of a second group of technologies used in the management of labour and delivery. The third and fourth groups of technologies, which are fraught with controversies and fierce debates, deal with assisting reproduction like artificial insemination, In Vitro Fertilisation (IVF), and technology for monitoring foetal development in early pregnancy like ultrasound and amniocentesis etc. (Ranjan 2007).

Despite being controversial in nature, these technologies have allowed one, to now have a child, with or without their own genetic material, while being at a geographically different place. It has led to the transnationalization of this industry which is also termed as Cross Border Reproductive Care (CBRC). People go to great extents to have their own child, and with the availability of reproductive services, people in this "quest for conception" as Marcia Inhorn (Inhorn & Patrizio ,2009) has termed, are ready to cross international borders, in order to achieve parenthood (Gupta, 2006, p 26). This reproductive industry has over the years, become a lucrative private enterprise (Sangari, 2015, p 71), and has found markets and resources in India as well as other parts of the global south. It has changed the way human reproduction is understood, as it has now provided an option where one can have a child

without having physical/sexual intercourse. As Payne has stated that as with the oral contraceptive pill, one could have sex without having babies; now one could have babies without having sex (Payne, 2015, p 107).

This global transnational ART industry relies heavily on the third party, to flourish, which comprises of the men and women who provides them with the gametes (eggs/ sperms) and gestates and gives birth for the others (Ikemoto 2009; Inhorn 1994). Through the forces of globalization and the process of commodification, these third parties are made available to the ART industry. There are many pathways through which the bodily reproductive parts are made "bioavailable' and 'biodesirable', which has shaped this 'reproscape', which remains in the 'shadows' and is unregulated. In this chapter I have attempted to understand the pathways of the global mobility and biocrossings of the bodily reproductive fluids, the push and the pull factors which drive this industry, the problem to which ART is seen as a solution, the processes through which bodily reproductive fluids are commodified and thereby becoming an indispensable part of this global transnational industry.

Infertility

Infertility is the problem to which ART came up as a solution. The desire to have one's own child is a very natural concept for many couples and that of the society at large. Moreover, it is the social norms, which expects couples to reproduce and have their own children, for it to be called a functional and acceptable family. It is seen as a major milestone in one's life. For many, conceiving children comes naturally and without much hassles, but there are many for whom this becomes one the major setbacks in life. For many couples their societal position is defined by their fertility, more so for the woman as it is a threat to her identity, status, economic insecurity and stigmatization and in the man's case it greatly affects lineage, familial and community continuity and also questions his masculinities. Though childlessness affects both the man and the woman, in India the socio cultural impact of infertility is much more on the lives of women, than on the lives of men (Meyer 1997). In the WHO report Widge states, that in India, *"the patriarchal, patri-local and the patrilineal nature of the family exists even today. Marriage is a relationship between two families rather than between two individuals but certain aspects of patriarchy are common to most patri-kin groups, irrespective of whether they are from the north or the south, especially when it comes to women's overall status in the family*" (Widge, 2002 p. 62). The only recourse for a woman to acquire respect and achieve social status is through motherhood.

Despite the high prevalence of male infertility, infertility is paradoxically considered to be a "*woman's problem*" around the world (Inhorn & Van Balen, 2002), and thus the role of male infertility is vastly underestimated and even hidden in many societies (Inhorn, 2002).

During the focus group discussion and during the field visit to Devgarh village in Rajasthan as a part of the M.Phil coursework, it was found that infertility is often seen as a fault on the part of women which has been reiterated in many other studies on this subject (Widge, p. 65). In the village in Devgarh, Rajasthan and Shrinivaspuri, Delhi, it was observed that while women would go any extent to provide a child to their husbands, the men would hardly get themselves tested. In Rajasthan there were many cases where the man was infertile, and despite repeated marriages, did not conceive a child, so that wife (wives in some cases), made their own arrangements with other men and had children. Even while interviewing the women would attribute male infertility to God's will and fate, which was not the case amongst women.

Studies, interviews with doctors and group discussions showed that ART then becomes the last resort of many childless couples, for whom adoption is not an option, reasons being the stringent adoption rules and the desperation to have their own biological child brings them to the doorstep of the ART industry which then becomes the part of the larger transnational fertility industry.

This industry is fuelled by the desire of people to have their own child. In the process a large number of actors come together to fulfill this dream. Thus in this process the most important actors are the commissioning parents, also called intended parents, the clinic, the actors in the clinics like gynecologist, embryologist, councellors, nutritionist and the most important agents/ agencies which act as 'middlemen' and the indispensable 'third party'- those who provide the gametes and the womb, the raw materials for this industry and whose shoulders this multi-billion-dollar industry rests. Infertility, as stated by Gillian Hewitson, which would earlier be a private affair within the home and then between the couple and their doctor is being managed by the market and the forces of globalization (Hewitson, 2014).

2. Globalization and its Interplay with the Transnational Flow of Reproductive Bodily Fluids

The ART industry and the commodification of the bodily reproductive parts can be understood by looking into the interplay between the forces of globalization and the reproductive industry. While globalization can be understood as the rapidly growing streams

of people, images, consumer goods, money, markets and communication networks around the world (Schaebler and Stenberg cited in Inhorn, 2011, p 89), it is important to look at the processes of globalization in context of the CBRC, for which the theory of 'scapes' given by Arjun Appadurai is highly relevant. Appadurai talks of a 'global cultural economy', where there are five major pathways through which global movements take place. It is the movement of people (*ethnoscapes*), technology (*technoscapes*), money (*financescapes*), images *(mediascapes*), and ideas (*ideoscapes*) at different speeds across the globe, which characterizes globalization. These movements are not culturally homogenizing, and the effects of these movements are not uniform around the globe as globalization is not uniform across the world. These transnational movements are also 'deeply historical' and 'inherently localizing process', thereby having different affects in different regions in the world (Inhorn, & Gürtin, 2011. p 667).

Marcia Inhorn explains that the process of reproductive tourism, mainly involve two of Appadurai's five scapes- ethnoscapes and technoscapes. Ethnoscapes, as defined by Appadurai as '*the landscape of persons who constitute the shifting world in which we live: tourists, immigrants, refuges, exiles, guest workers and moving groups and individuals*.' Similarly technoscapes involves '*the global configuration, also ever fluid, of technology and the fact that technology, both high and low. Both mechanical and informational, now moves at high speeds across various kinds of previously impervious boundaries*' (Appadurai cited in Inhorn, 2011, p 89). Here, Inhorn suggests, that Appadurai's theory can be expanded to understand the interplay between the forces of globalization and the transnational movement of bodily reproductive fluids, to include a 'bioscape', which would entail the moving of biological substance and body parts, of which 'reproscape' can be seen as a meta- scape, to understand the movement entailed in reproductive tourism (Inhorn, 2011, p 90). Reproductive tourism is not simply the circulation of technologies (technoscapes), reproductive actors (ethnoscapes) and their gametes (bioscapes), this has led to the development of a large global industry, which now involves the circulation of money (financescapes). For this industry to thrive on the idea (ideoscapes) about making babies, without much physical effort, while enjoying a holiday is also circulated with the help of the images in various platforms of the media (mediascapes). Internet which falls under the mediascapes, as Gupta in her work mentions "*lures people seeking infertility treatment, egg donors and surrogates, offering them cost- effective packages of services with the bonus, sun and the sea*" (Gupta, 2006, p 26). There is a distinct geography, which is transversed by global flows of the commissioning

parents, the agents and clinics and the third party, which provides the raw material for this industry. At the same time ever developing reproductive technologies (technoscapes), body parts, money and reproductive imaginaries, shapes this 'reproscape' (Inhorn, 2011).

This mobility of the bodily reproductive fluids, along with the forces of globalization has been also described as '*biocrossings*' by Bharadwaj, which he defines "*as crossing between biology, biology and machine and across geo-political, commercial, ethical and moral borders*" (Bharadwaj cited in Gupta, 2006, p 29). He brings out the picture how the ART has been brought to the world, a 'globalized reproduction', where it is not just the people who are physically crossing national boundaries and travelling thousands of miles in their attempt to have their own biological child, but also the movement of reproductive parts across the globe (Bharadwaj cited in Gupta, 2006, p 29).

The globalized reproductive industry can also be seen as 'global assemblages', which is defined by Ong and Collier (2006 p.3) as "*the actual and specific articulation of a global form"* . Producing 'global assemblages' of gametes and their donors, the network of brokers and agents, who act as the middlemen between the donors and the buyers- both the ART industry and the commissioning parents, who in doing so are interacting with various global moral and money economies, and through various forms of technical and political systems and processes (Cohen, 2005; Scheper- Hughes, 2005).

These global assemblages do not function in the same manner across the world as globalization and does not have a universal and a homogenizing effect, therefore having different effects at different places, contingent on the socio-economic condition of the place and the historical processes it has gone through. In this 'globalized reproductive industry', the factors which facilitate this globalization of reproduction, according to Gupta (2006) include transportation technology which persons and reproductive body can physically transport parts over long distances, to create these global assemblages. Another factor is the proliferation of information and communication technologies, especially the Internet through which the ideas as well as images, which lure people into participating in this global reproductive industry are transferred at great speeds to the targeted population. One of the most important factors guiding this ART industry and which foster in globalization is the liberalized free market economy, which allows capital to flow around the globe, unhindered.

The ART industry cannot be understood, without looking into the impact of the neoliberal policies. One needs to look into how the bodily reproductive fluids- sperm/eggs, embryos and

uteruses have become discreet entities and turned into commodities, which can be traded and donated, and how the human body and its parts have been made "bioavailable" and "biodesirable" in the neoliberal capitalist market? How the developments in the field of biomedical and health technologies in concert with the forces of globalization are shifting the geographies of the global labour flow?

Neoliberalism is a term which can be understood as '*a theory of political economic practices that proposes, that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices*' (Harvey, 2007, p. 10). As per the theory of neoliberalism, state intervention in the markets must be kept to a bare minimum, while at the same time set up military, defense, police and juridical functions required to secure private property rights and the free function of the markets (Harvey, 2007. pp. 22-23). Neoliberalism can be compared to a tidal wave, which has swept across the world leaving in its wake, massive inequalities with it, interventions, reforms and structural adjustment programmes. Furthermore, Harvey explains that even sectors like health and education are now set by financial institutions such as the IMF and WTO, and those who fail to comply have to face severe penalties (Harvey, 2007. p. 23). It is not just the financial institutions which have been affected by the neoliberal policies, its spread across the globe, has led to the creation of vast cleavages between rich and the poor, in terms of division of labor, social relations, welfare schemes and even affected the ways in which one feels and thinks.

Neoliberalism effects reproduction and how it has fueled the ART industry and the resulting commodification can be understood, from its effects on the family. As stated in Waldby and Cooper's work (2008), the pre-neoliberalism era in the west was characterized with the Fordism, with the Fordist model of family, which is consisted of a male breadwinner, and female as managing family affairs and a full time mothering, which then was supported by the state through welfare schemes.

With neoliberalism becoming the central guiding principle of economic thought and management (Harvey, 2007, p. 10), the Fordist form of the family could not subsist and with the increased costs of survival and the availability of opportunities, many women, especially belonging to the middle class, began delay in bearing children or avoid having children

altogether. Thus, the state which would rely on the natural way of reproduction of labour, was then limited in its access to over female reproductive biology- which was detrimental to the capitalist setup.

The development of the ART technologies answered their prayers. These technologies enable the privileged women to delay childbearing. The agents of neoliberalism soon realized that this is increasingly becoming medicalized, technologized, field of human reproduction and could be regulated by the market. This led to the development of the ART industry, which was privatized and made available for investment (Waldby and Cooper, 2002). This led to the establishment of global business of medically assisted reproduction, where the affluent could afford access to ART and donor gametes. However, this industry is excessively dependent on the availability of donor eggs, sperms, and the womb which cannot be made available without exploiting the bodies of the third world unprivileged women (Waldby, & Cooper, 2008).

Neoliberal Policy in India and its Effect on Health Services

In India with the implementation of the neoliberal form of economy, which was characterized with the opening up of the markets, from 1990s onwards. Owing to international pressures led to the retreat of the state as a provider of services, including healthcare services and was reduced to the status of a steward. The earlier held aspirations of creating a welfare state was abandoned and state accepted the Structural Adjustment Programme (SAP) under which its role as a steward was to help in opening up the sector to investments and international capital while at the same time withdrawing from the public sector (Pande, 2014; Qadeer, 2011).

The inequalities resulted out of the implementation of neo-liberal policies has created discriminatory access to reproductive healthcare services. Furthermore, it has led to a new of stratified reproduction with the reproductive labour of the poor being revalued, against the earlier devaluation and aggressive control of the reproductive capacity of the poor. Fueled by the ART industry the reproductive labour of the poor is being appropriated by the said empowered class (Pande, 2014). The participation of women in the sale of eggs involves a very literal form of bodily, reproductive labour, a kind of labour that has been traditionally available to women but has only recently been medicalized, technologized and standardized to an extent, where it can be organized on a global scale. While such practices also exist in the developed economies, more onerous clinical labour is increasingly outsourced to the poorer populations in the developing world, where the women not only face immoderation due to the neoliberal policies but also forced by the same threat end up as the main provider

of reproductive labour in an ever-expanding reproductive market (Hewitson, 2014) Thus, while one section of the of women found the liberty to delay childbirth, the neoliberal market forces ensured that it was done at the cost of the under-privileged woman, as she is the one who was to bear the child and produce the egg on behalf of the woman who isn't.

As with the recognition of the commercial potential the oocyte has become the most important part of ART industry, with an ever increasing demand for fertile oocyte in the private fertility medicine. In order to meet this ever increasing demand for eggs the reproductive industries are turning towards the unregulated markets where eggs are provided cheaply by women, in countries such as former Soviet Union nations, China, South Africa, India and other countries with developing economies (Hewitson, 2014).

When one argues that, the women from the developing economies are being forced to put a cost on their reproductive labour, the market forces argue that since in the neoliberal world, any individual is 'free' to take decisions on their own, without any coercion. However, what the market forces cleverly do in order to ensure that the woman has no option but to sell and rent out her body parts by creating desolate material conditions around her, and the removal of safety nets from the state (Hewitson, 2014). This, coupled with lack of earning opportunities in the organised sector has added to the difficulties in the life of the poor. The male members of the family often migrate to different cities or counties in search of a better wage, resulting in fragmented families (Hewitson, 2014, pp 491-492).

The success of neoliberalism depends on the levels of inclusion of the ideology of free market capitalism. It is vital that the policies incorporate the idea of the 'family'. Within the ideological periphery, the unpaid reproductive activities are taken for granted. The household becomes a marketplace within which, the ideas of profits, earned wages and returns on investment holds true. The old definitions and demarcations between family /market and public/ private are no longer based on gender; rather they are modified into racial/ethnic divisions at a national and global scale. 'Infertility' is just another financial risk in a neoliberal world (Hewitson, 2014, p.492). For sale are choice gametes, and the uterus can be rented. The gargantuan inequalities in such a market redefine themselves as the fallacies of "choice" which all capital endowments suffer.

The ideas of social reproduction are "both naturalised and reprivatized". Surrogacy becomes a transaction between independent agents - 'buyers' and 'sellers'. The neoliberal policies contribute to shaping the global demand and supply in both the 'buyer' and 'seller' countries.

However, despite the claims of neoliberalism as a 'neutral' ideology - neutral with respect to race, gender and sexuality - the intrinsic biology of human beings forces the economics of this market to be heavily dependent on gender (Waldby & Cooper, 2008).

It is also often argued that the path taken by neoliberalism, follows reproductive, sexual and slave labour in early capitalism, as they lie heavily on the earlier laid lines of race, class and gender discrimination in the recently developed global reproductive market (Waldby & Cooper, 2008, p. 10).

Commodification of bodies

In the recent years, commodification has become one of the most prominent debates about the body, as boundaries of the body has been reorganised with the recognition and creation of separable, exchangeable and re-incorporable body parts (Seale Clive et. al., 2010, p. 2). The debate on the body basically states that the body is a form merchandise which can be sold, bartered or exchanged or even stolen (Scheper-Hughes, & Wacquant, 2002,). Another defining feature of commodification is the fact that the process of commodification violates the understanding of the body held by the person and the society at large.

It is mostly considered that commodification of the body is the result of development of biomedicine and the increasing medicalization of the human body, as Leslie Sharp, (2000: 298), states the medicalization of the body has led to the fragmentation of the body, which are transformed into work objects. Sharp further points out to the fact that commodification of the body is not a recent phenomenon, it has existed in the form of slavery, a variety of exploitation of the women's bodies, the transnational trade in adoptable children, the sports industry and the military (2000). The advent of modern medicine saw a rising demand for corpses for dissection and a trade in organs such as kidneys, with the donors being increasingly objectified (Seale Clive et. al., 2010 p. 5).

Further, an object is turned into a commodity only when it acquires a use- value and then it is subject to commercial exchange (Marx, 1887), however, in the case of the body a process of objectification or reification is required, where it is necessary that the materials are separated from the body so that they can become objects (Seale Clive, 2010, p.4). With the newer biotechnologies, it is this process of reification, which has made objects out of babies who are made donors for their sick siblings and are given birth to, for the particular purpose, dubbed as 'designer babies' by the media, has led to many debates (Seale Clive et al, 2010, p. 5). A

similar process is involved when repeatedly eggs are extracted from women and return of monetary compensation for the IVF processes.

The unwelcomed process of dehumanising the meaning of the body parts by the means of bioscience, biomedicine and associated commercial infrastructures and are thereby seen as prime movers of objectification, commercialization and exploitation. However, in this process we often forget the role of mass media which contributes towards the commodification of body parts, which is fuelled by commercial interests and often becomes a form of entertainment (Seale Clive et al, 2010, p. 27).

In order to understand the process of commodification of the bodily reproductive fluids one needs to understand what a commodity is. As according to Marx, "a commodity is in the first place, an object outside us, a thing that, by its properties satisfies human wants… for an object or product to become a commodity, a product must be transformed to another, whom it will serve as a use-value by means of exchange" (McLeod, 1999, p. 263). All commodities are made up of two properties, which are use value and exchange value (Sweezy, 1964, p. 26). Mcleod (1999) and Nigel Thrift (2006) both emphasize in their works that a commodity is not always a material object, a service may also be a commodity such as reproductive service, where there may be no product in the end (no baby, no oocyte), yet the person who performs the service may be compensated nonetheless, which suggests that the service itself is the commodity.

Furthermore, as Marx has described, the commodity is what the human being desires or needs. These needs have been disciplined, shaped and brought into alignment with the needs and desires of consumer-oriented globalization. Commodification, Nancy Scheper Hughes states, is continuing with the earlier discourses on the desire, need and scarcity of human bodies and body parts for religious edification, healing, dissection, recreation and sports and for medical experimentation and practice (Scheper-Hughes, 2001, Pp. 31-34). Andrea Whitekar's (2011) also looks into the implications of marketing of reproductive services as a commodity. She has brought to the fore how reproduction is seen now as a miracle of technology rather than an intimate experience. Whitekar mentions Ginsberg and Rapp's work where they too state how over the years a "new geography and economy" for particular specialities concerning various body parts has emerged all around the world. These spaces catering to particular body parts have been a result of a combination of sophisticated medical

infrastructure, expertise, particular regulatory norms or, as in the case of India, the lack of it (Whitekar, 2011, p 108).

Nancy Scheper Hughes states that this global transplant medicine has allowed the world to be bifurcated into two unequal populations – one which demands the organs, and the other which provides them (2001, p. 32). The former are cherished patients, treated as moral subjects and as suffering individuals, while the latter remains invisible, unrecognized as anonymous suppliers of spare parts. The receivers have their biographies known, and their propriety rights over bodies and body parts of the poor, living or dead, are virtually unquestioned (Nancy Scheper Hughes, 2001).

With the use of the ARTs, there is a separation between genetic, biological and social motherhood/parenthood, and a new configuration of motherhood, fatherhood, and family are being created. Along with the commodification of the bodily reproductive parts, one can also see the commodification of motherhood and parenthood, which is also being technologized, industrialized and globalized. There is a "commercialization of intimate life" as Hochschild (2003) puts it, of the private realm of the family, of baby making (Gupta, 2006, p 30).

Globalization is leading to the growing interconnectedness and interdependence on a world scale. It is with globalization that capitalism, which is now aided by the neoliberal policies, has penetrated the global markets with minimal regulation. One can draw a clear resemblance between the manner in which the multinational corporations have found it profitable to shift their production and "outsourcing" to developing countries, both to capitalize on the cheap labour power and minimal legislation and social protection measures, so as the reproductive industry found both its resource base and new markets in those countries, leading to outsourcing of reproduction (Gupta, 2006, p. 30).

In the free market economy of a globalized world, reproductive body parts such as male sperm and women's eggs, embryos, and uteruses (in surrogacy) have become discrete entities and turned into commodities that are donated or traded, by individuals as well as infertility specialists, IVF brokers, research scientists, and so on, for commercial profit (Gupta, 2006, p 30). The provision of services for assisting reproduction has become an expanding and lucrative billion-dollar "industry" giving rise to a more recent phenomenon of transnational "reproductive tourism." There are vested interests of pharmaceutical corporations marketing fertility drugs and manufacturers of clinical equipment, not to forget the research industry

that has a stake in the "leftover" embryos resulting from ART procedures. The global bio-economy of assisted reproduction is booming, with the Internet often serving as mediator (Gupta, 2006, p 30).

Most of the countries where ART industry is flourishing offer these services from private clinics limiting access to those who can afford them. It is a business that operates within global relations that are characterized by stark economic inequalities and diverse and inadequate regulation and governance. Poor women from developing countries and from the underclass in the developed world are bearing children for the world market and for the more privileged classes in their own countries, and sometimes unknowingly providing the raw material for stem-cell research and cloning. Women from the poorer sections of society who lost out on the globalization that benefitted the urban middle class in India as the state adopted a liberal free market economy in the 1990s, are now being integrated into the globalized reproductive market as surrogates (Gupta, 2006).

According to Pfeiffer the iniquitous development effected by both neoliberal policies and forces of globalization working in tandem, the business in human eggs, follows the same path which the unregulated kidney trade did (Pfeffer, p. 2011). The lack of regulation aided by neoliberal policies has acted as a lubricant for the kidney trade to function, and the resulting exploitation of the donors. Kumkum Sangari also states in her work how this ever expanding, industry of transnational reproduction tourism, 'is a part of the overlapping expansion of the low wage informal sector (consequent on economic liberalization), the service sector which concentrates women in less skilled occupations, and state supported medical tourism' (Sangari, 2015, p. 74). As with the concentration of kidney donors within the global south, Kumkum Sangari argues that the trade in women's womb and eggs follows the same route which is followed in recruiting domestic work, hospitality and care work, and sex work- with the developed economies drawing most of its resources from the global south. Various factors work in favor of India becoming a prominent destination for commercial surrogacy, where, 'the state accommodated the practice as a mere extension of medical tourism and touted it as the second largest foreign exchange earner after information technology' (Sangari, 2015, p 71). This industry has found markets as well as resources in India, and therefore flourished. With women in the global south becoming the main suppliers of the egg for the global ART

and research industry, it is then pulled into the orbit of the transnational redistribution of reproductive services.

Sale for Survival : Gendered Dimension

The Reproscape, which has been discussed earlier, needs to be understood as a process that is heavily gendered. ARTs exact a significant physical toll on the body, especially for women as both recipients of ARTs and as oocyte donors. It encompasses the third party, reproductive labour termed as assisters by Marcia C, Inhorn, which mostly consists of women, who undergo risky forms of hormonal stimulation and oocyte (egg) harvesting (Inhorn, 2011). With the woman's egg and the uterus becoming central axis, around which the entire transnational fertility industry is based, the forces of globalization along with the neoliberal policies have pulled in the already burdened women from the erstwhile third world nations, to provide for the ever-increasing demand. This has happened mainly in response to the effects of economic globalization on developing countries, where with the fall of traditional business and increased foreign investment, the removal of subsidies and the increasing privatization of the public sector, there is a lack of job opportunities for both men and women, more so for women. At the same time due to the removal of government assistance, it is difficult for the family to subsist on a single wage. The countries, which are termed as 'developing' are those which were forced to accept the neo-liberal packages with stringent conditionalities handed out by the IMF and WTO in the late 1980s and 1990s. While there was a rise in foreign investment, in the present times unemployment is on a rise, as their economies are struggling, stagnant and even shrinking (Inhorn, 2011).

Neoliberal policies along with forces of globalization and privatization, has had a debilitating effect on the global economy creating vast inequalities. The Oxfam[1] report of January 2015 stated that "the combined wealth of 1 percent will overtake that of the 99 percent of people" by 2016, it further stated that "1 out 9 people do not have enough to eat and more than half a billion people still live on less than $1.25 a day". These conditions have thrusted additional responsibilities on to the women, who now have to find alternative means of living not just to support herself but also her family, thereby creating-counter geographies of globalization-survival circuits and shadow markets, as termed by Saskia Sassen (2002), or what Maria Mies (2007) calls an ice-berg economies where the visible parts of the of the economy is only the of the ice-berg with the biggest portion, remains hidden- where it remains unregulated,

[1] https://www.oxfam.org/en/pressroom/pressreleases/2015-01-19/richest-1-will-own-more-all-rest-2016

unprotected and invisible. Women are forced to invent new productive niches in the so-called 'informal' economy (Davis, 2006). The proliferation of low waged service work, as well as the 'outsourcing' of previously formal work to informal 'home workers', has fallen disproportionately on the shoulders of migrant or minority women.

Apart from the success stories one hears, there are small niches in the job arena that women have access to, which includes teaching, nursing, care giving jobs, housekeeping jobs, domestic helpers, which are traditionally seen as jobs meant for women, as they are closer to assumed natural attributes of being a woman- loving, caring, motherly. There is another sector, which has existed for centuries and remains unrecognized and in the shadows, which is the participation of women in sex trade (Sassen, 2002). It has been seen that the mobility in these sectors has been from the poor to the rich and from the global south to the global north. Now with the trade in human reproductive parts – especially the trade in the human egg, becoming one of the avenues of earning a living, more and more women are joining the global rosters of donors. Neoliberalism has set out the agenda for women, with the ever-increasing number of hetero-normative families; motherhood has become a form of self-actualization through consumption and a privatized management of risk such that social reproduction is reconceived as a series of investments generating productive citizens (Sassen, 2002).

These productive citizens are to then participate in the "subsistence production", which then forms the basis of capital accumulation. Economy is thought to be constituted of wage labour, market exchange of commodities and the capitalist enterprise [2], which generally counts for the visible parts of the economy. However, Maria Mies in her work states that for capital accumulation through subsistence production to continue, if one looks beyond and below the visible capitalist setup, one would find an "iceberg economy"(Mies, 2007, p187). These parts of the economy remain hidden, unrecognized, unregulated and unprotected. It excludes many types of essential economic activities, such as household production, the informal sector-mostly the sectors in which the labour and production are seen as free labour, and thereby unregulated and unrecognized, and it is these range of activities, which fall under the 'excluded others' upon which capitalism finds its coherence (Mies, 2007, p 270-271). With the process of primitive accumulation (Marx, 1867)[3] already in place, these unrecognized layers create further inequality among different layers of the society and the bottom layer

[2] http://www.communityeconomies.org/home/key-ideas
[3] http://marxist.org/

faces the maximum exploitation and the women in this are the worst sufferers, owing to patriarchy. Maria Mies states that it is exploitation of this bottom layer, which creates a group of women who end up selling their eggs, their wombs and literally their labour in order to sustain their families and communities. Even though this sale and renting out of the bodily reproductive parts is a clear case of appropriation of labour and commodification of the body, the inherent patriarchy in the society, which has then joined forces with capitalism and neoliberal policies, ensures that these processes are not recognized and thereby remain unregulated. Without the help of socio-cultural forces of patriarchy this appropriation of the surplus labour is not possible, as capitalism in order to survive cannot afford equality for all (Mies, 2007, p 270-271).

With the forces of patriarchy, neoliberalism already in place Kumkum Sangari (2015. P. 71) states, that the bodies of young fragile women, already a site for self- commodification, are drawn into the orbit of the transnational redistribution of reproductive services. India, like many other countries, has been the melting pot of all the above-mentioned forces. After being colonized and facing exploitation at the hands of imperialism, it could not stay away from the forces of neoliberalism for too long. It opened it gates to the neoliberal policies in the 1990's, with which we have seen an eventual destruction of the public health institutions, the rise in the costs of everyday living, the cutting of jobs in the public sector, the growth of the unorganized sector and the growing strangle hold of neoliberal logic in every sphere of our life. Without the help of government funding, surviving for those without economic, social and cultural capital is difficult, especially in a country like India, where along with the forces of globalization, neoliberalization, the forces of patriarchy as well as caste discrimination are wide spread (Sangari, 2015, p 71).

In India, as well as in the other developing economies, new conditions of globalization are being continuously formed, with the vicious cycle of surviving the burden of debts, it has to accommodate new conditions as well as accommodate new policies, including structural adjustment programmes which require the countries to open to more foreign intervention while at the same time eliminating state subsidies (Sassen, 2002, p. 188). Inevitably these economies fall into the debt trap, and the cycle of exploitation continues. With the ever-increasing economic problems, more and more pressure is falling on the backs of women, which has led to the feminization of poverty and labour (Rao, 2010). It is not just the immediate family, which depends on the woman for survival, whole communities are increasingly dependent on and even the governments, along with enterprises that function on

the margins of the legal economy, depend on women to move out of the debt trap. In fact, for many struggling countries these 'shadow economies' have become the last recourse to pay off their debts (Sassen, 2002, p. 188).

Women, belonging to the global south are then forced to sell their labour in the limited avenues, which are open to them- as domestic help, care givers- avenues which are mostly unrecognized and unregulated and send back money and these remittances contribute to the revenues of these deeply indebted countries. Furthermore, one of the immediate effects of neoliberal globalization is intensification of traditionally feminized forms of labour such as sex work. Thus 'survival circuits' are built, on the back of women of the developing countries (Sassen, 2002, p. 186). The women who form the supply side of the transnational reproductive care business, those who provide eggs and rent out their wombs in return of compensation, fall right into these survival circuits. Kumkum Sangari's work brings to the fore the survival circuits in India, where women working in the traditional survival circuits, such as domestic maids and sex workers are rerouted to this new survival circuit of egg donors and surrogates, while maintaining the caste- class relations of the previous circuits (2014). Globalization here enables the local and regional practices to assume a global scale, while at the same time helps forge links between sending and receiving countries in the commercial surrogacy business in India and elsewhere. The survival circuit in the human egg business, are constituted of women who are unable to bear children amongst the rich and those belonging to the global north who pay the price, and the women who due to the lack of better employment possibilities in the global south are forced to sell their bodies as commodities in the market, with the governments failing to recognize or regulate the transaction which take place in these shadow economies (Sangari, 2014, p.186).

This survival circuit of egg donors, resemble the counter geographies of globalization. Along with the formation of the global markets, including the intensification of transnational and trans-local networks and the development of communication technologies, which can easily surpass the conventional methods of surveillance, these circuits have now come to resemble the original dynamics of globalization, at the same time being mobile as well as vibrant. Those in control of these shadow economies also make use of the regular economy's institutional infrastructure to establish itself (Sangari, 2014, p.186).

In order to establish itself as a full-fledged, integrated market along with aping the other form of biomedical and health technologies in the shifting geographies of the global labour flow,

these circuits need to mobilize a sizeable reserve of egg-suppliers. A reserve of low cost suppliers of reproductive services and tissues, which is ready to perform unacknowledged reproductive labour with the lowest echelon of the bio-economy, is ensured through the neoliberal restructuring of capital, as it ensures not only the availability of permanent surplus power but also a surplus of reproductively (Waldby, & Cooper, 2008, p. 10).

While it is clear that oocytes are essential and are required in large numbers, it is also apparent that they are in short supply globally, as the process of oocyte retrieval is an onerous and a risky process, along with the fact that altruistic donations are not that common. Furthermore, while the sperm is self-renewing and is a more accessible tissue, women have only fixed number of ovas, with a single oocyte releasing per month (Waldby & Cooper, 2008, p. 10). However, for the ART industry to have access to a large number of oocytes, it is necessary that multiple number oocytes are produced per procedure, and detached from the female body. In order to have access to multiple oocytes in one retrieval the process of ovarian stimulation is used, in which drugs are administered to shut down the woman's normal reproductive cycle, more drugs are administered further, for multiple follicles to be formed, and in order to harvest the eggs invasive surgery is required (Waldby & Cooper, 2008, p. 10).

Oocyte donation is a painful process and scarring of the uterine wall may lead to inability to bear children. The procedure involves -daily subcutaneous hormone injections over a period of 7 to 10 days. Mature oocytes are retrieved under ultrasound guidance by the insertion of a needle through the vagina in a brief surgical procedure that requires anaesthesia. The ethics committee of the American Society for Reproductive Medicine cites an estimate that egg donors spend '56 hours in the medical setting, undergoing interviews, counselling, and medical procedures related to the process'. The injections are uncomfortable and have side effects. The retrieval of oocytes carries risks, such as those of anaesthesia and bleeding (Steinbrook, 2006, p. 324).

It also carries the risk of ovarian hyper stimulation syndrome, a usually unpredictable response to ovulation induction (Steinbrook, 2006) that involves pain, abdominal inflammation, possible renal failure and infertility, venous thrombo-embolism and cardiac instability (Hewitson, 2014, p. 10). Up to 5% of women in treatment develop hyper stimulation syndrome. It can be fatal as with Mumbai's Rotunda Clinic case, of 2010, where Sushma Pandey, 17 years of age died due to hyper stimulation two days after donating eggs.

While the clinic denied the charges and stated that the girl was not underage, the investigative committee found that she had died of brain haemorrhage and pulmonary haemorrhages due to ovarian hyper-stimulation shock syndrome, and this after she had already donated eggs thrice before the fatal extraction. Further, she was also unmarried and below 18 years of age, breaking all the Guidelines of ICMR for ART. She was sought after due to her fair skin and beautiful features[4].

While one can clearly gauge from the research, which has already been conducted that the women involved in these survival circuits, become a part due to financial necessity. As with the reduced opportunities in the organized sector, ever rising costs of the basic necessities of life, the women who participate as donors, research suggest that their families' income would not cover subsistence. However, the money that they get from going through the onerous procedure of egg harvesting drives to look over the physical damage in return of the money which could help them pay off debts, and assure a better future for their children. Now in this situation when the egg donation is not altruistic in nature and completely driven by financial motivations, if the women get paid more for more number of eggs per harvest, they at times without being aware of the risks readily agree to the procedure. While many countries have specified the number of eggs that is allowed to be harvested, at times the women don't even know the number of eggs, which have been harvested (Tanderup et.al. 2015). As seen in the case of the Rotunda clinic case such practices can lead to hyperstimulation syndrome, and even death. However, with the lack of regulation in this oocyte market, it is very difficult to assess, the number of times the women approach the clinics for donating eggs or the number of eggs, which are harvested during the procedure.

Even in this survival circuit not all eggs are biodesirable- a term which has been discussed later. In India, most of the commissioning parents making use of a donor egg demand for a phenotype, which matches them. Despite that, the demand for fair skin type is preferred over the others. As in many countries, infertility or the inability to bear a child is seen as a social bane and hence all efforts are made to hide IVF, surrogacy and the fact that a donor egg has been used as the physical similarity between donor and recipient makes the donation invisible (Gupta, 2006, p. 14).

Researcher notes that outside Europe, China and India have burgeoning stem cell industries and extensive clinical recruitment sites, due to the widespread use of assisted reproductive

[4] indianexpress.com/article/cities/mumbai/teenage-egg-donor

technology to favor the birth of sons (Junhong, 2001; Khanna, 1997). In India too, the commissioning parents would want to have boys, through the investment they've made for the fertility and IVF treatment. Moreover, recent media reports also suggested that it's not just the skin color which drives the oocyte/ sperm donation business but also caste in India. The media report suggested that there was an increased demand for '*Brahmin'* egg and sperm (ToI, 13 May, 2002). All these factors affect the way in which the donor enters the ART industry and the values that are attached to her.

It is often suggested that the kind of mobility involved in the global market often overlaps with sex trafficking. As women in the north have moved in greater numbers into the labour market, the kinds of female, domestic work, which the welfare state subsidized has been opened up to an increasingly transnational market of the female reproductive labour, one that is defined along complex lines of racial, ethnic and class difference. It is often argued that there has been a major effect on the realms of social reproduction and hence on the lives of women. These effects manifest themselves in a number of different ways on a global level (Gupta, 2006, p. 17).

While the nineties saw a phenomenal rise in the number of US – based contract research organizations, however in the past few years, the US and European based pharmaceutical industry has made moves to outsource clinical trials to specialized research service providers, who in turn have relocated the actual conduct of clinical trials in countries and regions such as India, China and eastern Europe. Now the sub-contractors are the ones who organize off shore clinical trials for pharmaceutical, biotech and medical device industries and are paid to navigate the complex arena of national regulations in order to secure the most cost effective access to clinical labour. The clinical trials and the access to bodily reproductive fluids follows the same path as manufacturing and assembly- line work and being relocated to environment where the costs and conditions are less onerous (Gupta, 2006, p. 17).

This emerging market of reproductive bodily fluids is developing in close synergy with pre-existing transnational economies of feminized labour. Literature suggests that the boundary between the actual biomedical, reproductive labour, on the one hand, and sexual and domestic labour on the other are extremely fluid. The emerging markets in India, appear to be positioning themselves as both developers of new biotechnologies and suppliers of reproductive tissues (Gupta, 2006, p. 17).

Carole Pateman (1998) too argues that these labour contracts which are based on female bodily capacities- one of them being the contract of surrogacy and the sale of eggs, are precisely concerned with depriving women of the rights of control and disposal over such capacities. Contracts concerning feminine bodily capacities (to labour, reproduce or sexual pleasure) are concerned with establishing one party's control over the other's capacities, and with denying them the right of civil self-possession, assumed to be a universal characteristic of contractual individualism. The feminine and the reproductive market engage in the use of another's use of the female body, rather than the performance of tasks and an expenditure of labour per say. The ambiguity of the feminine reproductive work is very apparent in the new forms of biomedical and clinical labour, all of which require direct, often highly experimental involvement of the body's biology in the creation of surplus value (Patemen, 1998).

One finds consistency with Marx's concept of primitive accumulation, as stated earlier -a pre capitalist mode of often violent primary resource acquisition (land, mineral wealth, forests etc.) on which the present day capitalist system is based, and the extreme forms of bodily indebtedness, which we are seeing in the sale of organs, eggs and biomedical labour in the poorest countries of the world. Primitive accumulation appears as a recurrent necessity of capitalist accumulation (Gupta, 2006, p. 19).

Bioavailability and Biodesirability

In the earlier section, it has been discussed in detail how the implementation of the neo-liberal policies led to the booming of medical tourism including the CBRC. This was achieved, as has been studied, with major cutbacks in the public sector while producing new inequalities where some women's bodies were made 'bioavailable' to other women. This is not without the repercussion of distributing the bodily risks of infertility treatment amongst different women (Payne, 2015, p.110). Lawrence Cohen (2005), coined the term 'bioavailability' to signify the selective disaggregation of persons' cells or tissues for reincorporation into another body, as in gamete donation or kidney transplantation. According to him, bioavailability is selective in that some persons, particularly in resource-poor settings, are more 'bioavailable' than others (Marcia and Gurtin, 201, p. 667).

Jenny G. Payne (2015), while discussing "bio-desirability", states sameness as a crucial factor that adds to a donor's 'desirability'. The idea of resemblance or similarity of the donor's characteristic traits with that of the recipient becomes the deciding aspect of the former being desirable for donation; the donor is expected to resemble the recipient in terms

of phenotype. They are expected to fulfill the obvious bio-desirable traits such as reproductive age, 'proven fertility' in terms of their own children and absence of any kind of diseases even while the less obvious but much desired aspects like preferred race, ethnicity and religion all play important roles in the process of matching a donor to a recipient. This bio-desirability often extends to dominant beauty standards (e.g. being tall and slim) and higher level of education (which is often considered a sign of intelligence) (Payne, 2015, p.113) as in the example of the friend, who was approached by the agent. The aspects of health, beauty and intelligence and the conventional standards of these traits contribute to a kind of 'sellability' which in turn generally corresponds to the 'biodesirability', thus promoting the practice of regarding these particular traits as those that make a person more desirable to others as well as those that improve one's chances of leading what is generally called a 'good life' (Payne, 2007).

A bio-desirable donor, for a recipient, is not merely 'an object to be chosen', but also a 'choosing subject', someone who donates eggs out of her 'free will'. However, the available literature, ideas of what constitutes 'free will' differs. The two positions held by and large on 'free will' – and that which are most often opposing to one other- are that of the 'altruistic egg donor' who donates her eggs because she wants to help a childless woman or a couple, and that of the 'egg seller' who participates in the fertility market as a financially motivated rational agent. These two opposing positions tend to co-exist with tensions arising between them from the paradoxical idea of 'paid donation'. Whether altruistic or not, the act of 'donating' one's eggs is always bound to their 'sellability' when their desirability comes into question. It can also be argued that 'altruism' itself is a part of the dominant idea of motherhood and femininity, and hence becomes a 'selling point' in the fertility industry, where female gametes are seen as 'gifts' being sold (Payne, 2007).

In the question of reproduction, choice is a powerful tool and cross border donation is indeed a way for many infertility patients to restore some of the reproductive choices they feel they have been deprived of. But this sense of empowerment and freedom on the side of the recipient has a capital implication: it greatly encourages the logic of the market to territorialize the terrain of reproductive rights, and reformulating thereby the reciprocal principles of equality and autonomy between recipient and donor that are otherwise supposed. It also reinstates the dominant notions of health, beauty and intelligence. Often cross-border patients think it preferable that the prospective egg donor be a 'free-chooser', motivated for, at least partly, altruistic ends. This adds to the capital implication of making

'altruism' the 'selling point' or a desirable trait that adds to the 'desirability' of the donor and hence aids the fertility industry. It is on this basis that this imagines donor is projected as a 'choosing subject', as somebody who does not 'have to' donate but who does so 'out of choice'. This 'donor of choice', then, is not only a donor possessing the desired genetic characteristics; the 'bio-desirable donor' has to be envisaged as one who is 'free to choose', be it for either entirely altruistic reasons or as a free economic agent in the reproductive market. (Payne, 2015, pp. 114- 116)

Such a scenario demands for a more sensitive approach towards the socio-political and/or historical contexts within which the 'free will' of the donor is regarded. The most pertinent question then, while accommodating larger tendencies, becomes: What does it mean to have a 'reproductive choice'? And how does such a choice differ (or not) for a 'choosing subject' vis-à-vis her socio-political position. While the answers to these questions are evident from the above given deliberations on the question of choice in 'paid donation', what needs to be highlighted is that even while 'reproductive choice(s)' may differ from each other with respect to the local positioning and the individual contexts, it is always a tool that is financially motivated in the fertility market and it only broadens up the capital implications when the market is transnationalized.

Bioviolence

Bioviolence is a term that is often associated with acts of crime and/or terror that are carried to impose harm on a specific living species by using various technological strategies. It is considered a 'threat' that has endless ramifications as it is carried out to fulfill vested interests. One of the examples of an act of bioviolence can be the use of terminal diseases in order to attack a section of human population. Bioviolence as a term is also associated with the commodification and sale of body organs. M. Moniruzzman (2012), who, with an ethnographic method examined what he called the 'body bazaar' in Bangladesh to understand and analyze the selling of human kidneys by the poor describes the buying and selling of human body parts as 'bioviolence' (Moniruzzman 2012, 87). According to him, bioviolence is used as 'an instrument, which transforms human bodies, either living or dead, either whole or in parts, as sites of diverse exploitation viable through new medical technologies.' With the study, he opens up the term not just as an act that inflicts harm on the poor, who are manipulated for exploitation by the affluent, but also as a term that stands for all the processes involved in the procurement of body organs wherein people – usually from the

marginalized and the deprived sections of the society – are deceived and tricked into selling their body organs like the kidney. As a byproduct of technological experimentation, he states that bioviolence can be a tool for structural exploitation of the deprived. What is to be noted is that acts of bioviolence are often carried out with the trial and error method, thus posing threats to the sections of population it is inflicted upon and humanity in general.

Moniruzzman (2012), calling the procurement of kidneys from the poor for sale to the rich as unethical, also sheds light on how similar violence is seen in assisted reproductive technology. In such cases, according to him, as other cases of bioviolence, it is an exploitation of the poor by the wealthy. He states the lack of 'free will' for a poor woman who is forced to carry and deliver a child for a wealthy infertile couple at the expense of her own physical health (Moniruzzman 2012). Within this analysis one can place the study of egg donation too, which is often considered as a 'gift' in the infertility industry overcoming the paradoxical existence of being a 'paid donation'. This payment then is not the financial gain a donor woman may receive at the end of surrogacy but also the physical costs that she in turn may have to pay due to the exploitative tendencies of the market. The medical need of the wealthy and the pressures from the market can truly have adverse effects on just the body of an individual female but the society at large. This then becomes a kind of bioviolence that requires intervention at the policy making levels of particular governments in different countries (especially countries like India) to avoid the rampant exploitation of female bodies in the name of 'gifts' that caters to the ever-increasing demands of the infertility industry (Moniruzzman 2012).

With the lack of socio-economic justice at a global level, the inherent discriminations at the local levels have become pronounced when analyzing the pathways of globalizations and commodification of the bodily reproductive fluids. While the ART industry is a boon to the privileged class, the poor who are the subjects to world-wide experimentation of population control have no answer to their infertility, when at the same time their bodies have been commodified, by the forces of neo-liberal globalization, which along with the forces of patriarchy has maintained the power relations, notions of gender, and in particular the notion of family and motherhood. This along with the removal of state support force the woman, on whose back many of indebted economies now rest, to sell her body, at the lowest of costs, expecting to make one's body biodesirable as well as bio-available. This fits perfectly within

the frame drawn by Moniruzzman (2012) on “bio-violence”- which is done by the socio-economically privileged section for their personal gain, but they conceal their actions through a “symbolic violence” that represents organ commodification as an indispensable act for “saving lives” of the dying patients and providing the invaluable gift of a child. All these pathways create a reproscape in the shadows (Moniruzzman 2012, p 90).

Thus, with the lack of socio-economic justice at a global level, the inherent discriminations at the local levels have become pronounced, when analyzing the pathways of globalizations and commodification of the bodily reproductive fluids. While the ART industry is a boon to the privileged class, the poor who have the subjects to world-wide experimentation of population control have no answer to their infertility, at the same time their bodies have been commodified, by the forces of neo-liberal globalization, which has along with the forces of patriarchy, has maintained the power relations, notions of gender, and in particular the notion of family and motherhood. This along with the removal of state support, the woman on whose back, many of indebted economies now rest, is made to sell her body, at the lowest of costs, thus making one’s body bio-desirable as well as bio-available. This fits perfectly within the frame drawn by Moniruzzman (2012) on “bio-violence”- which is done by the socio-economically privileged section for their personal gain, but they conceal their actions through a “symbolic violence” that represents organ commodification as an indispensable act for “saving lives” of the dying patients and providing the invaluable gift of a child. All these pathways create a reproscape in the shadows.

CHAPTER 3

Reproductive Policies and Practices: Germany, Italy, Israel, United Kingdom and India

Introduction

No market can function without the demand and supply. In the field of ART, the demand is generated with the lack of services and resources at the home country, as defined by Glenn Cohen (Cohen cited in Robertson, 2012), for which supply is sought or created by the means of proliferation of the forces of globalization, neo-liberal policies and domestic forces like patriarchy, which reinforce the commodification of the bodily reproductive parts in the destination country. However, the lack of services and resources in the home countries, is not always because of an actual lack of services, but also because of the laws, which are put in place by the Government of the home country, which restrict the use of ARTs for various reasons - which might be ethical, medical, political or religious in nature.

The development of technology, which allows external fertilization of human eggs has given hope to many women and couples who could not have children. This technology, commonly known as IVF, involves the surgical extraction of eggs from the ovaries after hormonal stimulation, after which, the husband's or the donor sperm is used to fertilize the eggs in a laboratory. As the embryo divides after a process of fertilization which takes somewhere between forty-eight to seventy-two hours, one or more of the dividing embryos are placed in the woman's uterus, with the expectation that at least one would get implanted and it would lead to a healthy pregnancy and birth. The rest of the fertilized embryos may be discarded, frozen for future use or donated - as decided by the commissioning parents. This technology has spread across the world and has led to the birth of over a million babies in past three decades (Robertson, 2012, p. 190).

Other reproductive and genetic options have opened up various other possibilities of artificial reproduction. In the case of an infertile couple, people can now substitute the lack of a fertile sperm or the ova with a donor sperm or egg and substitute gestation with a help of a surrogate. The extra embryos which are left, after a successful implantation also gives an

option of being donated and used by a sterile couple, or they might be used for research, including in the derivation of embryonic stem cells for research or treatment. Further research in the field of genome, has also opened up gates for the early genetic screening of embryos which can then be chosen for transfer to the uterus or disposal based on their genetic make-up (Robertson, 2012, p. 191).

While this assisted reproductive technique is available all over the world - including the developing world, the process of its acceptance and development is different in many such nations and it is marred with conflict and controversy. The controversy arises from the technology's ability to manipulate or destroy the embryo's genetic make- up, which can be of potential harm to the offspring and the devaluation of family and kinship bonds from the use of donors, surrogates and embryo screening (Robertson, 2012, p. 191).

The spectre that haunts the developing world is the knowledge that through this technology, reproductive cloning is possible, which can lead to genome engineering and the commodification of the offspring. This has led to several debates in the liberal democracies, which along with respecting personal freedom of people, recognizes the right of the people with religious objections to oppose technological control of reproduction. These recognitions have led to various implications and important legal differences among nations in the way in which ART is used. These differences vary over different procedures involved in ART such as egg and sperm donation - the use of donors and surrogates, the use, storage and disposal of embryos and preimplantation genetic diagnosis (PGD). While some countries leave this to the discretion of the physician and patient with minimum oversight, other clinics require prior regulatory approval of clinical procedures, and some have little or no regulations while at the same time some countries have very stringent prohibitions regarding egg donations and research on embryos (Robertson, 2012, p. 191, 226).

All laws are reflective of the society and the context from which they arise, it is because of the differences in the ethical, religious, legal and social issues that have developed with the progress and spread of ART that many countries despite being the most developed in the world have ethical and religious reasons to regulate or restrict it (Robertson 2012, p. 226). In order to have an in-depth understanding of these religious, socio-cultural, legal and ethical tenets which become the basis of regulation and restriction of ART, one needs to take a closer look at the countries with such regulations.

In order to understand these socio-cultural, religious and ethical concerns which formulate the pathway of the commodification of the bodily reproductive fluids, the objective of this study is to look into the policies of the states like Germany, Italy, Israel, the United Kingdom and India. While India has been selected in order to look into the regulations which made it so accessible to the foreign and domestic commissioning parents, the other countries have been selected in order to understand the factors which restrict the access to ART and in the case of Israel, where ART is state funded and is strictly regulated by the state, despite of which certain issues regarding egg donation persist. Europe has been the centre of scientific ingenuity for many years, however one finds that countries like Greece, Austria, Germany, Italy, Portugal and Switzerland have restricted access to ART (Cohen 2012, Margali 2015) especially in the case of egg donation. Although Germany, is considered to be one of the most technologically advanced countries in the world, it has one of the most stringent policies towards technological control of reproduction and egg donation, which are majorly based on historical and socio-cultural experience of the country as a whole. At the same time, a parallel can be found in Israel, which is a nascent state in comparison to Germany, but in this phase in history, where the populations of both the countries had stood on different sides, which has greatly affected the socio-cultural experience of the people of the country and their interpretation of their religious texts that makes it one of the advanced countries in the field of ART and its regulation. Italy, which is considered the birthplace of renaissance and scientific reformation, restricts the use of ART on religious grounds. The United Kingdom has been selected in order to understand the viability of altruistic form of egg donation and surrogacy. Further, this chapter also discusses some of the processes, which have resulted from the regulations in various countries, including the 'circumvention tourism' and 'reverse traffic repro migration', have become an important part of the pathways, that make the mobility of the human reproductive fluids possible. The chapter has been divided into two parts. In the first part regulations in Italy, Germany, Israel and the United Kingdom along with the resulting processes of 'circumvention tourism' and 'reverse traffic repro-migration' have been discussed, and the second part has an in-depth analysis of the regulations which guide the Indian ART industry and the implications of the recent ban on commercial surrogacy for foreign couples in India.

ART in Italy

Prior to the Law 40 of 2004, Italy was referred to as the 'wild west' of the ART industry, owing to the sensational work done by some of the doctors in the private sector. Presently it has one of the most stringent laws regarding the use of surrogacy and egg donation (Zanini 2011, Inhorn 2010). Though the law has been under constant change since 2004, it in its original form consisted of laws, which even restricted the use of ART to heterosexual infertile couples, as they wanted to curb all forms of the treatment, eager to get rid of the title of the 'wild west' of the ART industry as it was known earlier. Further, it is stated that 'three' was the highest number of embryos that could be produced during any cycle, imposed that all these embryos to immediately be transferred, limited the research on embryos, and banned cryopreservation of embryos, donation and surrogacy (Zanini 2011, p. 566). This has been constantly changed and modified, since its promulgation. In 2011, the law had been modified to allow access to married or cohabiting heterosexual partners over the age of 18. It excluded singles and same-sex couples from the treatments. It is often accused that Law 40 is the result of influence on the parliament of the Vatican, the Catholic lobbies and the Roman Catholic Church, who are especially committed to the promotion of the embryo and the admission of the third party in procreation - by the means of donor egg, sperm or womb (surrogate). Though the Vatican and the Catholic bodies may deny the role that they played in ensuring that Law 40 is passed and over the years have maintained a strict hold on the modifications in the law, the position of the Vatican acts as a moral guide to the people belonging to a deeply religious country like Italy. Even when a referendum was held in 2009 in order to modify the Law 40 as to include other groups and individuals who could then benefit from surrogacy, the special configuration of Catholicism in Italy made it possible for the Church and the Catholic groups to mobilize broad sectors of the public to oppose it. Pressure was also built on the Parliament to regulate and restrict the use of ART and its off-shoot research on the embryo, with the birth of the sheep Dolly in 1997 with the use of cloning techniques (Zanini, 566- 567).

Rather than basing its justification on reason, the Italian Law 40 is often viewed as a result of obliviousness, disinterest and distrust regarding ART. Cross Border Reproductive Care (CBRC) has become the norm for infertile individuals and couples wanting to have a child. Qualitative anthropological research, as one conducted by Guilia Zanini, as a part of her research has shown that the Italians, in lack of services at home, find it as a form of abandonment by the state (Zanini 2011, p.571). While the modifications in the Law 40 has

made ART available to certain sections, it still leaves out a part of the population on the basis of marital status and sexual orientation. Furthermore, they view the intrusion by the Catholic Church as an unnecessary and inappropriate invasion into a secular institution. People also argue that the conservative stand taken by the state in lieu of the Catholic Church, betrays the Catholic values which promotes the formation of the family and protection of life, here they feel not only abandoned by the state but also by the Church (Zanini 2011, p. 571).

However, this double abandonment by the State and the Church does not necessarily discourage the people from accessing ART through CBRC, it then takes the form of dissent against the existing restrictive local and moral laws. Circumventing domestic laws and accessing ART, then does not simply remain the safety valve for demonstrating moral pluralism in motion (Pennings 2002), but a proper instrument through which people's disagreement may be put into practice to claim reproductive rights (Zanini 2011, p. 571).

While transnational travel for ART in Italy is spurred by religious bans, in the United Kingdom (UK), while no such bans exist, and in fact has a liberal take on ART and its procedures, there are still couples who travel to other countries to seek ART. One of the major reasons for this travel is the scarcity of donor eggs. While the state has made provisions to cater to the problem, it persists.

ART in United Kingdom

As per the HFEA (Human Fertilization and Embryo Authority) in the UK, egg donation is to be altruistic and not commercial, and the woman should be compensated for the inconvenience caused to her, rather than putting a cost to the eggs she has donated, and it is this very regulation which drives commissioning parents overseas to avail ART services. This has been widely discussed in Hudson and Culley's work (2011). It is often touted that people travel from their home country because they do not have access to ART services, or that the laws are restrictive, but Hudson and Culley argue that this is not the situation in the UK, where the regulation of ART is comprehensive and is relatively liberal in terms of access. Other countries which provide ART often have restrictions based on their marital status or age, as in India and Israel, where only heterosexual couples are allowed to opt for surrogacy or IVF. In the UK, patients need not be married or in a heterosexual relationship and in private practice there's no restriction on the upper age limit. Furthermore, a wide range of ART facilities are available, including the use of donor sperm and eggs, non-commercial surrogacy is allowed, preimplantation genetic diagnosis is permitted along with the

cryopreservation of embryos and gametes, which is in contrast to the situation in Italy. So one can argue that the number of people travelling abroad from the UK to access ART should be very less. However, there are restrictions to the limits and conditions on the use of ART in the UK (Hudson & Culley,2011, p. 574). Also, the UK makes provisions for egg sharing, by which, a woman receiving treatment can donate some of the eggs to the clinic, in return of which the cost of her treatment is reduced- a feature which can be emulated in other countries.

One of the major breakthroughs in the field of ART was the treatment of infertility with the use of donor eggs. Feasible in the 1980s, this has greatly helped those women who suffer from ovarian conditions such as primary ovarian insufficiency. Owing to this treatment, the global demand for oocyte has been on a rise, as this form of treatment is not only beneficial for the heterosexual couples but also gay couples seeking to form their families. Since there has been a rise in the number of people availing this treatment in the UK, like other places in the world, is facing a major shortage of donor eggs (Milnes et. al., 2016).

One of reasons of the shortage of donor eggs and the resulting travel in search of donor eggs according to researchers such as Hudson and Culley, is that the surrogates and the egg donors cannot be compensated, amongst other reasons. There is also a restriction on the number of embryos which can be transferred in each treatment cycle (Hudson & Culley, 2011 p. 575). While the NHS does have provisions to provide support for the treatments, Hudson and Culley report that given the ongoing economic situation with funds being drawn away from the public funded programmes, little or no provisions are available to fund the IVF treatments.

Another reason which is the cause behind scarcity of donor eggs and the resulting travel is that in April 2005, the legislative changes in the UK required the donor of gametes to consent to the release of their identity to any offspring reaching 18 years of age. This decision is often deemed controversial, as it had led to a steady decline in the number of people willing to be donors. However, as research conducted by Timothy Bracewell et. al. (2016), suggests that while there was an initial decline, the donors willing to donate as per the new legislations have gone up again by 2013.

However as stated earlier, there remains a shortage of egg donors in UK and the waiting time is long. Some commissioning parents in order to cut short the waiting time look for donors amongst family and friends. Another solution that the UK has come up with, is regulation of

egg sharing since 1998 by the HFEA (Bracewell et. al., 2016 pp. 2-3). This process has been under constant scrutiny and there has been ethical and political debate since its introduction. One of the important features of this process is that it eliminates the third party which reduces the supplementary risks and benefit the recipient, since the donor has to go through an invasive medical procedure. It allows people who do not have access to insurance or the NHS, as in the case of the UK, to gain access to IVF. Furthermore, this is a pragmatic way of expressing altruism between the matched donor and a matched recipient (Bracewell et. al., 2016, 2016, p.3).

However, one of the major critiques of this process is that while it is based on altruistic notions, the fact that women often agree to donate their eggs for egg sharing in order to gain access to the treatment at much reduced costs, thereby raises questions about the motive behind the consent. Another aspect which greatly concerns the psychological wellbeing of the donor is the fact that if the treatment is unsuccessful for her, she might have regrets about donating eggs - she might feel that, had she not done so, she might have become pregnant. Apart from this, the reduction in the costs of the treatment for those who are willing to share eggs is completely contrary to UK's cultural preference for voluntary donation (Bracewell et al, 2016)

Hudson and Culley's research which involves interviews with several couples and individuals who have travelled overseas to access ART services, show that one of the major reasons for this is the lack of donor eggs in the UK, which results in long waiting time. Whereas, in the destination countries they were able start the process in a month's time (Hudson &Culley, 2011, p. 576). Furthermore, getting treated in a country, which is effectively cheaper than the UK gives the commissioning couples greater control over the process and larger array of treatments, while at the same time, they have access to the top clinics and facilities.

The ART industry has grown into a multibillion-dollar capitalist enterprise where the patients' interests are not always held paramount and there always exists a potential for the exploitation of the donors and surrogates. Travel for CBRC often encompasses potential hazards for the patients, donors and offspring. Efforts should be made to minimize potential harm to individuals and damaging costs to the public healthcare systems. However, Hudson and Culley state that it is difficult to impose a strong regulation at an international level, not because of the different ideologies on the role of the state and individual liberty, rather, it is the restrictions posed by the professionals and politicians in many of the countries and the

disjuncture of regulations which has resulted in the lack of a uniform effective regulation on CBRC (Hudson & Culley, 2011 p. 579).

While in the UK people travel to seek donor eggs and in Italy, access to ART and its procedures are restricted primarily because of religious reasons. In Germany, along with the religious reasons, there are other factors which influence its ban on egg donation and other ART procedures, which are based on ethical dilemmas arising from the historical process that the country has gone through, which has had a collective effect on its socio-cultural milieu. During the course of the Second World War, Germany saw many eugenic experiments, hinging on the developing a super race, and at the extermination of another, which brought out the horrors of what can be the misuse of these technologies, if are not used with caution. Their past experiences along with other considerations of the present world has framed restrictive policy in Germany towards the ART industry.

ART in Germany

Sven Bergmann's ethnographic study in the fertility clinics of Spain and Czech Republic, has shown that the majority of the German patients who approached these clinics would seek egg donation, which under the German law is strictly forbidden. The Embryo Protection Act, states that, for the practitioners, "*anyone will be punished with up to three years' imprisonment or fine, who 1. Transfers into a woman an unfertilized egg cell produced by other woman. 2. Attempts to fertilize an egg cell artificially for any purpose other than bringing about a pregnancy of the woman from whom the egg cell originated"* (Bergmann, 1990 p. 601).

This law is more focused on prohibiting the research on embryos, which is possible with donor eggs, rather than protecting the donor. This law is based on the old Roman legal principle *mater semper certa est,* which focuses on the prevention of 'fragmented motherhood'- which may happen when a third party gets involved (Bergmann, 2011, p. 601). The third party in this case is the egg donor. With the use of the donor egg the naturalised definition of the genetic lineage, in which the genetic lineage can be ascertained with certainty through the mother gets complicated. At the same time, sperm donations are allowed in Germany. IVF has come under major state regulated interventions and has become a controversial issue as it challenges the legal definitions of kinships, which are based on naturalised assumptions. The increasing travel for reproductive medicine is seen as an

'unsolvable moral dilemma' and a threat for the state in German bioethical discourse, patients' mobility via circumvention of (national) regulative and ethical 'container' can also be regarded as 'moral pluralism in motion', while most of the people who have to travel abroad for the purpose of reproduction would prefer that the procedure be made available in their own country (Bergmann, 2011).

Many of the people who moved beyond borders, which are formed by regulatory rules or societal norms, they are mostly driven by their own initiatives and intentions, this motivation is thereby, described by Bergmann as 'reproductive agency' (Bergmann, 2011). They also move across the description of the 'patient' which means passiveness in Latin. The agency that the people use in order to move across the borders set by the national regulations, they circumvent national rules to fulfil one's own goals, and in the case of Germany contradicts the law and the majority moral beliefs. These aspects of human reproduction, are making people push boundaries to achieve their reproductive goals. In this transaction the internet becomes the most important platform for information and research about the procedures involved in IVF. The patient-pioneers who circumvented and crossed national regulations and ethical dilemmas have become beacons via the internet to the other couples who are ready to circumvent laws and moral dilemmas in order to achieve their reproductive goals. For information about assisted reproduction and the exchange of personal experience with it, the internet has become the most important medium for IVF patients, as well as for the advertisement of internationally orientated infertility clinics (Speier, 2011).

For most patients the internet forums have become platform to exchange experiences of grief, desperation, happiness about their experiences in a bid to achieve parenthood. There are several internet communities, however, there is a division into conventional IVF users and recipients of oocytes; some members of the latter group feel discriminated and excluded inside general IVF communities, because of the different legal status and also as a result of media reports about the dark sides of egg donation such as bad treatment for donors and the risk of hyper-stimulation (Speier, 2011). Egg donation is the means by which the 'project of parenthood' is enabled by the means of substituting gametes. Since it helps retain the experience of gestation, the kinship is seen as more authentic in comparison to adoption and in many a case, it is easier to have a child through an egg donor than to opt for adoption. Achieving pregnancy through egg donation and cryopreservation of eggs not only crosses the regulation set by the state, it also allows one to achieve motherhood by crossing the bodily

boundaries of age. It is the fear of non-acceptance of a child being born out of egg donation, that this process is seen as a stigma, because of its illegitimate status (Speier, 2011).

Germany being one of the most technologically enhanced countries, with a rich scientific tradition, one would expect that it would be on the forefront of the advancement of reproductive and genetic technologies. However, the dark past of the country in regards to human rights abuse, has made Germany very careful in its decisions with regard to technological and genetic control of the population, despite having an aging population along with Austria, Ireland, Italy and Portugal. Germany has strict restrictions on ARTs, PGD and research on embryos (Robertson, 2012, pp. 193-194).

Germany's law which prohibits the donation of eggs and research on embryos is because of their different experience of histories and traditions. In the West, namely the United States of America, the laws are mostly based on the country's long tradition of individual liberty, free market and free enterprise orientation, and grants wide variety of autonomy to physicians and other professional in the field of ART. Even though there are religious groups which are against these practices, the State while letting a free hand to the physician and the individual, provides no support to cover the expenses which the procedures might incur (Robertson, 2012, p. 193-194).

Given the legal changes that Germany and Europe as a whole has gone through in the past 200 years, it has led to the formation of laws which recognize the dignity of every living person and thereby tries to grant equal place in the society. The Article 1 of the German Constitution, which is known as the *Grundgesetz* which means 'the basic law', grants the right of every person to the "*free development of his personality"* (Robertson, 2012 p.194). This comes as a strong repulsion to the abuses of Nazism and the agonizing experience of the Holocaust, which governs the use of reproductive and genetic technologies in Germany. Eugenic sterilization policies, which had been sanctified by the US Supreme Court in 1927, were applied before the Nazis came to power, to sterilize the mentally ill and the deformed. However, their extensive application has led to the term 'eugenics' becoming a term of abhorrence and opprobrium. Once the Nazis were in power in 1933, eugenics took the most nefarious form and sterilization lead to euthanasia, and became a part of their 'final solution' the annihilation of the Jews, the Gypsies and others who did not fit their understanding of the Aryan biological model. This was often accompanied with cruel experiments that has led to the Nuremberg Code for Human Experimentation (Robertson, 2012 p.195). Such abuse of

technology which was designed to aid reproduction i.e life, itself became a mode through which millions lost their lives. Hence in Germany till date, the practice and use of these medical and genetic science is imbued with deep aversion in German society as to the use of genetic science to classify and extend rights to people and thus to reproductive and medical technologies that control the earliest stages of human life.

According to the *Grundgesetz* (already explained above) in Germany, the implanted embryos and foetuses are constitutionally protected and are entitled to the same right to life and dignity that all people have. Furthermore, apart from the laws being a direct reaction to the horrors of the Nazi past, they are also based on the religious sentiments held particularly by the German Catholics. This priority given to implanted foetuses and embryos by the basic law in Germany, has thereby become the basis on which the embryo protection policies which have shaped the access to ART, embryo research and preimplantation genetic diagnosis, in Germany (Robertson, 2012, p.196).

The country has stringent policies with regard to the egg donation and the embryos not just because of their historical experience with ART and the religious views held by the people, but also because of the probability of the misuse of the technology. In the late 1980s, many German doctors with the technology at hand started creating embryos for research. This lead to an intense debate on the probable destruction, instrumentalization and abuse of the embryo. A strong group which comprised of the greens, feminists and the conservatives all rallied behind the state to protect the embryo from the aforementioned probabilities (Robertson, 2012).

Though extracorporeal fertilization was seen as a significant step towards the technical and medical control of reproduction, it led to many premonitions about the legal and moral status of the donated eggs and the preimplantation of embryos. Thus, in 1990 the Embryo Protection Act was passed, according to which a person can face up to three years in prison under certain circumstances. These were, if one is to engage in egg donation and gestational surrogacy, if one is found to fertilize eggs that have attained syngamy that can be transferred to a woman in one cycle, to transfer more than three embryos to the uterus or is to create embryos for research. It also prohibits posthumous in vitro fertilization and non-medical sex selection. This law however, does allow the freezing of zygotes or pronuclear embryos before syngamy, which allows the people the advantages of post-syngamy freezing - as it defines an embryo as existing only after syngamy (Robertson, 2012, p.225).

However, in Germany egg donation is banned along with the disposal and freezing of embryos and it is understood that this decision is based on the acceptability of donor- created families and of payments to gamete donors and surrogates for their contributions for making it possible for the infertile couple to have a child, which hinges on the debate of the commodification of the body parts and whether one can put a price on bodily reproductive parts, if yes, then what is the measure by which one does so. Though this measure, protects the rights of the donor, it puts the infertile couple or woman out of option to avail surrogacy at their own home state (Robertson, 2012, p. 210). Many argue, that these measures are based on moral objections and are not in the interest of the infertile woman, the woman who cannot bear children because of age, or the woman who might have lost her uterus but retains the ovaries. This hostility towards egg donation and surrogacy has made it increasingly difficult for infertile women with ovarian or uterine problems to have children (Robertson, 2012, p.225). This also does not explain why sperm donation is allowed but procedures which enable treatment of female gamete failure are curbed (Robertson 2012, p.210) since recipients are able to gestate embryos and viable eggs can be spontaneously donated by the IVF patients. However, with the number of women affected by this ban on the donation of eggs is small to mount pressure to change the legislation (Robertson 2012, p. 226).

Egg donation which has become a business in many countries and which is strictly banned in Germany, has led to less cases of hyper-stimulation of the ovaries, as we have seen in the case of India and in Israel. The doctors, in order to have greater success rates extract excess oocytes which then can be sold to various other infertile commissioning parents, often would hyper-stimulate the ovaries to produce a larger batch of eggs. However, with Germany as an example one can see that the stringent laws have resulted in the reduction in the number of embryos which are created, reduced the chances of multiple embryo transfers, fewer disposals and reducing the chances of the creation of a market for human oocyte, which then falls into the trap of commodification. However, one needs to keep in mind that while Germany has stringent laws within its own borders it has extra-territorialised, what it considers to be a moral dilemma, with German citizens circumventing the rules of their country to avail egg donation in other countries where such rules does not exist. Should not the moral dilemma which stringently restrict egg donation in one country be applicable in the other, when the justification for the restriction lies in the manipulation of the genesis of the human life itself? Each nation faces contradictions at arriving at the optimal balance among

the competing interests and values at play in the use of reproductive and genetic technologies. (Robertson. 2012, p.227)

While it is the ethical dilemma and concerns which arise from their collective experience of the Nazi past, the misuse of then developing ARTs makes Germany careful about its policies towards the ART industry and hence the restrictions in the use and donation of human egg. Israel whose population consists of a majority of Jews, who were the victims of the inhumane atrocities of the Holocaust, promote ART as a form assertion against those atrocities. Not only that, ART also finds support from the religious bodies in Israel, and has one of the most successful regulations of domestic surrogacy. One needs to analyse its policies and the basis of the regulations as to ascertain whether it would be possible to emulate the framework in India.

ART in Israel

Israel has one of the most successful regulation policy regarding surrogacy, and also was the first state to regulate and permit domestic surrogacy (Gruenbaum et. al., p. 45). It has reported very few cases of problems and the application of the ART remains high, therefore, it is important to analyse the regulations of Israel and explore whether it can be emulated in a country like India.

Be it their collective traumatic experience and memory of the Holocaust or it is the Jewish perspective towards procreation, which they derive from the first of the Jewish Torah, which is stated that "*Be fruitful and multiply*", Israel has been a predominantly pronatalist country (Birenbaum, 2016; Gruenbaum, et. al., p. 40). Which means that barrenness, like in many other places in the world, including India, is seen as a quintessential form of female suffering and child- bearing, on the other hand, is viewed as one of the greatest joys in life for which the state as well as the religious authorities have gladly accepted the assisted reproductive technologies. So much so, that all forms of fertility treatments are state funded since the very beginning, and the birth of the first Israeli IVF baby in 1981 was seen as a national achievement. It is noted in the research conducted by Carmeli and Daphna Birenbaum, (2016) that on average more Israeli women undergo and avail ART facilities than any other country. The ART technologies are subsidized by the state and all activities which included gamete donation, freezing and banking are practised legally. The Ministry of Health (MOH) has set the regulations for ART which entitles every Israeli woman between the age of 18 to

45, irrespective of their family status or sexual orientation to unlimited, funded treatment up till the birth of two live children (Birenbaum, 2016, pp. 2-4).

Regulation of surrogacy and egg donation in Israel is done in the most stringent fashion. In order to attain a domestic surrogacy agreement, one needs to petition the approval committee. The committee's task is to ensure that the agreement is arrived upon informed consent and on the free will of the parties, especially the surrogate and the donor, along with the fact that agreement does not infringe on the rights of any of the parties and does not entail harm to either of the parties. The regulations focus on the preservation of the welfare and rights of the three main parties to the agreements; the conceived child, the surrogate/ egg donor and the commissioning parents. The committee ensures that both the parties would undertake explicit stipulations to preserve the resulting child's privacy and avoid any detrimental publication of private information which may harm the child. Furthermore, the commissioning parents have to take custody of the child right after birth, even if the child is not perfect. It is only after the committee comprehensively ascertains these facts, along with the required documents from both the parties that the committee may approve of the agreement. Such regulations need to be put in place anywhere, where commercial surrogacy and egg donation is being practiced (Margali, pp 45-46).

However, one must keep in mind that though ART is open to all and state supported, surrogacy was illegal in Israel, until 1991 (Birenbaum, 2016, p. 8). Only after a perplexing case over the transplantation of the embryo, between a separating couple, that Israel formed its Embryo Carrying Agreement Law in 1996, and became the first country in the world to regulate surrogacy. Surrogacy, when it takes place in Israel, is funded by the state, however the other expenses such as legal fees, are paid by the commissioning parents. It is to be noted that Israel's law only allows gestational surrogacy, and it is only available to stable heterosexual couples and thereby, containing surrogacy within the traditional footholds of the family. Cross border surrogacy then remains the only option left with the single and gay Israelis and is an expensive option. The donor eggs have to bought from Caucasian women, mostly from Eastern Europe, and those opting for non-Caucasian eggs buy it from India or Nepal, and then the donor or the embryo is then flown into the gestational surrogate's clinic which is mostly situated in developing countries in Asia, and all the expense is borne by the individuals themselves, which goes against the prevalent image of pronatalist Israel. In the recent years owing to the protest by gay men to be able to avail the right to contact a Jewish surrogate, the Mor-Yosef committee has been set up, which recognizes the demands of gay

men and if its recommendations are accepted then it would further expand the scope of surrogacy in Israel. Despite that surrogacy has been accepted and practiced in Israel in a big way (Birenbaum, 2016, pp. 8-10). Egg donation presents a different picture, however. In order to get a clearer picture of how oocyte donation regulated in Israel, one needs to examine the phenomenon from the aspect of religion and then secondly one needs to consider the ethical reasons which guide egg donation and IVF in Israel.

Religious Concerns

A child's Jewishness is inherited matrilineally which means that is through the mother that one is considered a Jew. In ART, the surrogate carrying the child in her womb, then became the criteria which decided the child's Jewishness, however, with the development of new technology, which then allowed the ability to separate the egg from the womb, destabilized the criteria. Religious heads- the rabbis, were divided in their opinion as to what component would define the child's Jewishness. With one group contending that the egg defines it while the other applying the logic that eggs from non-Jewish donors would remove the future chances of incest, prefer the womb to be the decisive factor. With the lack of Israeli egg donors, 'Jewish eggs' are very expensive, which pushes most of the Israelis to opt for non-Jewish donors. However, there are countries from where they readily accept the ova, which includes Romania and other countries in Eastern Europe, while they completely reject reproductive fluids from Arab countries and Palestine. This behaviour clearly displays that their preference is not only motivated by physical appearance but also influenced by extra-genetic nationalist notions of 'chosenness' (Birenbaum, 2016, p.7). Furthermore, in regards to the religious concerns which affect the oocyte donation in Israel, Islam being the second popular religion in Israel, encourages IVF as a means to procreation, a duty which Islam regards highly, however, it requires that the gametes used for the IVF procedure belong to the commissioning parents, thereby, prohibiting the donation of oocytes, as involvement of any other party in procreation is treated as infidelity. However, under the new law for ovum donation, the couple can designate a relative to receive their egg, only when there are religious reasons on which the decision is based. If one looks at the Catholic Church, it prohibits the donation of eggs either altruistically or for payment (Gruenbaum, et. al., p. 41).

Ethical Concerns

Despite ART being supported and promulgated by the Israeli state, both the donor egg and sperm are not sponsored by the state and therefore not many people opt to act as donors, and those who do, do it at higher rates than that available outside the country. Even when the Israeli want to avail foreign eggs, they would have to pay out of their own pocket, thereby rendering the treatment out of reach for many. This lack of egg donors as well as the lack of state support created a shortage of donor eggs, with more and more women opting for ART. In 2010 a major clinical scandal took place which made the country reconsider their regulations on egg donation (Birenbaum, 2016, pp. 6-7).

Up until 2010, one finds that only the women who were undergoing IVF were allowed to donate eggs, other forms of egg donation, both altruistic as well as commercial, were banned. However, when it was found that a senior fertility expert was over medicating patients as to procure a large number of eggs. He would then sell the extra extracted eggs to other patients without the actual consent of the donor women as women undergoing the procedure had little or no idea regarding this. When this malpractice came to light, it shook the ART industry in Israel. This invoked a strong reaction from the feminists, who went into dialogue with the Ministry of Health, which resulted in a change in the MOH guidelines and resulted in the passing of a new law that allows healthy, single women aged 21 to 35 to donate eggs up to three times in her life, while keeping the donor's well-being as the top most priority. The expenses undertaken for the donation are partly covered under state insurance plans. It is under the Jewish law that the oocyte donor must be an unmarried woman, as to avoid any form of adultery. Furthermore, the law demands that the donor's identity is to be kept confidential, till child turns 18, in an attempt to prevent interfamilial breeding. The regulations also keep a check on the number of times the woman is able to donate eggs which thrice in her lifetime (Birenbaum, 2016, pp.6-7; Gruenbaum, et. al., 2011, p. 41).

It is very important to understand how these laws affect the autonomy of the individual, especially in the case of the egg donor. The new law in Israel means that women have the freedom to choose to become egg donors, however, one needs to understand whether one is agreeing to donate eggs, with an actual intent to help or to avail the new financial incentives; the autonomy of the individual is undermined to make proper decisions. On one hand the compensation needs to be high enough to cover the inconvenience one goes through to donate eggs, on the other if the compensation is too high, the level of payment itself might become the coercive factor on basis of which the individual decides to act as an oocyte donor. It is often argued that, it is the financial condition of the women that makes them take this

decision, and often enough it has been found in the research conducted, it is in fact the economic drudgery which makes them sell their oocytes. So in this situation it is important to see whether, the donors are coming from different socio- economic sections and cultural backgrounds, in order to gauge that, whether the decision is overridden by the financial factor or not (Gruenbaum, et. al., 2011, p. 41)

Earlier all donations were altruistic, however, it has been repeatedly pointed out why should one of the major contributor in the IVF process should not be compensated for their services, the new law in Israel recognizes this injustice and attempts to correct it by providing compensation to all those involved in the egg extraction process. It is often argued that commercial egg donation would lead to corruption and illegal behaviour, however the Israeli Ministry of Health aims to tackle this problem by closely monitoring and controlling egg donation and IVF, along with proper testing of eggs so that they are free of disease along with proper regulation of the compensation payed against the donation (Gruenbaum, et. al., pp. 41-42). The State hopes that, with the option open for state assisted egg donation, the shortage which forces people to find egg donors abroad will be curbed and the overall costs of the treatment in the country will be reduced, thereby making the treatment available to a larger population. However, the researchers have noted that the change in regulations has not resulted in the desired change they had hoped for, as the Israeli women looking for donor ova, and are able to afford it keep travelling abroad (Birenbaum, 2016).

When looking at the efficacy of the regulations in place in Israel in regards to ART, one draws out measures which can be emulated in a country like India, but at the same time must probe the policy critically as well. The features which make the surrogacy regulation successful in Israel include intensive nature of Israel's surrogacy contract which outlines all possible scenarios, further their extensive donor matching industry, which helps recipients of donor gametes to "pass off as natural", which greatly helps in establishing kinship on the basis of "nature"; this goes against the commonly held notion that technologization of the reproduction through ART would eventually erode 'nature' as the basis of kinship. Further, women get praised for persisting in exceptionally long fertility treatments by the media, which is only possible because of the generous public funding of the ART industry in Israel (Birenbaum, 2016). Though not to that great an extent this can help remove the stigma that women or couples have to face when confronted with the inability to have children – infertility. With the state's generous support of ART, the policy in Israel ultimately follows the trajectories of proliferation, globalization and privatization. Furthermore, on one hand the

state provides extensive funding for heterogeneous families, which at the same time leaves, a small group of Israelis who have no option but to seek ART services abroad, in a highly globalized and privatized world. It is clear that Israel as a state promotes biogenetic relatedness, which can be seen in their choice of purchase of oocytes, whereas, single and homosexual individuals are left on their own to make all transactions on their own. ART and its patterns in purchase of human ova, in Israel has become an instrument to further the state's broader national project (Birenbaum, 2016, pp.12-13).

Reverse traffic repro-migration

When cross-border travel is undertaken by doctors, embryologists, gametes, hormones and other surgical equipment rather than the commissioning parents or donors, the process is termed as reverse traffic in repro-migration. It is essentially a reversal in the direction of travel - instead of clients travelling to access to ART facilities, the facilities travel to meet the clients. However, the aim of both travel is the same, that of capital gain.

The process can be best understood through studies carried out by Michal Nahman (2011) during her anthropological research in a clinic in Bucharest set up by an Israeli doctor. Prior to 2010, it was illegal to import embryos to Israel and viable frozen oocytes were difficult to produce. Women had to undertake expensive and inconvenient journeys to avail ART facilities, in order to be implanted with the fertilized ova. The establishment of this clinic in Bucharest reversed the tradition repro-migration. Rather than the women or the donor travelling, it is the doctor and the embryologist who would travel to Bucharest with canisters of cryopreserved spermatozoa. They would procure eggs from willing donors which would be then paired with the spermatozoa by the embryologist. The clinic would then take the donated oocytes, fertilize them with the spermatozoa from the commissioning couples/ donors, to turn them into ova. The fertilized ova would be then cryopreserved and at the end of the entire process, the canisters would be then taken over to Israel where it would be implanted into the uteri of the commissioning women (Nahman 2011, p. 627).

Reverse traffic can be surmised to three key points, viz, reversal of direction of travel, the hiding and dividing of women and the way it eludes a definition of trafficking. This process of reverse traffic in the repro-migration basically entails that rather than the commissioning

parents or the egg and sperm donor traveling across borders to avail ART facilities it is the eggs, surgical equipment, doctors and embryologists who travel. It is the reversal of the direction travel of objects and people- a reversal that uses mobility and immobility to increase capital gain. The doctors, embryologists, gametes, hormones and equipment all make transnational journeys rather than the patients. This brings to the fore how gender performs differently when it intersects with race, locale, and class, making some women more vulnerable than others. In fact, reverse traffic further reduces or completely eliminates the interaction between the woman who is the egg donor or surrogate, and it also helps in circumventing the anti-trafficking laws and ethics.

Reverse traffic also circumvents the legal definition of trafficking, the UN Convention against Translational Organized Crime of 2000 states that, "*trafficking shall remain the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion… of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organ."* Going by this definition one can see that some facets of trafficking can still be found in the process of reverse trafficking of repro- migration, which includes the removal of bodily tissue and the exploitation of people (Nahman, 2011, p. 628).

While traditional forms of repro-migration would allow some form of interaction between the donor and the recipient, however this completely eliminates interactions between the egg donor or the surrogate, and circumventing anti-trafficking laws. Reverse traffic hides women from one another and from critical scrutiny. This invisibility is central to the effective functioning of reverse traffic repro-migration. Reverse traffic also highlights the uneven relationship between women globally, it separates differently positioned women in the global North and the South, the women belonging to different economic classes thereby, fostering an illusion for egg recipients that one is simply having a medical procedure of embryo transfer involving monetary payment. Reverse traffic repro-migration unmasks global and national unevenness existing under capitalism, and that is heightened in the intersecting relationships between egg donation policies, access and risk with other social and political categories such as race, gender, national borders, citizenship and immigration, class and religion (Nahman. 2011, p 628).

Some women's bodies are made more vulnerable to reverse traffic repro-migration because of economic or geopolitical positioning. In many cases, there is opacity in terms of consent and the legal definitions of trafficking do not apply because it happens in reverse. A major feminist criticism of this process is the exploitation of impoverished women in poor nations. Most women who donate eggs belong to the economically backward sections of the society and live in the poor parts of the world, thus are subject to low standards of care and the prevalent oppression under the neoliberal pinafore. The physicians and surgeons are not completely responsible for this as they too operate within the neoliberal system, which provides them with lesser funds by the day and encourages them to see out novel ways of profiting from differently situated bodies. They too are under immense pressure to extract as many eggs as possible. Furthermore, studies have shown that reverse traffic repro-migration turns some women into available resources and others into consuming bodies. It seems to do so to a greater extent than 'normal' CBRC. This is due to the increased financial profits involved and the way it facilitates getting around human-centered values (Nahman, 2011).

While women as gendered beings are constructed by and through their class and race positioning, they are also gendered through their relationship to the state and the wider global order. The state plays a complex role here: on the one hand legislating against certain kinds of reproductive trafficking and on the other hand letting the market decide the outcomes of these practices. It is this kind of complexity that reverse traffic repro-migration takes advantage of by skirting policy, hiding women from one another, taking advantage of the desperation. In reverse traffic repro-migration, perhaps more than in other forms of CBRC as tissues/ embryos/ eggs and recipients have been prioritized over the wellbeing of the oocyte seller herself (Nahman, 2011, p. 629).

This helps to highlight some central themes for analysts of repercussions of this liberalisation, problems of access and cost, and race, class, gender and reproduction and the construction of gender as it intersects with global inequalities and capitalism. These are four key themes which demonstrate the political nature of practices of cross-border reproduction. Reverse traffic repro-migration thus, links oocyte sellers and recipients in a kinship of visibility and invisibility, connected with blood and tissue, capitalism and biomedicine (Nahman, 2011, pp 630-632).

The Process of Circumvention Tourism

This reverse traffic repro-migration and other ways through which the humans as well as tissues and bodily reproductive fluids move across borders, because of the restrictive regulations in the one's own country, fall under what Glenn Cohen has described in his work as 'circumvention tourism'. Cohen takes up the example of medical tourism to explain how this rapidly growing multibillion dollar industry of medical tourism, where patients travel from the "home country" to the "destination country" in order to avail services that are legal in the patient's destination country but illegal in the patient's home country. The circumvention of domestic prohibitions on accessing by the patient, has been termed as circumvention tourism (Glenn Cohen 2012, pp. 1311-1312).

Many countries limit or ban certain assisted reproductive technologies. For example, Italy's Law 40 confines use of reproductive technologies to infertile women of 'potentially fertile age' who are married or part of a stable heterosexual couple and prohibits the use of donated sperms or eggs. Greece and Japan also restrict access to ART for women aged fifty or younger. Egypt, Iran, Kuwait, Jordan, Lebanon, Morocco, Qatar, Turkey, Indonesia, Malaysia and Pakistan ban all forms of sperm or egg donation. Austria, Germany, Switzerland, the Australian States of Victoria and Western Australia, the Netherlands, Norway, and, most recently, New Zealand and the United Kingdom do not allow anonymous sperm donation. Britain, Canada, and the Australian states of Victoria and New South Wales have banned or limited compensation for egg and sperm donation. In countries Canada, the Australian states of Victoria, New South Wales, and Western Australia have made commercial surrogacy a crime. In Britain without showing before the court that "the surrogate received no financial or other beneficial consideration in exchange for her services", one is not allowed to transfer parentage rights, thereby effectively forbidding commercial surrogacy. In France, "all types of surrogacy are illegal," and violations may result in severe punishments (Cohen2012, 1323).

These restrictions have resulted in the opening up of markets for reproductive tourism in other countries, major destinations for these services include Australia, Canada, India, Israel, South Africa, and the United States. Apart from the main markets there are also the niche markets which include: Romania, Ukraine, and the United States which have become common destinations to source ethnically Caucasian sperm or eggs (Cohen, 2012, pp. 1323-24).

The destination country is also influenced by the efforts made by the people to circumvent the prohibitions at home. Most of the commissioning parents select countries which are nearby and fit their budget, like, Taiwan attracts patients from China and Japan. Some patients select destination countries on the basis where commercial sale of sperm and egg is possible, which is either limited or completely banned in their own countries, such as patients coming in to Romania from Israel, as the sale of egg was prohibited up till 2010 and even after the provision of the compensation for egg donation, it is limited to the heterogeneous families. Which leaves a group of Israelis who have to seek egg donors abroad (Grudenbaum et al, 2011, Birenbaum, 2016). Furthermore, India had become the hotspot for ART as it allowed commercial surrogacy, without stringent regulations and the availability of state-of-the-art facilities for the fertility patients. At times it has access to large number of surrogates and donor eggs as exemplified in the case of Akanksha clinic in Anand, Gujarat (Pande, 2012).

Some countries like the UK, Germany and Italy have strict domestic laws which deter or restrict the use of ART within its national boundaries. This leads to the people in want of the services to seek them abroad in countries like India and Thailand. While research conducted by Marcia C. Inhorn (2010), Amrita Pande (2012) and many others suggests that rampant circumvention of domestic prohibitions continue, and many countries fail to protect the interests of the third party - those providing the raw material for the ART industry - sperms, oocytes and the womb. While countries like Italy and Turkey which already have restrictive laws have taken further steps to deter the practice, little had been done in the destination countries. Turkey has extended its domestic criminal prohibition on reproducing with donor sperm or eggs, to women who are getting inseminated abroad. In Italy the doctors can get prosecuted, if they refer patients abroad for prohibited reproductive technologies (Cohen, 2012). However, in the destination countries like India and Thailand, little had changed over the years. However, in the past couple of years both these countries, which were a hotspot for transnational reproductive industry, have made amends in their laws, with Thailand banning surrogacy and India calling for a ban on commercial surrogacy in November 2015, for foreign couples. In India, the domestic market for ART continues to boom, however, the foreign couples for whom India had been their last hope are disappointed with the decision.

It is often touted that in the neoliberal market an individual has the agency to make decisions, thereby a woman's consent to sell her eggs or rent out her womb for the purpose of surrogacy is seen as an informed decision on the part of the woman. However, as Cohen (2012) brings

to the fore that just by getting a signed consent from the woman, does not mean that the woman in the destination country is not a victim. Keeping this in mind, many countries, as discussed earlier, have restricted the use of ART or some of the procedures such as IVF, commercial surrogacy (gestational or traditional), non-commercial surrogacy, egg donation or artificial insemination by donor, for which they have divergent justifications (Cohen 2012, p. 1373). However, at the same time the justifications that are applicable in the home country are not applicable in the destination country, thereby the victim is the woman in the destination country, where the practice is allowed or lacks regulation. Cohen exemplifies this phenomenon by explaining how a commissioning couple from Turkey, who travel to India, to engage a surrogate. It appears that while Turkey has protected the rights of the surrogate and the egg donor, India has shunned that protection for its own citizen, perhaps by deciding that the 'victim' i.e the surrogate or the egg donor is not being harmed or wronged through participation in commercial surrogacy (Cohen 2012, p. 1374). Here, we can clearly see that the home country is thereby extra-territorializing their problem, which is leading to the circumvention of reproductive tourism.

This again doesn't mean that, as Cohen puts it "*that the home country has a greater interest in the intrinsic corruption of its citizens' sexuality or reproductive labour than it does in protecting the intrinsic corruption of the destination country citizens*" (Cohen 2012, p. 1379). Again this circumvention cannot be justified on the basis of the consent obtained from the surrogate or the egg donor, as in many a case the decision taken by the woman and whether she is getting a "raw deal" (Cohen 2012, 1382) is often motivated by factors such her position in the economic curve, which would ultimately decide, whether the money that the woman is being offered is worth the risk, or does it refusal even more difficult. Furthermore, in a country like India, where there is no official language and contains a population which speaks thousands of dialects, more often it is found that the woman entering the contract, who mostly belongs to the poorer section of the society a research as proved, cannot read and understand the contract. Therefore, to get a consent, it does not diminish the corruption, and this leads to the extra-territorializing of the problem (Cohen, 2012 p. 1379). Thus, one can see that circumvention tourism falls completely in line with the argument that many have stated, that the ethical dilemmas of one country has been "outsourced" to the other, with countries banning egg donation and commercial surrogacy. This has led to the creation of a foreign market, where both the commissioning parents and the surrogate or the egg donor knowingly or unknowingly suffer (Cohen 2012, pp. 1385). Cohen explains the phenomenon

"If we understand this as a more metaphysical objection—that something wrong has been done through the act of value denigration at the moment sperm, eggs, or surrogacy services are sold irrespective of what follows thereafter—it seems that the home country has just as much of a reason to extend its criminal law to the actions of its citizen abroad as it does when the citizen acts at home. Wrong has been done at the moment the act is done (whatever its consequence), and the act of criminal condemnation is needed both to deter that act and, on retributivist or corrective justice type grounds, to re-right the balance" (Cohen, p. 2012, pp. 1379).

Here, one must understand that if the justification for the domestic prohibition is intrinsic corruption, then there lies enough reason for home country to restrict the sale of eggs and other ART procedures, not just at home but also those who indulge in the same in the destination country. The evaluation of whether the transaction between the commissioning parents and the surrogate or the egg donor is exploitative or not can be assessed by the level of risks that these women subject themselves to. The risks largely depend on the prevailing standard of care for the procedures for egg retrieval, surrogacy, and postoperative care, as well as how these risks compare to the other risks of the woman's everyday life (Cohen 2012, pp. 1381). This is where the major difference arises between the conditions in the destination country and the home country.

Furthermore, Cohen also brings up another factor which deeply affects whether the practice of ART is exploitative or not, which can be determined by looking into the representation of the said exploited party in the governance of the destination country or at least in the formulation of the policies which would regulate the market, and decide whether the practice needs to be criminalised or not. What one needs to keep in mind is the fact that whether the powerful majority has chosen to ignore the claims of victimization of a disenfranchised minority that will bear the brunt of the exploitative transaction. How would citizens from the destination country in a very heavily gender-subordinate societies behave, this constraint would seem to require a country-by-country analysis rather than the on-off approach to extraterritorial application, though, perhaps some of that could be accomplished through prosecutorial discretion. If wrongful exploitation is the reason for the domestic prohibition on the ART procedures, the home country should not extend its criminal prohibition to the extraterritorial activities of it citizens, at least in some instances. Further, if the basis on which the domestic prohibition is sought relates to matters of distributive justice and not to physical harm, and the exploited party's country of citizenship (the destination country),

which has determined that it is not exploitation, and it is the choice i.e. voluntary on the part of the donor or the surrogate to participate in the in the transaction. Even if choice means, that immediate coercion is missing, though not in the deeper sense of freedom and autonomy. At the same time if the said exploited party is adequately represented in the governance of the country and the procedure takes place within the country's territorial sovereignty then the home country does not have good reason to criminalize extraterritorially. Moreover, one must also keep in mind the fact that the justifications used for the domestic prohibition on reproductive technology use are crucial and decisive in determining whether a country should criminalize circumvention tourism. If the basis is child welfare or the intrinsic corruption concerns, as Cohen states, the normative extraterritorial application of the prohibitions should be sought. However, Cohen states that if the concerns are the consequentialist corruption or exploitation, the home country can then justifiably refuse to extend its criminal prohibition in other countries (Cohen, 2012, pp. 1384- 1386).

ART in India

Introduction

While looking at the pathways of the physical traffic involved in the movement of the bodily reproductive parts, India often emerges as the destination country. Countries like Germany and Italy, as discussed earlier, have regulations which vary from religious ban to ethical and moral justifications, which restrict the access to ART procedures for the citizens, necessitating their travel to countries like India. Many argue it is the lack of regulations in India which has promoted the proliferation of the ART industry, as it provides easy access to the otherwise expensive ART procedures and also helps create a market for ART services. It is necessary to analyse the available regulations in India, and whether they do become the basis of the ever growing industry of ART. India has been the surrogacy capital of world as according to the BBC (Nov. 2015). The ART industry in India was worth around 2.3 billion dollars, while more than 30,000 clinics provide ART services, as reported in 2003 (SAMA, 2011, p. 25), the number has surely doubled if not tripled in the past thirteen years. India has long been the 'destination country' for many ART customers. While there are many reasons of the conditions which make it a favourable destination for those seeking ART services, it is not just the foreign patients who seek ART services in India, even the people in India access

this multibillion-dollar industry. Therefore, it is necessary to look into the process and the factors responsible for India to become a hub of ART services. Furthermore, one also needs to look into the regulations which are supposed to guide this multibillion dollar industry in India.

Setting the Stage- Motherhood and preparing for the advent of the ART services

As one has discussed in the case of Israel, motherhood is seen as the most important role of the woman in the society. In India too, a woman fully becomes a part of the society only when she fulfils her role of becoming a biological mother, she is then elevated and venerated to the exclusion of the other roles that she performs in the society. A childless woman is looked down upon and often faces social stigmatisation (Sarojini et. al., 2011; Widge, 2005). Therefore, couples often try all avenues to achieve parenthood. The ART industry has been a blessing for them as treating infertility has remained an ignored area in the public health system in India, which does not include health infrastructure for addressing preventive and secondary causes of infertility which can be combated at a preliminary stage. However, in India, not all have equal access to the facilities of the ART industry and their position as consumers or suppliers, largely depends on where they fall in the socio-economic strata (Sarojini et. al., 2011 p. 8). This is largely due the process through which the ART industry got established in the country, which has made a business out of motherhood with the help of the globalised neoliberal forces. This coupled with the movement of reproductive body parts and women's reproductive labour and care – egg donors, surrogates- has led to the "globalisation of motherhood". Here it is essential to ascertain that the crossing of geographic and biological boundaries does not become a crossing of ethical boundaries (Sarojini et. al., 2011 p. 8).

With the onset of market liberalisation in the 1990s, the Indian market was thrown open for foreign investment and this is seen as the main reason behind the development of the private health care sector. With the support of the government, Indian private healthcare has established itself as the global health destination (Chinai & Goswami, 2007). One needs to understand this development of the private health sector to understand the growth and proliferation of the ART in India. As Imrana Qadeer states, the present infrastructure of healthcare in India is in direct conflict to what India sought to achieve after independence. National policies had pursued to build a healthcare system inspired from the socialist and social- democratic countries, seeking to provide basic healthcare to all citizens irrespective of

their paying capacities (Qadeer, 2011, p. 223). However, Qadeer notes in her work that with the weakening of the Government funded policies and the increasing influences of international bodies like the International Monetary Fund (IMF) and the World Trade Organization (WTO), along with the growth of the middle class in India, there was a demand for advanced medical services and five star hospitals in the urban areas. This demand was realised and brought to the fore with the help of the medical bureaucracy. The urban middle-class played an important role in supporting the State in shifting to neo-liberal policies, with their own mind-sets being fixed on the bio-medical aspect of health. The then ruling parties, taking advantage of this support ushered in the neo-liberal policies, consolidated their international patronage and transformed health services in this country into yet another commodity. In doing so, they were able to shed the burden of responsibilities for the services they were earlier committed to provide to the public (Qadeer, 2011, pp. 223-224).

The intervention by the foreign bodies to manipulate the Indian health policy is clear, as in 1992 itself, the World Bank set the directives for the health care infrastructure in India in a document titled, financing for India's Health Sector and another in 2001, 'Better Health Systems for India's poor' (Qadeer, 2007). The work of such international bodies which are in the position of being able to arm-wrestle India, majorly influenced the health planning in the 1990's and reinforced the privatisation of medical care at all levels by delegitimising the public health institutions. This was done by labelling these institutions insufficient, lethargic and corrupt through the use of inept measures of efficiency and without any consideration of reductions in the resource allocation, as subsidies were and are being constantly shifted from the public sector to the private sector. All this was accompanied by the opening up of the public sector to private sector. Chinai and Goswami, too state in their work that the state of private health care stands in marked contrast to the reality of health care for the majority of India's indigenous population, especially in the rural areas (Qadeer, 2007).

The State, rather than being the main actor, was reduced to the role of a steward (Qadeer and Reddy, 2006), existing only to ensure that the private market in healthcare is able to function without any hindrances. It had further become a client or a buyer and purchased the services that the poorer sections were not able to buy on their own. In its attempt to ape the West, the country became subject to policies such as 'Poverty Removal Strategies of the Millennium Development Goals', which has an economic motive in tune with their national interests but in conflict with the needs of India's poor (Qadeer, 2011). The withdrawal of welfare and the

emergent neoliberal agenda with its thrust on monetarism, markets and centralised control by the global economy, have seriously impacted health sector planning.

This is one of the reasons why medical tourism found a foothold in India, with private interest groups pushing the envelope encouraged by the Government. Subsidies were provided to the private hospitals and super-speciality hospitals, and additional subsidy was provided for buying imported drugs and equipment (Qadeer & Reddy, 2010). The National Health Policy boasts of the emergence of a robust [private] health care industry growing at 15 percent compound growth rate (CAGR). As per the World Bank's International Finance Corporation, which invests in private sector, the Indian private healthcare industry is the second highest destination for its global investments in health (Mohan Rao et al, 2015). This has happened in tandem with a structural neglect of the public healthcare system, and private capital has massively invaded the health sector. The excerpts from the Draft National Health Policy 2015 gives an essence of the policy, which would only provide the latest medical benefits to those who can afford it, essentially transforming a public right into a commodity. This falls right into the fragmented individualistic world view that underlines neoliberalism, with its detrimental effects in the field of health. The manipulations by the international bodies of the health policy in India continues with the General Agreement on Trade in Services (GATS) which includes trade in medical services. This offers financial incentives to private hospitals and encourages them to treat foreign patients. (Mulay & Gibson, 2006).

As a result of these processes of globalisation and neoliberal forces, medical tourism has flourished in India, as pointed out in the works of Giuseppe Tattara. He outlines the major push and pull factors which encourage the growth of reproductive tourism in India, including the availability of latest medical technologies and a growing compliance with the international quality standards. Additionally, foreigners are less likely to face language barriers in India and the cost of treatment here is far less when compared to the costs in the developed nations, especially in the UK and the USA (Tattara, 2010). In India, one can have access to quality healthcare at very low costs with the commissioning parents having a greater control over the process, as we have seen in the works by Hudson & Culley (2011) in the UK. This is possible because of the availability of relatively cheaper but quality manpower, low-priced drugs and other infrastructure. As Qadeer and Reddy have emphasised in their work, medical tourism has grown into a full-fledged industry, drawing on cheaper air fare, internet and communication channels in developing countries, as well as hi-tech super-speciality medical services for people who can afford it, irrespective of the fact that they

belong to a different country or to India itself. Furthermore, this industry also makes use of the Indian 'exotica', and packages health care and upcoming technologies in the ART industry with other traditional therapies (2010).

The ART industry and the need for its regulation:

With the expansion of the private health care system along with the help of the globalised neoliberal forces, the ART industry had found a foothold in India. However, it was the low costs and the easy access to the otherwise expensive and highly regulated technologies as seen in the case of Germany and Italy, the easy availability of egg donors and surrogates and along with the lack of regulations which has been attracting the people seeking ART services from across the world. The Sama team reports that in 2009, an IVF cycle in the US would cost around $20,000 which is approximately Rs.9 Lakhs in India, while the same procedure would cost around $2000 which is approximately Rs. 90,000 in India. The entire procedure of surrogacy would cost around Rs.25-35 lakhs in the US while the same would cost Rs. 10 lakhs in India (SAMA, 2009 p, 25).

Furthermore, the ART clinics are not the only players in the business of promoting 'reproductive tourism' in India, there are sectors whose interests lie in promotion and promulgation of the reproductive tourism, which includes a wide array of organisations catering to clientele, both national and international. These range from ART consultants, surrogacy agents, medical tour agents, the hospitality industry, the tourism department to other organization specialising in medical tourism promotion (Sarojini et. al., 2011, p 6).

There exists a pressing need to regulate this industry because it is not only the ART clinics in India which are catering to the people accessing this procedure, there now exists large international collaborations, wherein ART clinics have tied up with international hospitals and agencies to solicit clients globally. Such as the Rotunda clinic in Mumbai has tied up with California-based medical tourism agency Planet Hospital (PH), which now sends couples from California to avail treatment in India. Furthermore, such collaborations also set the stage for reverse tourism, as companies bring in women from the first world countries to donate their eggs as well as travel in India. An example of this is the Florida based Proactive Family Solutions (PFS), which recruits intended parents and egg donors, and then provides the intended parents with a pool of potential egg donors based on the client's criteria, which would typically include hair, eye colour and level of education. The company then takes care of everything that the donor needs in India, also scheduling the procedure around her college

break if the donor happens to be a student and she is allowed to bring a person along. (Sarojini et. al., 2011, p. 26). Here one needs to question that with such wide networks along with such competitive market model, with free market principles in place, should the ART industry remain unregulated?

Further, with the lack of a central registry, accurate statistics for the number of infertility clinics, or even births through surrogacy, as the work of Nadimpally Sarojini, Vrinda Marwah and Anjali Shenoi (2011, p. 4) has shown, one cannot ascertain the number of clinics which are providing ART services. In recent years, the ART industry in India has proliferated from big metros to semi-urban areas which otherwise lack even basic health care facilities. Furthermore, many reports in the media as well as academic research suggests that it is the women from the marginalised, economically weaker sector who are generally roped into participating as surrogates and egg donors. An uneducated woman with limited access to both financial and socio-cultural resources has limited alternative opportunities to generate comparable levels of income, and limited autonomy in patriarchal family contexts. These factors exert economic and family pressure to participate in surrogacy. (Lal, 2009; Qadeer, 2009). As little research exists on the long term health repercussions, both physical and mental, of this practice, regulation of this industry becomes of paramount importance. If continued unregulated, this is detrimental to the women involved as it further endangers their physical and mental health.

Efforts to regulate the ART industry in India - the Guidelines and the Draft Bill and its shortcomings

Attempts have been made to regulate this industry. The National Guidelines for Accreditation, Supervision and Regulation of Assisted Reproductive Technology (ART) was drafted by the Ministry of Health and Family Welfare (MOHFW) with the Indian Council of Medical Research (ICMR) and the National Academy of Medical Sciences (NAMS) in 2005. These guidelines basically set forth the medical criteria for fertility treatments and procedures for the government to regulate ART clinics. Amongst other things, it demanded that the commissioning parents should provide for the surrogate's medical expenses during the course of the pregnancy; the surrogate must give informed consent, witnessed by a non-member during the pregnancy. Further, the guidelines stated that the birth certificate must be in the names of the commissioning parents and not in the name of the surrogate, also the surrogate

is supposed to provide information about her role as a surrogate and/or as a genetic donor (Margali, 2015, p. 41).

The 2005 Guidelines were criticised for being vague and not legally binding, and the stated rules and regulations were not mandatory for all the clinics that provide ART services.The regulations were thereby not implemented stringently which resulted in the lack of any regulation for this industry (SAMA, 2009, p. 25). It is further criticised for failing to protect the rights of the surrogate as well as the resulting child. While the draft mentions that an informed consent is required, it was not a binding prerequisite and was dealt with in a ambiguous and superficial manner. Moreover, ART is an ever evolving technology the draft lacks clarity on the issues related to the approval of newer technologies and the accreditation of the ART clinics. Despite these shortcomings, the draft at the basic level does recognise the legality and enforceability of surrogacy agreements in India under both domestic and international law and includes the notion of the surrogates and intending parents (Margali, 2015, 42).

In 2008, the MOHFW and the ICMR came up with the Draft Assisted Reproductive Technologies (Regulations) Bills and Rules, which was published in 2010, after several revisions (Yehezkel Margali 2015; SAMA, 2009). This proposed Bill along with other safety nets such as, no clinic would be allowed to go forward with the IVF treatments with the regulatory body's documentation from the commissioning parents' home country, which should clearly state that the home country permits surrogacy and the child which is born in India will be allowed entry as a legal child of the commissioning parents, also recognises the legality of surrogacy and the enforceability of the surrogacy agreements. This draft Bill also demands that the health of both the commissioning parents and the surrogate along with the preliminary check of the egg donor, to ensure that the most comprehensive information is provided in order to obtain an informed consent (Yehezkel Margali, 2015, pp, 42-43).

The research conducted by SAMA suggests that though this Bill is still to be legalised as an Act, it forms the basis which emboldens the necessity to obtain an informed consent. However, it actually fails to protect the rights of the women who are involved as surrogates or as egg donors in the procedure (SAMA, 2009). While the Bill mentions the term 'regulation' and it is thereby expected that such a bill will regulate the practice of ART and safeguard the rights and interests of the users i.e the women, and incorporate provisions to prevent misuse and malpractice, thereby making those providing the services accountable to

the women/ commissioning parents and the laws of the land. The bill permits gestational surrogacy and is criticised for promoting the interests of the private sector rather than regulating them and remains inadequate in protecting and ensuring the health and well-being of the women and the resulting children (SAMA 2009, p.26 ; Palattivil et. al., 2010).

The draft Bill suggests that a national advisory board should be set up to recommend modifications in the regulations regarding permissible ART, the minimum physical infrastructure of the ART clinics, guidelines for counselling, research on human embryos and other policies on assisted reproduction. Moreover, all the states are to establish state boards, who may advise the state government to constitute a registration authority, to register the ART clinics, semen banks and other research organisations dealing in human embryos for a period of three years, only after inspecting the premises of the applicant (SAMA 2009 p. 25).

The draft bill also deals with the permissible procedures under ART, the basic infrastructure which is required for any ART clinic to function. It also mentions the guidelines for counselling, research on human embryos, and other policies on assisted reproduction, specifies the duties of the ART clinic, which includes maintaining an accurate record, the regulations which the clinics would implement in regards to the use of gametes and embryos and the duties regarding Preimplantation Genetic Diagnosis (PGD) and sex selection. This draft also specifies how gametes should be sourced, stored and handled at the same time maintaining accurate records by the semen banks and restrictions on sale of zygotes and embryos and the regulation of the research on embryos and gametes or other human reproduction material (SAMA 2009, p. 25).

Semen Banks - Semen banks play a peripheral role in providing donor semen for couples in need, which is sent directly to the ART clinic. A number of clinics have an in- house semen bank, providing all the services under one roof. The SAMA study states that the Bill in its current form hands over a substantial part of the managing and running of the ART process to semen banks without providing any rationale. According to Clause 26(1), the semen bank will handle the collection, screening, storage and handling of gametes, andcan also advertise and source surrogate mothers for couples seeking surrogacy services. Another provision for the semen banks in the draft Bill is that they should register and operate as an independent entity. Both the clause and this provision are mentioned in the draft Bill without much explanation and has helped the semen banks to function freely without any regulations (SAMA, 2009, p. 26).

It is clear from the research carried on by SAMA (2009) that the semen banks which are presently functioning are not equipped to carry out these tasks assigned by the ICMR. Without clear directions regarding mandatory equipment and personnel in the semen bank, the bill does not make itself clear on how they are going to equip themselves for the responsibilities. More importantly the draft Bill does not lay down any clauses specifying who can open and operate a semen bank - the qualification and background of the person and the team necessary to run it - as it has been specified for the ART clinics.

While the Bill envisages separation of the semen bank with the ART clinic, the question remains whether this means that the ART banks which have their own semen banks would now register their banks separately and continue to function in the same way. It is a commendable attempt by the draft Bill to prevent ART clinics from sourcing the donors and surrogate by handing over this function to the semen banks. However, by doing so the MOHFW and the ICMR simply replaced one agency with another, without actually resolving the issue of maintaining certain ethical and moral standards in the process of sourcing the surrogates and the egg donors (SAMA, 2009, p. 26).

In the matter of disclosing the identity of the donor, the draft Bill requires the semen bank to identify a responsible staff member from the bank, who would then take the donor to the clinic, which would ensure that the donor's identity is not disclosed. The draft Bill does not venture into the fact that what is to be done with constantly evolving technology and addition of new players to the process of the donation, with which the risk of disclosure of the donor's identity keeps increasing. Moreover, such complex procedures only complicate situations where the clarity of the ART clinics and the semen banks gets diffused (SAMA, 2009, p. 26).

Oocyte Retrieval- It is well known that the process of oocyte retrieval is completely different form sperm donation - it is an invasive procedure which requires ovarian stimulation with hormones and entails medical complications for the woman and therefore, must be conducted in a clinic set-up under proper medical supervision. It is more important to regulate the oocyte retrieval process. The Clause 26 in the draft Bill states that *if more than fourteen oocytes are retrieved from the donor at one occasion, they shall not be used for more than two recipients thus ensuring that at least seven oocytes are available for each recipients* such clauses which are to form the basis of the regulations for egg donors in India, is alarming, as there no explanation as to how they arrived at the number fourteen and also it lacks clarity on what is supposed to happen with the spare oocytes. Fourteen oocytes are a large number and

there is a chance the spare ones may be routed for research or for egg sharing, which should be monitored. Another shortcoming of the draft Bill is the fact that, while it specifies the number of eggs which can be retrieved from an egg donor, no such specification is mentioned for the women undergoing IVF or the women who agree to share their eggs. In context of egg sharing, which is often offered in lieu of a subsidy in the IVF procedure, there are chances that this will encourage providers to retrieve more oocytes, thus putting women under greater health risks, in order to maximise the chances of producing "enough eggs", the woman would be subject to large quantities of ovulation inducing drugs. The draft Bill should therefore spell out clearly the number of eggs which can be retrieved for egg sharing (SAMA, 2009, p. 27).

Further, it also raises concerns regarding the number of times the woman has gone for egg retrieval. The draft Bill mentions that there should be a period of three-months before the woman is allowed to go in for another cycle of egg retrieval. However, this three-month interval stipulated between the donations is inadequate for a woman to start with the hormonal injections again and undergo another cycle of oocyte retrieval. This interval as the SAMA (2009) study shows should be increased.

The bill does not specify the actual oocyte retrieval and screening process i.e, is it supposed to take place in the semen bank or at the ART clinic. As the draft Bill states that the collection, screening storage and the handling of the gametes shall be done at a semen bank. While at the same time it states that ART clinics must ensure that the patients and the gametes should be medically tested, so that they are disease free, thus making it unclear where exactly the extraction of the oocytes are to take place. The semen banks are not equipped to handle oocyte retrieval (SAMA 2009, pp. 30- 31). Apart from these ambiguities, the bill also fails to specify the age of the oocyte donor. While one section under the clause 26(3) of the bill says that the donor's minimum age should be 21, while another rule 4.7.1 in the same draft states that the donor should be a healthy woman in the age group of 18 to 35 years (SAMA 2009, p.31)

While drafting a Bill which should be aimed at protecting the rights and the health of the women participating the process, the draft Bill, does not even acknowledge the risks involved for the women undergoing the procedure. The bill terms ectopic pregnancy, spontaneous abortion and Ovarian Hyperstimulation Syndrome (OHSS) as "*small risks*" (Rules 6.13). The draft Bill fails to recognise life-threatening risks such as multiple gestation and others. It

clearly displays the apathy that the drafting committee had for the wellbeing of the women for whom they should be drafting the Bill (SAMA, 2009, p. 27).

The draft Bill should look into the regulations of the technologies so that they can ensure safe delivery for the women. The Bill nowhere discusses the risks that arise from the implications from the ART procedures (SAMA, 2009, p. 27). The extraction of the eggs with the help of the aspirating needles entails a risk of bleeding, infection and damage to the bladder or a blood vessel or the bowels. The Bill fails to explain the risks of the drugs which are used and the procedures which may potentially harm the health and wellbeing of the women undergoing them (SAMA 2009, p.28).

Furthermore, the Bill sees the women undergoing the treatment because she cannot bear children naturally as 'patient' and who is accessing the ART facilities as a 'client', which completely reduces the identity of the woman. Moreover, a woman cannot become a surrogate or an egg donor without the consent of her husband, which is completely in conflict to when a woman wants to terminate pregnancy, she does not need permission from anyone. While the Medical Termination of Pregnancy (MTP) Act of 1971 recognises the agency of the woman when she wants to terminate a pregnancy, it has made it compulsory that women who want to give birth, cannot do it without the permission of the spouse. This completely obliterates the woman's agency over her own body. One can clearly see the patriarchal forces at play, as the Indian society still remains unable to handle pregnancy outside wedlock and is often seen as a matter of shame for the woman. The pregnancy can be terminated without question while at the same time if a woman wants to bring in life on her own with the help of ART, obliterating the need for a husband, it is simply made impossible (SAMA 2009, p.28).

With the lack of clarity as to where the oocyte retrieval is to take place, the age of the oocyte donor, the lack of sensitivity to the life-threatening risks involved in the egg retrieval procedure and the number of eggs which can retrieved, the draft Bill also fails to regulate payment of the egg donor. Since the sourcing, the eggs is supposed to be done in the semen bank, the potential of exploitation and commercialisation is greater for the egg donor than the surrogate, as the flow of the payment to the egg donor is not regulated. The various clauses as discussed above, coupled with the complicated payment process, puts the egg donors in an even more vulnerable position (SAMA 2009, p.27).

Thus, we can see that the ART industry is not just a commercial enterprise, it throws up many medical, social and ethical issues, and has begun to change the existing perceptions which

exist around procreation. It directly affects the lives of many people who are involved at one stage or the other, especially the women who are the egg donors and surrogates, as they come from the lowest strata of the society, lacking any information about the procedure she is to be a part off. Moreover, there is a need for research which can ascertain the mental and physical repercussions of the invasive procedures of oocyte retrieval which also involves ovarian stimulation with the help of drugs. While money is offered for the sale of the eggs which are retrieved, neither the cost of the eggs is specified nor is the criteria which decides their costs. So we see that the women participating as an egg donor is in the most vulnerable position in India. While those who are flown in from the global north as a part of reverse tourism are provided with the best of facilities as we have seen above, the Indian counterparts are not even provided with counselling as to make them aware of the risks involved (Sarojini et. al., 2011). Considering all of this, it is only natural to expect that some regulatory mechanism is going be to be put in place in order to safeguard the interests of the egg donor. However, one can see in the draft Bill in India, that it hardly provides any rationale behind its provisions, as the provisions clearly support the commercial interests of the international collaborations and not the welfare of the women. Further the draft Bill lacks any clarity on how the ART industry is going to be kept under check and how effectively the regulations are going to be enforced, monitored or amended. The Bill needs to be reworked and that the process is simplified, the intermediaries are eliminated, the activities which allow the exploitation of women is prohibited, and encourages activity which upholds the dignity of the couples and individuals involved in the process (SAMA, 2009, p. 31). While present draft of the Bill falls short in many aspects, there is a requirement of a set of regulations which have to implemented. One of the follies in India is that the draft ART bill has not been passed as an Act for years. Though it remains weak in many aspects which can be improved with revisions and further research in the field, but foremost it needs to be legalised so the industry can be regularised and at least some positive aspects which have been discussed earlier can be implemented and enforced on the increasingly commercial enterprise of ART. Further, it is important that those involved in the drafting of the bill belong to different arenas and not just medicine and policy, as a field like ART has many socio-cultural and economic implications. Along with legal expertise, it is necessary to involve social- scientists in the decision making level, as it is they who can bring to the fore the moral, ethical and socio-cultural barriers which the Indian society and the women have to face when they encounter an industry like ART.

Implications of the Ban in India

Media houses such as the BBC reported, in their article- Despair over ban in India's surrogacy hub, dated 22nd November, 2015, right after the ban imposed on commercial surrogacy for foreign couples came into being in November 2015, that there's "despair over ban in India's surrogacy hub", by which they meant Akanksha Clinic in Anand, Gujarat which has been the, the site of study on surrogacy in India for many researchers in this field. For many childless infertile couples, as the articles states, the facilities in India was a blessing, and was the reason behind India becoming a surrogacy hub. The article further states that the reason behind India being such a popular destination among the fertility patients is because "it's easy to find women here who are willing to be surrogates, there's good medical technology and it's cheap". Dr Nayna Patel who runs the Akanksha Clinic states that she gives a chance to earn to the women, who have very less chances of making money on their own. $10,000 from the $25, 000 which is roughly the total payment made by the commissioning parents, is given to the surrogate, and a little less money when they are carrying a child for Indian couple. In one of the other articles the doctor states that nearly 5000 families depend on surrogacy for their livelihood in Anand. Which includes the people involved in transportation, hospitality business and other jobs which support the ART industry in Anand. The doctor states that a ban of surrogacy would adversely affect the economic condition of the place and the people involved. Even a petition has been started by couples from foreign countries who have benefited from the services in India, while restrictions remain intact in their own countries.

While the reasons cited by the article and the couples is that India does not have a law on surrogacy, as till now the industry has somewhat followed the guidelines laid down by the ICMR, the draft of the law which is called the "Assisted Reproductive Technology Bill", is ready however, has not been passed by the Parliament. Quoting Dr. Soumya Swaminathan (BBC, 2015), the Director General of the ICMR, the article stated that women are being exploited and if given a chance of earning a decent living, they would not choose to be surrogates, and it is by utilizing the financial weakness of the women that the clinics are making more money than the women. Dr. Swaminathan also stated that the decision has been taken only after a discussion with the major 'stakeholders' which included government

ministries, doctors and women's right groups. However, the opinion of the surrogate was not asked.

The surrogates who have been interviewed by the various newspapers have found the decision to ban surrogacy as unjust, as this was an avenue for them to better their lives. Here one needs to understand that a blanket ban cannot be the answer to problems. Furthermore, Natalie Gamble (BBC, 2015) a lawyer who advises British and American couples on international laws surrounding surrogacy, also fears that a ban of such nature will only push the business underground and would result in the creation of an unregulated market in other countries, which would not only endanger the surrogate and the egg donor but also the commissioning parents. The women agree to become egg donors and surrogates mostly because they have financial difficulties, especially with ever increasing effects of the neoliberal policies, survival is becoming difficult by the day. So poor women in countries like India, who have very little chances of getting well-paying job, opt to become egg donors and surrogates. Therefore, the authorities should also be concerned with providing avenues for these women, where they can earn their livelihoods without having to sell or rent their body or body parts.

CHAPTER 4

MANUFACTURING THE PERFECT EGG DONOR

Introduction

In the second chapter, I has discussed the global pathways which map the movement of the bodily reproductive fluids across the globe and processes which keep these pathways in the shadows. It is the neoliberal capitalist agenda which guides the transnational movement of the

bodily fluids and the people. Further, in the third chapter, the regulations in four countries (Italy, UK, Germany and Israel) have been discussed as an example to understand how the movement of the reproductive fluids are guided by the various forms of restrictions applied to the access to ART services, how people in want of a biological child, circumvent the laws in their home country to achieve parenthood in the destination country. The implications of these regulations have also resulted in reverse traffic of the gametes across the globe. Further, it has been attempted to select some of the finer features of the regulations in the other countries, which can be emulated in India as it still lacks a law regulating the ART industry. In the same chapter, the development of reproductive tourism in India has been mapped along, with a discussion on the features of the ART draft Bill in India, as it is often claimed that it is the lack of regulations in our country which has resulted in it, becoming one of the major destinations for ART for both, international and national infertility patients, and the repercussions of the recent ban on commercial surrogacy for foreigers in India.

It can be concluded, from the earlier two chapters that with the onslaught of neoliberal globalized policies with an increasing control of the woman' s body along with the lack of regulations has been beneficial for the commissioning parents and the clinics offering ART services, but has majorly resulted in the exploitation of the women who participate in the ART procedures as third party egg donors and surrogates, by various means. While in the others two chapters the macro processes which guide the movement of gametes across the globe have been mapped, in this chapter one attempts to understand the micro- processes which facilitate the ART industry in India, specifically answers questions like; what are the processes through which a woman becomes an egg donor, despite the risks attached to the process? What are social constructs which creates as well as normalises the role of a woman as an egg donor? What are characteristics, which the industry looks for while hiring an egg donor, and what do these preferences mean in the larger context? These processes have discussed with the help of some of the interviews and the already existing research in the international and national context, while one must mention that very little research exists in the Indian context for the egg donors.

The process of egg retrieval and the risks involved

In order to understand the processes which, drive women to participate in the ART industry as third party egg donors, it is important to understand the process of egg retrieval and the risks associated with it. With the development of new scientific methods which facilitated the

treatment of infertility with the help of donor eggs has resulted in the rising demand for donor eggs. While initially the treatment was based on altruistically donated eggs, with more and more women accessing the treatment, the demand for eggs has increased while the number of altruistic donors hasn't. This scarcity of altruistically donated eggs has led to the commercial sale of eggs. With the eggs going through reification and turning into a commodity which can be bodies are for sale, whether whole or in parts, and are sold, bartered for or even stolen (Scheper-Hughes & Wacquant,2002)

It is stipulated that a woman spends 56 hours in the medical setting, undergoing interviews, counselling and medical procedures related to the process in the US, here in India as there exists very little or no research on the egg donors, one cannot say state the total amount of time spend in the process. As the eggs donors in India receive little or no counselling regarding the procedure they are about to be a part off, which can be understood from the studies done on the surrogates, who are exposed to greater risks than the egg donors and receive little counselling and have diminutive knowledge about the entire procedure (Sheela Saravanan, 2010).

This has created a market for donor eggs which are generally sourced from young women (Beeson 2006, p. 573). Over the years it has been considered that the process of extracting eggs is a safe one. However, there exists a dearth of research on the long effects of egg harvesting on the women's health. The process of egg harvesting involves 'ovarian stimulation' and ovarian suppression, both processes require the use of powerful hormones and other drugs which manipulate the woman's body in producing many more eggs than the normal monthly production of one or two eggs. Mature oocytes are then retrieved under ultrasound guidance by the insertion of the needle through the vagina in a brief surgical procedure under anaesthesia.

Beeson states that the most immediate risk from ovarian stimulation is Ovarian Hyperstimulation Syndrome (OHSS). The syndrome is characterised by an exaggerated and usually unpredictable response to the ovulation- induction therapy, in which capillary permeability is increased and fluid is shifted from the intravascular space to third space compartments (Steinbrook, 2013 p. 324,). Beeson in her work reports that according to the BCC News, by 2005 five women had died because of OHSS (2006). In India too, in 2010, Sushma Pandey a 17-year-old donor died due to the complications which arose from the OHSS. This was the third time that she had donated eggs at the Rotunda Clinic based in

Mumbai, one must also note that she was a minor and the clinic had allowed her to donate eggs thrice in the past (Indian Express, 2010). Another death in Delhi took place in 2014, of a 23 year old Yuma Sherpa a mother of a three year old and worked as a help in a shop, as she sustained internal bleeding in her pelvic region and her ovaries were "hypertrophied"- enlarged. The ovaries were enlarged due to hormones injected to trigger the ovaries to produce more than the usual number of eggs, since she had undergone a procedure to donate her eggs. In oocyte donation procedures, hormones known as Gonadotrophins are administered to the donor during her menstrual cycle to boost ovaries to produce a number of eggs, against the normal production of one follicle that matures into an egg every month. Sherpa was given general anaesthesia in the procedure, and the ovary had been probed by a catheter to retrieve the eggs under suction puncture, which had led to the internal bleeding and OHSS (Indian Express, 9 Feb 2014).

Beeson further states that according to the American Society of Reproductive Medicine (ASRM) mild forms of OHSS occur in 10-20% of cycles (ASRM 2005). Mild forms of OHSS include abdominal distention, nausea, vomiting, diarrhoea, respiratory difficulty and other abnormalities. If the conditions worsen then the woman needs to be hospitalised, such occurrences are not rare according to ASRM. Egg retrieval can also cause renal failure, adult respiratory distress and haemorrhage from ovarian rupture (Beeson, 2006, 573). The risks involved in egg retrieval are life threatening and the lack of a longitudinal research on the long lasting effects of the drugs on the women in the long run, makes one question why would young women be expected to volunteer to go through such a procedure at the risk of their own lives. Here one needs to look into the processes through which a woman agrees to become an egg donor and how these women are roped into becoming egg donors.

Before, we contextualize the women who agree to become donors and take up risks of egg donation and the ways in which the donors are recruited for the ART industry, one must understand the inherent forces in the society which have created fertile conditions for the globalised neoliberal agenda of commodifying the bodies of the women in the developing countries like India.

Stratified Reproduction and the Eugenics Imperative

With the spread of the ART industry, the very private sphere of women reproductive capacities, according to Amrita Pande are valued and monetized outside the private sphere.

She further states that while for long the reproductive capacities of the women were subverted; the ART industry has simultaneously reified them. While the women have been using their bodies, wombs and sometimes breasts as instruments of labour, with the reification of their reproductive capacities the woman is essentially reduced to her reproductive capacity with their reproducing bodies becoming the only source, requirement and product of a labour market, thereby resulting in fertility becoming the only asset that the woman can use to earn wages (Pande, 2014, p. 166). The reification of the eggs or the womb, the commodification of the women's reproductive labour is the manifestation of, according to Pande, the conscious state policies and neoliberal eugenic imperative, to control the composition of the population as the undesirable groups – namely the poor and the marginalised, are discouraged to reproduce. Which basically defines stratified reproduction where a certain category of people being empowered to nurture and reproduce while the other would be systematically disempowered (Pande, 2014)

This eugenic agenda of the state could be clearly seen when during the years of National Emergency, the men were forced to undergo sterilization, with the majority of the men who were forced were illiterate, poor, scheduled castes and Muslims (Pande, 2014, p. 31,33,167). This stratified eugenic agenda is still being carried out on unprivileged women, the state forced birth control on the women as they are considered to be recklessly fertile and who could not be trusted to not have babies, and this is done without trying to establish a dialogue with the targeted population. The government hospitals and the primary healthcare centre, which are the only source of health for the poor communities tries to implement the state's birth control policies as and when a woman seeks treatment and have to undergo intense pressure to accept sterilization or accepts IUDs immediately after giving birth. This results in the further distancing of the poor women from the public healthcare system as they are reluctant and scared, the tensions are compounded for women belonging to the marginalised sections (Pande, 2014, pp. 31-33).

Here one needs to question, how does a country with such an aggressive population control policies become the hub of assisted reproductive technologies. Betsy Hartmann has explained the process by the means of positive and negative eugenics, which is a part of the 'revised eugenics script' (2006). As a part of the revised eugenics script the state continues with policies like its sterilization programme aimed at the poor illiterate population and on the other provide ART services as a part of positive eugenics for the privileged population which has appropriated the liberal language of "individual choices" (Pande, 2014).

Imrana Qadeer, states that such risky, unregulated technologies are allowed to flourish at the cost of primary health care in India, as it, at the same time fills the coffers of the private health industry, which is in the hands of the privileged class (2010). Otherwise there is no way to explain, that how in a country which has the highest number of maternal deaths and just 51 doctors per 100,000 people is so aggressively promoting the reproductive services to the international and the moneyed class (Pande, 2014). Blyth and Auffrey too, express the same sentiments when they state that the practice of surrogacy in India often is a plain reflection of the blatant exploitation of the vulnerable women, who are made available for very low costs to bear children for the rich western surrogates, while thousands of them die in India each year during pregnancy and childbirth (2008, p.697)

Patriarchy, Autonomy And Alienation

This booming of the reproductive labour market in India, with the help of the global neoliberal policies and the resulting reification has reinforced the global inequalities, as stated by anthropologist Rayna Rapp "*all of our lives are not only globalized; they are stratified as well*" (Deomampo, 2013, 169). The reproduction in this country was always stratified with, but with the onset and spread of the ART industry in India the fertility of the of the socio-economically weaker class is temporarily revalued as the women from the weaker class are to becomes the bodily modes through which they will reproduce for the privileged lot. These novel forms of technologies which assist birth have turned out to be more conforming than liberating and has only reified structures of inequality. The stratified nature of reproduction in India has further become more complex, with an increasing interclass social divisions between the commissioning mother and the third party egg donor or surrogate (Pande, 2014; Deomampo 2013).

As a result of the commodification of the women's reproduction which has further compounded the stratified nature of reproduction in India, the social forces which reinforce the social inequalities have gained ground and the reproductive technologies are ought to be fraught with problems. Reproduction which was already stratified on the basis on one's socio- economic position, intrinsic social forces like patriarchy, have helped in the creation of the subjugation and reification of the women's reproductive labour, and has also worked hand in hand with the neoliberal forces to maintain the status quo as stated by Jyotsana A. Gupta (2010). The patriarchal claims over women's reproductive organs is exploited by the global market in human eggs (Petchesky, 1995).

As in the capitalist mode of production women are marginalised from their productive labour, Gupta states that the women are marginalised from their productive, in this form of globalised reproductive labour, women are marginalized as well as alienated from the reproductive labour, and patriarchy essentialises the women's reproductive labour as a means of her survival (Gupta, 2010). Further the capitalist infrastructure of the biomedicine the female body is considered nothing more than a factory and the women mere labourers working under the administration of the physician-managers. Radical feminists regard surrogacy as the ultimate form of medicalization, commodification, and the technological colonization of the female body (Sharp, 2000). This factory model of reproduction denies any agency to the woman and appoints the physician in charge. In case of surrogacy, both the intending couple as well as the infertility specialists own a woman's body for the interim. She does not remain a woman with a name but is reduced to a gestational carrier with minimal legal rights. The legal rights of the commissioning couples/individuals are far superior to the legal rights of the 'gestational carrier' as seen in the study conducted by Malene Tanderup et. al. (2012). In the patriarchal mode, the females are considered to exist for the service of others and therefore expected or pressurized to earn a living for their families. It is a confluence of patriarchy, capitalism and biomedicine where women are reduced to tools for the commercial interests of the fertility business (Gupta, 2010).

Although the transfer of reproductive materials is euphemistically called a "donation", in actuality it is a market transaction at various levels. Leslie A. Sharp states, while the sale and extraction of the human ova, is a highly commercial process, it is termed as a donation, or a "gift" from an "angle" in order to hide the inherent exploitation of the process (2000). By terming the process as a process of gifting the market claims that the reciprocal amount which is given to the donor is equivalent to the value of the human egg, and the labour associated with it and softens the pecuniary, commercial aspect of the entire transaction. Anindita Majumdar states that "*the gift relationship within surrogacy is seen to involve the collective misrecognition of the compensation paid to the surrogate; the unequal relationship between the surrogate and the intended parents; the privileging of certain bonds of kinship over others; the importance given to technology as the most important element within the arrangement; and the representation of the fetus as more important than the surrogate"* (Majumdar, 2014, p 289).

Gametes banks have literally become like commercial enterprises with commodities such as human eggs, sperms, embryos and cord cells for sale, with donors having no say in the use of

the parts of their own bodies (Reddy and Patel, 2015). Furthermore, in India, as Pande states in her work that the women participating in the ART procedure are told, what they are doing is an opportunity to serve God, not only is the egg or the baby a gift she gives to the childless couples, the opportunity is in itself a 'gift' from God to improve their lives (Pande, 2014).

Under patriarchal capitalism there is an alienation of women from their own bodies (Mies 1988). The women are viewed as objects, as property, who are dispossessed of the ownership of their own bodies, and as a result the women have no say in the use of her own body parts, as we have seen in the study conducted Malene Tanderup et. al. (2012), as the new reproductive technologies, alienate the women from her reproductive labour, from her body parts and fluids and the resulting transformation of the body parts and fluids into commodities raises the questions of ownership, property rights and their transformation into commodities (Reddy and Patel, 2015, p. 4). Patriarchy while facilitating the process of alienation also modifies the society so that the process of capitalist exploitation becomes axiomatic and in order to do so, its starts early with the socialization process of the girl child.

Manufacturing The Perfect Donor

For a woman in India the process of becoming a prefect donor or a surrogate begins even before there is a possibility of her ever becoming one. A girl child, in India is inculcated from a very early age with characteristics like self-denial and self-effacement and taught to dedicate her life in the service of others. These characteristics are instilled in females as virtues which train them to live their lives in service to their families, and live according to the norms and gender roles set by the patriarchal society. So when they are faced with situations, where the family's condition can be improved with her putting her health on the anvil, many women with little convincing would readily do so. Further, these virtues of women are exploited and the women are put under pressure to rent out their wombs and sell their eggs because that would fetch much more money than waged work would in several years (Gupta, 2012; Pande, 2009).

While, the agenda of the assisted reproductive technologies are based on the idea that the woman in the neoliberal world is self-actualised, and is capable of making informed, independent decisions. The decision of the Indian donor, in most of the cases is never an independent, informed decision. Sheela Saravanan states that the very aspect of the surrogacy contract is based on self-denial of maternal instincts which can be only achieved by the means of objectification and alienated labour (Saravanan, 2010, p. 26). Amrita Pande further

states in her study that the women who participate in the ART industry are made docile and are disciplined according to the rules and regulations, while the women are made to believe that the task that they are doing is of the most pious in nature and is a worthy cause, this is only done to make them believe, that it is not the amount of money that they get in return of their donation or service which is important, but the donation itself and she should not engage in negotiating the wages she gets from this labour. By doing so the clinic and the agents are often successful in tricking the woman in providing her services at much lesser costs, than what they have quoted to the commissioning couples (Pande, 2014, pp. 102- 103).

Who Become The Egg Donors?

K.K. Ahuja and E.G. Simon (1996) state in their work that cross border reproductive services have become increasingly competitive and lucrative, more and more poor women are drawn to it to act as third party egg donors or surrogates (Pande. 2009, Sheela Saravanan, 2010).

However, the remuneration levels are different. The remuneration is based on the preferences of the commissioning parents, in India, as Ahuja and Simon state it is the fair-skinned, Brahmin girl who is educated and speaks English commands a much higher fee than a lower caste, uneducated woman (Ahuja and Simon, 1996, p. 1151). Also the research conducted by Sunita Reddy and Tulsi Patel (2015, p. 9.) state that often the commissioning parents demand that the donors are fair, good looking and educated.

Analysing the websites by the agencies which are involved in the surrogacy business, like the website www.surrogatefinder.com, in which many registered profiles from across the world, has the highest number of women who have registered as egg donor from India. Most of the profiles state that the registered donors are in good health, do not smoke. However, it's surprising to see that none of the profiles carry information about the skin colour of the donor which is in contrast to the information that I got from the discussion with the embryologist at the South Delhi IVF Centre. He, when asked, what is the main preference of the commissioning parents in regard to the characteristics of the donor egg, he pointed out that the main preference is the skin colour so that the child resembles the parents as the process of surrogacy and childlessness is still stigmatized in the society.

While the website itself does not ask for the skin colour, some of the Indian women describe themselves as being "*Fair, 23 years old, 5'0" tall, 3rd child amongst 5 children, have 2 elder*

and 2 younger siblings. healthy, Brahmin, vegetarian, engineering graduate, working. parents are retired teachers."[5] Here the woman is trying to fit in all the most preferred qualities required from an egg donor. This description basically tries to convey that she is a young woman with no fertility problems in the family, belonging to the highest caste, is vegetarian, and healthy, thereby checking all the boxes of the preferences of the Indian commissioning parents.

The Indian Express article of 9th February 2014, notes that the regular donor gets about Rs 30,000-35,000 per procedure here, while those in the premium list, i:e matching the most preferences of the commissioning parents draw Rs. 50,000-60,000. In the same website which carries profiles from other countries the women registered as egg donors are mostly married with more than two children and with their age varying from 20 to 45. While many of the profiles belonging to the young women show that they want to become egg donors to make quick money and pay off loans, the older women often state that their purpose is to help those who cannot have children. Profiles of the Indian women explicitly express their need for money whereas, the profiles of the women belonging to the developed nations registered as egg donors, sugar-coat their needs.

Such preferences arise from the already deeply stratified society, and where one is given a choice, the self-financing commissioning parents would want to have a child which matches all their characteristics if not better. This sentiment was echoed in the interview with the clinician and embryologist at the South Delhi IVF centre, when asked what are the preferences of the commissioning couples, they stated that most of the couples want the child to look like them, with further probing they did reveal that most of the couples want donors from the same religion and if possible caste. Other factor which all the commissioning parents asked for was the egg donor should be educated. One such incident was narrated by a friend, that while working in Noida, she was once approached by man, who probably was an agent, and asked if she was interested in becoming an egg donor, she had asked him why had he approached her, his response was that since she is tall, fair and educated she command the highest compensation for her eggs, she declined the offer though. This fetish behind having an egg from an educated donor, hardly makes sense as other factors such as skin colour, height might get transferred to the child through the genes, education is an acquired process. But the clinics would go to any extent to satisfy and maintain their clientele claim to have

[5] http://www.surrogatefinder.com/surrogates/29539/

many MBBS graduates, airhostesses, and young entrepreneurs in their donor registries (Indian Express, 9 Feb, 2014).

The other marker which makes for a successful egg donor is the proof of fertility. Sushma Pandey the 17-year-old, who died in 2010 due to OHSS, in Mumbai, was roped in as donor by Noorjahan Munir, an agent, who had met Sushma on a local train, befriended her and Sushma had revealed that she had a miscarriage, thereby giving proof of her fertility. A widowed mother of two, Vadodara based schoolteacher donates eggs every two months, which is against the medically suggested gap of at least 3 months and maximum of three times in her reproductive period. In each sitting she is able earn upto 1 lakh for a dozen eggs retrieved, as according to her doctor her eggs have a higher success rate, and she is able to command a higher price. While her school teacher job only brought her Rs. 7000 a month she is able earn much more because of the commodity inside her body (Indian Express, 9 Feb, 2014).

The preferences of the commissioning parents shape the required characteristics of the egg donor, however it is mostly the material conditions of the women which makes them take the decision to become egg donors, as described by the Maria Mies (2007) and Saskia Sassen (2002). This can be understood from the narrative of a 25 year old wage- labourer from Malda, West Bengal. Her husband, who worked as tailor lost the ability to do any work after he suffered major burns when a stove blew up in their home. She heard about egg donation from her cousin and came to Delhi, to become an egg donor. She earns about Rs. 60, 000 per donations which is much more than the meagre Rs. 5000 she would make monthly as a wage labourer, and can send her son to school (Indian Express, 9 Feb, 2014).

While all the women who seem to have willingly become egg donors in the past narratives, one can see that all of them belong to the lower economic strata and have decided to become egg donors, in order compensate for the loss of income which otherwise their husbands would get. This is supported by Reddy and Patel's study which looks into the commodification of eggs in medical markets in India, many women who had opted to sell the eggs and become surrogate stated, state that their primary motive was to improve the condition of their families which was otherwise not possible because of the husband's meagre earnings, debts and family responsibilities or the complete absence of the husband due to death, desertion, separation or migration. Other reasons mentioned in the study are often women are left with no option but to sell their eggs and rent out their wombs in order to pay

back the loans which the husband took in order to abroad and was duped in the process (Reddy and Patel, 2015).

With the onslaught of neoliberal policies, the state has increasingly withdrawn social welfare, and without any sort of support these women are left with very few options where they can ensure their survival as well a better future for their children and surrogacy and egg donation is the only possibility of getting quick money (Reddy and Patel, 2012). Deborah Spar suggests that such decisions are often a result of the 'desperation caused by inequality' (Spar, 2005, p.302). Thus, the decision might be of the women but that the decision is guided by the hidden hand of material conditions, which if the state wants can be changed for the better, especially with the speed with which the cross border reproductive tourism are increasingly thriving on the economic plight of the developing nations as Reddy and Patel have stated in their work (2015, p. 9)

Recruitment Of Egg Donors

Amrita Pande in her book 'wombs in labour' (Pande, 2014 p. 65) in her extensive study on the surrogacy business in the world renowned IVF hub in Anand, Gujarat and other places, has explained the process of recruiting egg donors. While in conversation with a doctor who has her own maternity clinic which offers ART services like IVF, intrauterine insemination, embryo freezing and others, stated that the one of her first surrogate was her own employee from the clinic. While this completely goes against the ICMR guidelines which state that the ART centre should not be involved in the recruitment of the surrogate. The doctor further stated that, it was through word of mouth by which other women relatives of the initial surrogate started coming in and the clinic convinced them to become egg donors (Pande, 2014, p.66). While the doctor swears by the fact that it is through word of mouth that she gets her maximum donors and surrogate, and since they approach the clinic by being impressed by the success of the source surrogate, they needn't be convinced further and they make an informed choice of becoming donors or surrogates. However, as Pande states, while the doctor may claim that the process of word of mouth might be the most effective way of drawing women to participate in the ART procedures, the reach of this process is limited, as childbirth is celebrated within the family and the community, however, surrogacy is stigmatised. Therefore, word of mouth might work in some cases but cannot be successful on a large scale. The next process through which the clinics gather egg donors, is by convincing

the women who come in for other treatments to donate eggs in return of reduced costs of the treatment, as we have seen in the case of egg sharing in the UK, or in exchange of money which might range up to Rs. 5000 or more (Pande, p 66).

Brokers and Agents

However, the most successful method of recruiting donors, which the doctor in Pande's hardly mention is through brokers or agents. Pande states, that due to the stigma attached to surrogacy, brokers play an important role in recruiting egg donors and surrogates. Pande, explains that since the targeted population for these IVF clinics are uneducated and have little or no access to media or advertising, the clinics cannot wait for the word of mouth to spread or the stigma around the ART procedures to break, for women to approach the clinic on their own. Here, the most viable option are brokers, who are women from the same locality or the same caste- class background, who are able to win the trust of the other women in the community. Most of these brokers are either former surrogates or those who could not become surrogates for medical reasons, or it is the midwife or a dai who become brokers or agents (Pande, 2014 p. 66). Daisy Deomampo's three year long, ethnographic study in Mumbai, shows that this job as a broker or an agent is a much sought after job, as it provides them with an opportunity to earn (Demampo, 2013, 187)

Dais or traditional midwives are found not only in the rural areas but also found in the urban slums, such as Shrinivaspuri in New Delhi, which is home to families who have migrated to the capital in search of a better livelihood. I have worked in that area in the capacity of a facilitator for conducting meetings based on women centric issues at Shrinivaspuri. Most of the women in that locality work as domestic helps. As we have discussed earlier in the first chapter, we seen that the recruitment for the third party donor follows the same pathway as in the domestic help, care work and sex work (Kumkum Sangari, 2015, p. 71). The *dais* are also functional in the Shriniwaspuri area and have also come across a dai who now works as a recruiter for the IVF centres in Delhi, but could not interview her due to non-availability. As Pande has stated in her work that these women are the most mobile in their communities, and have access to the most intimate knowledge about the bodies of the women, their reproductive lives, household histories and even the financial condition of the family. This knowledge is useful when it comes to recruiting women to participate as third party donors or surrogates (Pande, 2014, p. 66).

These recruiters often use this knowledge to convince the women to participate in these procedures, by playing upon the women's anxiety to be better mothers to their children and ensuring a better future for them, which is not possible on the salaries they get, working in the unorganised sector. Pande states that, though the Indian society recognizes the father as the breadwinner of the family, it is the mother who is castigated by the community when anything goes wrong with the children, including failing to get the daughter married at the right time. Plying on these fears and envisioning for them, a better future the brokers and agents are able to then recruit women to act as egg donors and then as surrogates (Pande, 2014, p. 66). After a successful recruitment, they become the middlemen between the clinic and the donor or surrogate, often drawing a cut for oneself, from both the clinic and the donor/ surrogate (Deomampo, 187, 2013). Amrita Pande further states in work that these brokers and agents become the most trustworthy person for the surrogate, as broker is the only contact which the surrogate has with her family when she stays in one of those surrogate homes, away from the prying eyes of the society, where surrogacy is highly stigmatised.

While conducting an interview with a South Delhi IVF centre, in order to have a better understanding of the process, the clinician as well as the embryologist stated that until and unless the donor is family or friends with the commissioning parents, the donors are sourced from by the agent. This centre has two agents, who provide the centre with donors. The agents, as I understood from the conversation, have a pool of donors, from which they provide, not just this IVF centre but also to the other IVF centres across the city. When a matching donor is found she is brought to the IVF centre in South Delhi and the process of egg retrieval (described earlier in this chapter) is done at the Clinic. The ICMR guidelines state that the ART centre should not be engaged in any monetary dealings, when dealing with the third party donor/ surrogate. However, since there is no law regarding the same, the ART centres have their own clincal standards, none monitored and regulated. From one telephonic conversation, with an agent I understood that since this is a highly competitive field the donors even refuse to state from which socio- demographic population do they source their donors, or the amount which is given to the donor or the agent. However, the embryologist at the South Delhi IVF Centre stated that, apart from the normal preference of matching the skin colour to the commissioning parents, there is an increased demand for gametes from educated women and men, from which one can decipher that remuneration for egg or sperm or egg would be higher.

It is quite apparent that due the lack of any law which regulates the ART industry in India, the egg donors remain at the mercy of the agents and brokers. The draft bill has no mention of the role of agents or brokers, and therefore they function in accordance to the wants of the IVF centres, which ask for donors who match the preferences of their clients. This has become a very mechanical process, similar to what real estate brokers do, rather than following a humane process. The well-being of the donor is not the priority, the success rate of the IVF centre and the satisfaction of the commissioning parents is paramount, as the study conducted by the Malene Tanderup et. al. (2012) regarding the decision making power of the third party donor or surrogate, one can see that the woman hardly has any say in the process, despite the fact that it is the woman who has to undergo the process which is painful, invasive and at times life threatening. As the law still remains to be made, the policy makers should invest in understanding the pathways and procedures through which the donor becomes a donor, regulate the process keeping the wellbeing of the donor in mind and the brokers role should be regulated, if not done away with.

The Internet As The Caterer

While the brokers bring the egg donors to the IVF centres, it is the internet which makes them available to the rest of the world. Websites like www.surrogatefinder.com, will present one with scores of egg donors, surrogates, sperm donors. One can also register oneself as an egg/ sperm donor or a willing surrogate and also register oneself as commissioning parents. The Indian Express article titled 'The great Indian egg bazaar', dated February 9th 2014, states that there are some 149 countries hich are registered with the website, with the highest number of egg and sperm donors- 5,293 registered from India. If one goes through the profiles of the registered egg donors, assuming that the information provided on the website is true, it is evident that most of the registered women are of a young age – between 20 to 32 – mostly single, with no children and with no experience of donating eggs. This again contrdicts the ICMR guidelines of being married and having her own biological children. Most of them state their reasons for becoming donors so that they can support their education, pay off loans, make quick money, and in one singular case of a separated woman who wants to sell her eggs so that she can support her children.

Though such websites which at least have some sort of registration make such transactions a bit more transparent, in India there is no central registry for egg donors which leads to incidents like the death of Sushma Pandey in Mumbai because of OHSS. She was 17 years of

age, fair, and had donated eggs thrice. Had there been a central registry such mishaps could have been avoided.

Further after looking at the websites of two of the leading IVF centres in Delhi, namely the NOVA IVI fertility centre and the Delhi IVF. Their main concern seems to be the most attractive to the foreign patients and advertise their success rates. While the Nova IVI website (www.novaivifertility.com), states that the centre would arrange for the pick up as well accommodation of the foreign patient, the Delhi IVF website (www.delhi-ivf.com), in giving reasons why the foreign couples should choose India for treatment stated the first reason as the treatment being much cheaper here, than in the other countries. Further, they stated, that since in the UK and the USA they do not allow compensation to the surrogates, and therefore not many women are ready to become surrogates. In India, since commercial surrogacy is allowed and one can make payment for the services, women can "rent" their wombs. This statement makes it quite apparent how those in control of this industry, see a poor woman's empty womb as a commodity which can be 'rented out' at the the right price.

Another reason mentioned, simply brought out the patriarchal conditioning of this industry as it stated that it is easier to find and meet a surrogate here, as in the "*Indian culture which allows a woman to become surrogate with her internal desire"*, by stating this the centre blankets all the material conditions of a surrogate, which we have seen have actually colour her decision to become a surrogate. Further, by stating that's its her internal desire, they are hinging on the rhetoric of choice, which suggests that in a neoliberal world, a woman is self-actualised to make her own decisions (Mujumdar 2014, Sharp, 2000) which we have seen is not the case. Since it is her 'internal desire', she would be the perfect 'mother- worker', as stated by Pande (2014), submissive, docile, would think of this opportunity as a gift from God and when the baby is born would readily give up the child. So when the foreign couple reads this, the entire commercial aspect of the transaction, the exploitation of a body of a unprivileged women is made invisible and the entire process which brings the woman to a condition that she has to sell her regenerative body parts is again kept in the shadows.

Both the websites had portals where one could contact them if one wanted to be an egg donor. The Draft ART bill and the ICMR guidelines specifically mentions that, the IVF centres are not contact the donors, have any monetary transactions with them, but that remains on paper, the ground reality is different.

The experience of browsing the website for donor profiles is a blatant reminder of the many websites which cater to the wants of the neo-liberal population be it online websites for food, clothing or future husband or wife. Such websites provide you with options to choose an egg/ sperm donor with certain features and qualification and thereby 'design' your own baby. The websites run by the IVF centres belong to the top- most doctors in the field of IVF, who, represent the medical fraternity, when there are meetings for policy making in the field of ART. Their websites show that they clearly prioritise the satisfaction of the commissioning couples the most which is followed by their own interests of having the best success rates in the business, the interests of the surrogate and donor is last on the list. One should understand that while making policy decisions it is also necessary to represent the interests of the surrogate and donor, who is actually going through the physical process on which the industry is based and her health is on stake and such doctors wouldn't and aren't doing that. Thus, we need more public experts who have worked in this field and social workers who would be able to represent the surrogates and the donors in order to make the system a bit more humane and less commercial, than what is increasingly becoming.

Payments and Exploitation

As stated in research conducted by Reddy and Patel (2015), when it comes to deciding the payment which has to be made to the donor, the ART draft Bill states that the Clinic is not to engage in any sort of monetary exchange with the donor (Pande, 2014), the commission parents are to decide the costs. But that exists only on paper and it is the clinic itself, which decides the amount which the donor gets, and not only that it the body, which decides the cost of the treatment, how much the commissioning parents pay, how much the surrogate (if involved) will get, the payment of the agent and the legal team, is all decided by the ART centre which is complete contrast to the ART bill. The egg donor has to pay Rs. 5000 as a compensation to the agent, from the Rs. 25,000 she receives. The Surrogate gets paid in full only when all procedures are followed submissively and deliver the final product the 'precious child', if not she might not get payed the full amount. In order to avoid exploitation, the government should regulate not only the transaction of payments the entire industry needs to be regulated.

Manufacturing Consent

The study conducted in New Delhi by Malene Tanderup, Sunita Reddy, Tulsi Patel and Bruun Nielson in 2012, highlights the ability or the inability of the women participating in the ART procedure to make an informed decision. It is established that the women who work as surrogates and egg donors mostly belong to the economically weaker section of the society, for them understanding a heavily worded technical document which is the consent form is difficult. To understand medical terminology for any person without medical knowledge is difficult, therefore it is the responsibility of the medical staff to make sure that the woman who is being exposed to health risks by participating in the ART procedures is well aware of the potential risks and the side effects of the treatment. As expressed earlier explaining medical jargons is even difficult for people belonging to the socio-economic backgrounds, in the case of surrogates and egg donors who come from an uneducated, non- English speaking background, it is more complex. Further the busy schedules of the medical staff, the language barrier further exacerbates the problem (Tanderup et.al., 2015, p. 2). While it is difficult to explain the procedure, the medical staff hardly venture into explaining the risks and all the processes involved to the participating women, as the study notes.

Further the submissiveness and inertness which is required of a good donor or surrogate as Sheela Saravanan (2010) has expressed in her work, also adds to the inability of the women to make an informed decision or to object to, what is being done to her body. Moreover, in India, as the study shows a self-assured attitude among doctors is the norm, the women are mostly in awe of the doctor and hardly think that they could challenge their knowledge (Tanderup et. al., 2015, p. 2). However, the women are kept in the shadows about the priorities of the doctor, and their wellbeing often lies at the bottom of the list.

As woman belonging to the neo-liberal world, the surrogate or the egg donor is supposed to make to the decision of participating in the process based on comprehensive information and is viewed as an expression of the woman' autonomy. However, given the authoritative nature of the governing bodies in the private health care set up, to expect that the woman will receive comprehensive medical counselling is a far-fetched idea. (Tanderup et. al., 2015, p. 2). Looking in to the ethical dilemmas involved with women participating and subjected to ART procedures and clinical practices the Federation of International Gynaecology and Obstetrics (FIGO), has raised medical, ethical issues of conflict of interests of the various parties involved.

One can exemplify this conflict of interest in the transfer of multiple embryos, in the case of a self- financed IVF treatment, where the commissioning parents see multiple embryo transfer as a guarantee to a successful procedure and makes the decision on fetal reduction. The doctors in the business target high success rates and low costs in order to maintain their international and national clientele, and prioritise the commissioning patient's wishes. The surrogate, belonging to a lower socio- economic background evidently facing financial crisis, and under pressure from societal patriarchal forces is attracted by the handsome payment. While bodies like the FIGO have emphasised that the risks faced by the surrogate should be minimized by reducing the number of embryos transferred, and also the participating surrogate, though without any medical knowledge, knows that carrying multiple foetuses is risky for her own health and the child's, from her own experience of being a mother, the practice continues. When a surrogate express discontent, as noted in this study, in carrying more than one embryo, often the amount of compensation is increased, which further puts the women in dilemma. However, the medical fraternity has explained in the study that they never inform the surrogate about the number of embryos being transferred, and the women are only happy when they are carrying twins as they would expect to get more money (Tanderup et. al., 2015, pp 2-7).

This conflict of interest in obtaining an informed consent can be taken to understand the dilemma that egg donors face. While the risks involved in the surrogacy are much greater than that in egg donation and also the time period that one is subjected to, it can be derived that the egg donor is also not informed or counselled properly in matters of the procedure and the risks. Further, when put under anaesthesia she wouldn't even know the number of eggs which have been harvested, and excessive extraction of eggs is life threatening. The gap between two donations, which is considered safe for the process to be repeated, is stated as three months, however, as we saw in the case of the widowed school teacher from Vadodara, she was repeatedly going through the procedure with a gap of two months, which was encouraged by her doctor. Moreover, in matters of the compensation that the donor receives is based on what is decided by the clinic and the agent after taking his or her cut. In order to ensure that the women who are entering such contracts to become and egg donors or surrogates, the commercial aspect of this ART industry should not weigh heavily in the decision making process. There should be an open discussion, as suggested by the recent study done by Tanderup et. al. (2015), and the decision making should be shared process, which should include all interest groups, especially when there is a potential conflict of

interest, as in the case of surrogacy and egg donation. The ART Bill needs to be strictly enacted, not only to guide but also to regulate the clinics to follow international ethical medical standards, to register the clinic, and to send the clinic's database to a centralized regulatory authority. Unregulated clinics endanger basic human rights, doing so is the only way in which we can make surrogacy and egg donation a respectable line of work, not exists in the shadows.

Treatment with the help of donor eggs came as a gift to the many who could not achieve parenthood because of ovarian failure or other reasons associated with the ovary. This was also a miracle, discovery for gay couples for now they too could have their own family. This scientific discovery which was a source of joy for many has been appropriated by a capitalist money-making industry. The human ova which earlier had its value, defined in its ability to create life was now turned into a commodity with a price tag which would vary with the donor's height, phenotype, years of education, and, in the Indian context, caste.

While the process is a painful and invasive one and the demand for donor eggs has only increased to an extent that altruistic egg donors cannot fulfil the requirements. So the ART Industry has started recruiting women from the most marginalized and exploited section of the society. It plays on the helplessness of the woman who is unable to improve her situation, while at the same time giving the rhetoric of choice. The egg donor is generally a women from weak socio-economic background who aspire to have better life for her children and her family, widow with a family to look after, a young mother who has been deserted, a wife of an alcoholic or simply a teenage girl who has been misguided with the dreams of quick money. While the state is increasingly shutting down all other avenues through which these women can improve their lives and seek help.

A discovery which was supposed to bring in life has now become a source of income, for the marginalized, poor, illiterate part of the population who in order to survive has to now resort to selling parts of their body, though under unregulated and exploitative circumstances. This industry is largely facilitated by the global capitalist forces in parlance with the patriarchy and casteist forces in India. While it's difficult to dismantle these forces, one must attempt to regulate the industry by the means of policy interventions. In depth research needs to be conducted to understand how this process can be made more altruistic and humane for the policy interventions to be effective. Presently, the ART Bill is the closest that we have to a

law in order to regulate this industry. It is also proposed to have Surrogacy Bill in making. Interested and concerned bodies should work proactively towards getting the bills passed but with modifications to the existing provisions and clauses. The regulation should not be limited to getting a consent form signed, which we have seen is of no consequence in assuring ethical standards of work. Experts in the field of public health, social workers, and not just policy makers should be included in making laws which would regulate the industry.

CHAPTER 5

SUMMARY AND DISCUSSION

There is a sufficient evidence about the growing infertility around the globe. Further, most societies value childbirth and especially children on ones own. Wanting to have a biological children has led to movement of couples across borders to seek reproductive services. With the advent of new reproductive technologies, and ARTs, it is possible to have children using various bio-technologies. The purpose of this research is to look at the global reproscapes, which are in the shadows and understanding commodification and the global pathways of reproductive bodily fluids. Due to time limitations and not able to access permission to conduct interviews in IVF clinis, only one clinic was covered for emperical study, and modified the scope of the dissertation to make it a review study. The study was conducted in one IVF clinic at South Delhi, also group discussions were conducted in the slums of Srinivaspuri, where women tend to go for egg donation and surrogacy. Thus, largely this study is a review study. Secondary literature from the journals, magazines, media and websites have been reviewed and analyzed. The broad objective of the thesis is; to understand the process of commodification and the map the global pathways of the bodily reproductive bodily fluids especially in the case of the human ova, to look at the socio-cultural, ethical and religious basis for regulating the ART industry, and to understand the socio-cultural milieu of the egg donor.

Analysing the literature, it was found that the successful implementation of the neoliberal policies across the globe, saw the development and spread of the ART industry. The reason behind this being that neoliberalism along with forces of globalization, with its policy of open markets and equal level playing fields, resulted in the exaggeration of the inequalities inherent in the societies across the world. With the help of the state, the neoliberal forces were able to push back the public sector, remove the welfare schemes and other safety nets, which left the most vulnerable section of the population; the woman belonging to the socio-economically weaker background, exposed to be dangers of the free market, which by then had found a way only to exploit the labour but also exploit and appropriate the fruits of her reproductive labour. The ART paved the way for the commodification of the human ova.

Further, the processes which have commodified the eggs and debate on the women's 'choice' to make their own informed decision, whether they want to donate their eggs or not, as they

are self- actualised members of the neoliberal world, hides the exploitation rife in the process. The reality is that lack of permanent jobs and social securities, large majority of population is in the onctractual, unorganzied ssector, largely doing manual, unskilled and semi skilled jobs and struggling to survive. The neoliberal policies have shut down all other avenues of work, for men and for the donors/ surrogates, who have no other option but to look for subsistence in the commercial, but, unregulated IVF trade, selling and renting out eggs is a part of these survival circuits (Mies, 2007) .

These forces of neoliberalism have resulted in stratified reproduction with the reproductive capacity of the poor women being revalued, to cater to the needs to the of the privileged class (Ginsberg & Rapp, 1991). Further, these processes of neoliberalism have created bodies, which are more bioavailable than the others, as they sourced from the poorer sections of the bodies. further these processes have to a systematic structural violence, against the bodies of women belonging to the poorer sections of the society, which has been looked at from the lens of bioviolence (Moniruzzman,) . It is amply clear that the women, who become egg donors are nowhere, doing this out of choice. The market forces have commodified the human ova, and that, on the basis of which socio- economic background, one may belong plunge into this risky strategies for survival.

The ART industry is thriving on this commodification of the human ova, and is able to maintain the supply because of the structural, systematic attack of the neoliberal forces on both labour as well as the reproductive labour of the woman and its appropriation. Furthermore, this industry in India is able to flourish, as there are not yet a law in place, except for ART preention and regulation bill, pending for years, and unregulated IVF clinics follow their own clinical practice, which are unethical leading to the ever growing greed of this industry (Tanderup, et.al. 2015). Lack of regulations, the low costs of the services of the surrogate and the egg donor has increasingly made India one of the most preferred destinations for seeking ART, thereby tracing the pathways of the movement of reproductive bodily fluids, across the globe, making it India a ‘cradle’ for birthing babies (Qadeer,2010; Tanderup et.al., 2015).

It is not just the neoliberal policies which become the basis of the making pathways for the global movement of the commodified, bodily reproductive fluids, it is also the regulations in countries regarding ART. All laws are reflective of the society and the context from which they arise (Robertson 2012, p. 226), it is because of the differences in the ethical, religious,

legal and social issues that have developed with the progress and spread of ART that many countries despite being the most developed in the world have ethical and religious reasons to regulate or restrict it The spectre that haunts the developing world is the knowledge that through this technology, reproductive cloning is possible which can lead to genome engineering and the commodification of the offspring. This has led to several debates in the liberal democracies, which along with respecting personal freedom of people, recognizes the right of the people with religious objections to oppose technological control of reproduction. These recognitions have led to various implications and important legal differences among nations in the way in which ART is used (Robertson 2012, p. 226).

The global pathways for reproscape are created due to legality and illegality in various countries. Taking on few countries, which completely bans like in Germany, altrusitic and regulated like in UK and liberal in Israel, India becomes a preferred destination, due to its unregulated IVF industries, with legal and liberal policies to promote medical and reproductive 'tourism'.

While transnational travel for ART in Italy is spurred by religious bans, in the United Kingdom (UK), while no such bans exist, and in fact has a liberal take on ART and its procedures, there are still couples who travel to other countries to seek ART. One of the major reasons for this travel is the scarcity of donor eggs. While the state has made provisions to cater to the problem by the means of egg sharing, it still persists. While in the UK people travel to seek donor eggs and in Italy, access to ART and its procedures are restricted primarily because of religious reasons, in Germany, along with the religious reasons, there are other factors which influence its ban on egg donation and other ART procedures, which are based on ethical dilemmas arising from the historical process that the country has gone through which has had a collective effect on its socio-cultural milieu. During the course of the Second World War, Germany saw many eugenic experiments, hinging on developing a super race, and at the extermination of another, which brought out the horrors of what can these technologies can do, and are used with caution. Their past experiences along with other considerations of the present world has framed restrictive German policy of banning egg donations, embryo transplanst and surrogacy. Similarly, the ethical dilemma and concerns which arise from their collective experience of the Nazi past, the misuse of the developments in science and technologies, developing ARTs makes Germany careful about its policies towards the ART industry and hence the restrictions in the use and donation of human egg.

Israel on the other end, whose population consists of a majority of Jews who were the victims of the inhumane atrocities of the Holocaust, promote ART as a form assertion against those atrocities, Israel has one of the most successful regulation policy regarding surrogacy, and also was the first state to regulate and permit domestic surrogacy (Gruenbaum et. al., p. 45). Be it their collective traumatic experience and memory of the Holocaust or it is the Jewish perspective towards procreation, which they derive from the first of the Jewish Torah, which is stated that "*Be fruitful and multiply*", Israel has been a predominantly pronatalist country. Despite ART being supported and promulgated by the Israeli state, both the donor egg and sperm are not sponsored by the state and therefore not many people opt to act as donors, and those who do, do it at higher rates than that available outside the country. Even when the Israeli want to avail foreign eggs, they would have to pay out of their own pocket, thereby rendering the treatment out of reach for many. This lack of egg donors as well as the lack of state support created a shortage of donor eggs, with more and more women opting for ART. In 2010 a major clinical scandal took place which made the country reconsider their regulations on egg donation (Birenbaum, 2016, pp. 6-7).

Various regulations in their own countries, have led to the process of reverse traffic in repro migration, which entails that rather than the woman travelling to donate eggs or receive them, it is the doctor with a canister and equipment which travels across borders to faciliate ART. Furthermore, these laws pave the pathways of the movement of reproductive bodily fluids, when they circumvent laws in their own countries to access ART in another. Here a question arises that the justification, such as that in UK, that it wants to stop the commercialization of the oocyte, and hence has banned it, shouldn't this be applied to the rest of the women in the world, where that citizens of UK travel to seek donor eggs.

In the case of India, the draft ART bill, has not been made into an Act for almost 6 years,. Which has also become the basis of the ever-increasingly proliferation of the ART industry in India. Thus, we can see that the ART industry is not just a commercial enterprise, it throws up many medical, legal, social and ethical issues, and has begun to change the existing perceptions which exist around procreation. It directly affects the lives of many people who are involved at one stage or the other, especially the women who are the egg donors and surrogates, as they come from the lowest strata of the society, lacking any information about the procedure she is to be a part off (Tanderup, et.al., 2015). Moreover, there is a need for research which can ascertain the mental and physical repercussions of the invasive procedures of oocyte retrieval which also involves ovarian stimulation with the help of drugs.

Though egg donation happens in every ART clinics, the cases of deaths of egg donors due to overstimlation, do not come into the public domain, except for two cases which came out in media, one from Mumbai and one in Delhi. While money is offered for the sale of the eggs which are retrieved, neither the cost of the eggs is specified nor is the criteria which decides their costs. So we see that the women participating as an egg donor is in the most vulnerable position in India.

While those who are flown in from the global north as a part of reverse tourism are provided with the best of facilities as we have seen above, the Indian counterparts are not even provided with counselling as to make them aware of the risks involved (Sarojini et. al., 2011). Considering all of this, it is only natural to expect that some regulatory mechanism is going to be put in place in order to safeguard the interests of the egg donor. However, one can see in the draft ART Bill in India, hardly any safe guards for the egg donors or surrogates, are provided. However, the provisions in the bill, clearly support the commercial interests of the international collaborations and not the welfare of the women. Further the draft Bill lacks any clarity on how the ART industry is going to be kept under check and how effectively the regulations are going to be enforced, monitored or amended. The Bill needs to be reworked and that the process is simplified, the intermediaries are eliminated, the activities which allow the exploitation of women is prohibited, and encourages activity which upholds the dignity of the couples and individuals involved in the process (SAMA, 2009, p. 31).While present draft of the Bill falls short in many aspects, there is a requirement of a set of regulations which have to implemented. One of the follies in India is that the draft ART bill has not been passed as an Act for years. Though there has been many rounds of discussions and debates, the bill is still pending and it is heard that the new 'surrogacy bill' too is going to come.

Though, the bill remains weak in many aspects, which can be improved with revisions and further research in the field, but foremost it needs to be legalised so the industry can be regulated and at least some positive aspects, which have been discussed earlier can be implemented and enforced on the increasingly commercial enterprise of ART. Further, it is important that those involved in the drafting of the bill belong to different arenas and not just medicine and policy, as a field like ART has many socio-cultural and economic implications. Along with legal expertise, it is necessary to involve social- scientists in the decision making level, as it is they who can bring to the fore the moral, ethical and socio-cultural barriers which the Indian society and the women have to face when they encounter an industry like ART.

Understanding the profile of the donors, the treatment with the help of donor eggs came as a gift to the many who could not achieve parenthood because of ovarian failure or other reasons associated with the ovary. This was also a miracle, discovery for gay couples for now that they too could have their own family. This scientific discovery which was a source of joy for many has been appropriated by a capitalist money-making industry. The human ova which earlier had its value, defined in its ability to create life was now turned into a commodity with a price tag which would vary with the donor's height, phenotype, years of education, and, in the Indian context, caste.

While the process is a painful and invasive one and the demand for donor eggs has only increased to an extent that altruistic egg donors cannot fulfil the requirements. So the ART Industry has started recruiting women from the most marginalized and exploited section of the society. It plays on the helplessness of the woman who is unable to improve her situation, while at the same time giving the rhetoric of choice. The egg donor is generally a woman from weak socio-economic background, who aspire to have better life for her children and her family, widow with a family to look after, a young mother who has been deserted, a wife of an alcoholic or simply a teenage girl who has been misguided with the dreams of quick money. While the state is increasingly shutting down all other livelihood avenues through which these women can improve their lives and seek help.

The experience of browsing the website for donor profiles is a blatant reminder of the many websites, which cater to the wants of the neo-liberal population be it online websites for food, clothing or future husband or wife. Such websites provide you with options to choose an egg/ sperm donor with certain features and qualification and thereby 'design' your own baby. The websites run by the IVF centres belong to the top- most doctors in the field of IVF, who, represent the medical fraternity, when there are meetings for policy making in the field of ART. Their websites show that they clearly prioritise the satisfaction of the commissioning couples the most, which is followed by their own interests of having the best success rates in the business, the interests of the surrogate and donors is the last priority on the list. And also they are invisible as, their identities are kept confidential. One should understand that while making policy decisions it is also necessary to represent the interests of the surrogates and donors, who are actually going through the physical process on which the industry is based and her health is on stake and the ART clinic are hardly bothered about them. Thus, we need more public experts who have worked in this field and social workers who would be able to

represent the surrogates and the donors in order to make the system a bit more humane and less commercial, than what is increasingly becoming.

A discovery which was supposed to bring in life has now become a source of income, for the marginalized, poor, illiterate part of the population who in order to survive has to now resort to selling parts of their body, though under unregulated and exploitative circumstances. This industry is largely facilitated by the global capitalist forces in parlance with the patriarchy and casteist forces in India (Qadeer, 2010). While it's difficult to dismantle these forces, one must attempt to regulate the industry by the means of policy interventions. In depth research needs to be conducted to understand how this process can be made more altruistic and humane for the policy interventions to be effective. Presently, the ART Bill is the closest that we have to a law in order to regulate this industry. It is also proposed to have Surrogacy Bill in making. Interested and concerned bodies should work proactively towards getting the bills passed but with modifications to the existing provisions and clauses. The regulation should not be limited to getting a consent form signed, which we have seen is of no consequence in assuring ethical standards of work. Experts in the field of public health, social workers, and not just policy makers should be included in making laws which would regulate the industry.

While many including the film stars have benefitted from the services of the egg donation and surrogacy, while the anonymity clause hides their identity, the society has been successful in hiding the helpless condition of the egg donor.

Keeping all these in mind, one can recommed, for stopping the commercialization of egg donation and surrogacy as it has for long survived on the poverty and socio- cultural subordination of women. At any given instance, a woman, without altruistic motives, will put herself through the painful procedure and literal labour, until and unless she is coerced, though not physically or visibly in this matter. This encroachment on the woman's selfhood, is against the basic human rights.

The ART bill should be made into a law as soon as possible . It is also proposed to have Surrogacy Bill in making. Interested and concerned bodies should work proactively towards getting the bills passed but with modifications to the existing provisions and clauses. The regulation should not be limited to getting a consent form signed, which we have seen, is of no consequence in assuring ethical standards of work. Experts in the field of public health,

social work, and not just policy makers should be included in making laws which would regulate the industry.

While the risks from the egg retrieval are life threatening, it should be ensured that the donor knows about the risks and has gone through the right tests, to ascertain that she is fit to go through the procedure. Here, one must note that the ART industry gives the excuse that the medical jargon is too difficult for lay people to understand, so the ART industry should invest in methods which should ensure that the donor is aware of the risks involved. Even if it is by putting up signage as they have done on the cigarette packets.

Furthermore, the fertility treatments which have become a part of the private health care sector, should be provided in the public health care sector. Without strengthening the public health care system in India and making partial changes and improvements will not help in the long run.

The ban on commercial surrogacy for the foreign couples is a welcomed decision. However, the government must ensure that this industry which is the already in the shadows, should not seep in underground, as this would result in even further exploitation of the women. While for long we had held the notion that capitalism, with it accumulation of surplus was an economic system, it has seeped into the basic structures of our lives, commodifying and putting price on everything. There should be some things which should not be bought or sold, and human life should be one of them.

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