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JM14476

Labor of Care and Contracts: A Study of Surrogacy after the Transnational Ban in India

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DOI: https://doi.org/10.18778/1733-8077.21.3.02

Keywords:
Commercial Surrogacy; Ethics of Care; Mothers; Contracts; Stigma; Secrecy

Abstract: Characterized by the interplay of care and contracts, surrogacy is an exclusive form of gendered work. The paper is based on a micro-level ethnographic study exploring the lived and embodied challenges of commercial gestational surrogates in Gujarat, India, who were undertaking surrogacy work after the ban on transnational surrogacy. The experiential accounts collected through in-depth, face-to-face interviews bear the challenges, stigma, and shame involved in surrogacy work. Not only is surrogacy work devalued, deprived of dignity, and shrouded in secrecy, but it is also corrupted by contracts, complicated by alienation and relinquishment of the gestated child. Surrogates disguise their work and stay in surrogacy hostels. Poverty in India compels many women to engage in surrogacy to eke out a living and improve their living conditions. Surrogate mothers are poorly paid, deprived of health benefits and legal security, they receive only twenty percent of the total cost of the surrogacy arrangement, and are also treated as fungible and disposable. The paper adopts the ethics of care perspective to analyze surrogacy arrangements. Such a perspective is directed toward promoting a responsible and humane attitude toward commercial surrogates. It is motivated by the need to uphold the dignity of the surrogates, their legal rights, and the social recognition of their work. The application of care ethics can alleviate the neglect and oppression of surrogates.

Funding Information: Not applicable. **Conflicts of interest:** None. **Ethical Considerations:** The author assures that no violations of publication ethics have occurred and takes full responsibility for the content of the publication. **The percentage share of the author in the preparation of the work is:** RB 100%. **Declaration regarding the use of GAI tools:** Not used.
Received: 2024-11-18 Verified: 2025-03-11 Accepted: 2025-05-19

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This paper explores the lived and embodied challenges of commercial gestational surrogates in India who have entered into surrogacy for the second time. It focuses on the unique nature of their labor and work, as they nurture life in their wombs for relinquishment. Sociological relevance of surrogacy lies in the fact that it is both a gendered and a highly stratified practice, often sustained by the disparity between the rich and the poor. The paper adopts an ethics of care approach to cognize the motivation for entering into surrogacy arrangements. Such a perspective emphasizes the interdependence and relationality among human beings for their sustenance and development. Surrogacy relations are premised upon interdependence and relationships of care. The study shows that the commitment of the surrogate mothers to bear a child for *others* is generated by their need to provide care and nurturance for their *own* children. The surrogacy industry in India is fueled by the symbiotic relationship between wealthy commissioning parents and the surrogates who belong to the underprivileged sections of society. While the former pine for a genetically related child, the latter are desirous of improving the life chances of their biological children. Focusing on the surrogates from the perspective of care ethics, the paper suggests means that can turn surrogacy arrangements into humane, responsible, and dignified relationships of care. Since the research was conducted after the ban on transnational surrogacy in India, the paper highlights its effects on the fertility clinic.

Indian Council of Medical Relations (ICMR), an apex body that regulates biomedical research in India, defines a "surrogate mother" as a woman who "agrees to have an embryo generated from the sperm of a man who is not her husband and the oocyte of another woman, implanted in her to carry the pregnancy to full viability and deliver the child to the couple/individual that had asked for surrogacy" (ICMR 2010:4). As per ICMR guidelines, an essential pre-requisite to qualify as a surrogate is that she should be married with at least one child of her own. Surrogacy was legalized in India in 2002 to promote medical tourism, and soon the country

became a hub of transnational commercial surrogacy and the world's fertility tourism hotspot. Within a decade, the Indian surrogacy industry generated US$2 billion annually, with more than 25000 children born to surrogates in India, of which nearly 50% were commissioned for parents from the West. This is because the surrogacy services in India have been considerably cheaper compared to other parts of the world. In the UK, surrogates received 15,000 (US$) and 18,000-25,000 (US$) in the US, while in India, the surrogates received 5000-7000 (US$) only (Shetty 2012).

Describing the medical tourism industry in India in her essay "The Surrogate's Womb," Hochschild (2015:43) writes:

> In 2012, medical tourism to India was worth about $2 billion and had become second only to Internet technology as a source of national revenue. Advertisements describe India as the global doctor offering First World skill at Third World prices with shorter waits, privacy, and—especially important when hiring surrogate mothers—an absence of legal red tape… In India, commercial surrogacy is legal and, as of early 2013, still unregulated; nowadays a Westerner of moderate means can go to an Indian clinic to legally hire a surrogate mother to carry a baby to term.

The surrogacy market also provided services for heterosexual infertile couples, same-sex couples, and single women (Reddy 2016). But poor regulation and ambiguity with respect to laws pertaining to transnational commercial surrogacy, dubious and unethical practices, and exploitation of surrogates resulted in bad press and public interest litigations. The Law Commission of India (2009) in its 228th Report recommended the prohibition of commercial surrogacy. The issue was raised in the Lok Sabha[1] and subsequently, transnational surrogacy was banned in 2015, permitting only heterosexual Indian couples who had been married for five years. To further regulate surrogacy practices and to streamline the role of fertility clinics and the relationship between commissioning parents and surrogates, the Government of India introduced the Surrogacy Regulation Bill (in 2016 and again in 2019). The Bill proposed to prohibit commercial surrogacy and permit altruistic surrogacy wherein the surrogate should be a close relative, belonging to the same generation as the commissioning parents. The Surrogacy Regulation Bill was passed in the Lok Sabha on 5th August 2019 and subsequently referred to a Select Committee of Rajya Sabha[2] (2019) for further examination. The Committee suggested that commercial surrogacy be replaced with altruistic surrogacy and be extended to PIO (people of Indian origin), NRI (non-resident Indians), OCI (overseas citizens of India), live-in couples, divorced women, and widows. Further, the Committee recommended that the clause of "close relative" be removed to widen the scope of getting surrogate mothers from outside the close confines of the family of the intending couple. The Surrogacy Regulation Act, 2021, came into force on 25th January 2022, whereby commercial surrogacy was banned. The amended act exclusively permits charitable surrogacy, preventing those with financial means from abusing and taking advantage of the surrogacy option. It prohibits commercial surrogacy, as well as the trade of human gametes and embryos in India.

The study discussed in this paper was conducted in 2019. At that time, the ban on transnational sur-

[1] The lower house of the Indian Parliament.

[2] Rajya Sabha is the upper house of Parliament in India.

rogacy, introduced in 2015, was operational. Still, the ban on commercial surrogacy and the Surrogacy Regulation Act, 2022, had not come into force. Commercial surrogacy for resident Indians and those with Indian passports was legally permitted, as it was banned two years later, in 2022. At the time of the study, the talk about banning commercial surrogacy was on the anvil. In the absence of stringent regulations, the scope for unethical malpractices and covert commercial surrogacy cannot be eliminated. It is in this context that this study, conducted before the ban on commercial surrogacy in 2019, is still relevant. The rationale and significance of the study lie in the fact that it has explored the measures secured by the fertility clinic to put on hold further investment in hiring new surrogates and making do with those who have proved their worth earlier.

Surrogacy in the Indian context has been widely researched from myriad perspectives of sociology, anthropology, economics, law, philosophy, and medical ethics, resulting in a highly contested and controversial terrain of study. Debates on commercial surrogacy in India feature mainly around commodification and objectification of the surrogate's body due to patriarchal capitalism (Gupta 2012), alienation, marginalization, and exploitation of the surrogates for commercial interests (Qadeer and John 2009; Tanderup et al. 2015). Another recurrent theme in surrogacy research highlights the fragmentation or disaggregation of a mother's role into biological, gestational, and social mother (Gupta and Richters 2008; Vora 2009). Studies by Pande (2009; 2010; 2011) and Rudrappa (2015) highlight the dimension of care involved in gestating the baby by the surrogates. The ethnographic scholarship based on the lived experiences of surrogates in India (Pande 2014; Rudrappa 2015; Tanderup et al. 2015) is contextualized in the pre-transnational ban milieu. This paper fills the gap in existing sociological literature on surrogacy in India by adopting the ethics of care perspective and substantiating that the second-time surrogate mothers epitomize care in more ways than one. It argues that care is not manifested in the emotional labor of gestation alone, but more importantly, the decision to enter into surrogacy is motivated by a sense of care and responsibility toward the biological children of the surrogates.

For Virginia Held (2006:25), "the ethics of care conceptualizes persons as deeply affected by, and involved in, relations with others…The ethics of care attends especially to relations between persons, evaluating such relations and valuing relations of care." The ethics of care has grown out of the response of feminism to the biases against women. Feminists like Firestone (1970) attributed women's subordination to their mothering roles. She considered childbearing and child rearing as the biggest impediments to the emancipation and empowerment of women. Sara Ruddick's (1989) *Maternal Thinking* is credited with laying down the seminal ideas of the ethics of care perspective. Held (2006:26) notes that her "essay showed how women's experience in an activity such as mothering could yield a distinctive moral outlook, and how the values that emerged from within it could be relevant beyond the practice itself, for instance, in promoting peace." The feminist validation of women's experiences has been of salience to ethics. The ethics of care "takes the experience of women in caring activities such as mothering as central, interprets and emphasizes the values inherent in caring practices, shows the inadequacies of other theories for dealing with the moral aspects of caring activity, and then considers generalizing the insights of caring to other questions of morality" (Held 2006:26).

Carol Gilligan's (1982) book, *In a Different Voice*, gave further impetus to the development of ethics of care. She highlighted that the self and others are interdependent (Gilligan 1982:8). Further, she emphasized that care is not a women's issue but a concern of human interest and is as important as justice. It has been ignored because it was developed solely in the private, domestic life of which women were the protagonists (Gilligan 2013). Developing further on Gilligan's approach, Susan Sherwin (1989) upholds that caring is associated with both gender and oppression, and furthermore that the medical profession contributes to this oppression by supporting patriarchal policies in the medical institutes. Reproductive technologies such as in-vitro fertilization, amniocentesis, and surrogate pregnancies function within the larger structure of perpetuating control over women's bodies. Feminist critics, therefore, warn against the abuse of medical power that can be disempowering for the patients. From the perspective of feminist medical ethics, there is a need to restructure "the power associated with healing by distributing medical knowledge in ways that allow persons maximum control over their own health. It is important to clarify ways in which dependence can be reduced, caring can be offered without paternalism, and health services can be obtained within a context worthy of trust" (Sherwin 1989:70).

Tronto (1993:102) asserts that ethics of "care implies a reaching out to something other than the self: it is neither self-referring nor self-absorbing. Second, care implicitly suggests that it will lead to some type of action." It focuses on interdependency and vulnerability of human existence and identifies relationality, care, vulnerability, and responsibility as privileged concepts and attitudes. As an ongoing practice, caring involves four phases: (i) caring about; (ii) taking care of; (iii) care-giving; (iv) care-receiving. "Caring about" refers to the acknowledgement that care is necessary; "taking care of" is about assuming some responsibility for the identified need and responding to it; "care-giving" is meeting care needs; and lastly, "care-receiving" invokes the experiences of having received care (Tronto 1993:127). Feminist care ethicists argue that human beings are socially embedded and our moral understanding of ourselves is contextually situated.

For Parks (2010), caring practice is the basis of human communities and has effectively applied the care perspective to the analysis of surrogacy. For her (Parks 2010:334), the Baby Manji case is symbolic of the "crisis of care." She argues that "if we imagine human beings as first and foremost caring subjects, we can imagine an entirely different global reproductive system that alters our relationships with the individuals we 'hire' to provide reproductive services" (Parks 2010:336). Similarly, Krause (2018) highlights the significance of caring relationships for an ethical evaluation of surrogacy and advocates that surrogacy arrangements must not be reduced to economic terms.

Discussed below is the methodology adopted for the exploratory study that delves into the motivations, rationale, and justifications for undertaking surrogacy for the second time. It focuses on the experiences of the surrogates in steering through the familial, medical, and legal disquiets surrounding their decision. It also examines the impact of the transnational ban on their earnings. Further, the bearing of the economic advantages of surrogacy on the power dynamics in the family is also investigated.

Methods

The study was conducted in 2019 in an internationally reputed center for the management of infertility situated in Gujarat, India. This center is located in a multi-storey building with state-of-the-art technology and infrastructural facilities. For decades before the ban, it had attracted international clientele for surrogacy services. The ban on transnational surrogacy introduced in 2015 has impacted the industry adversely. The manager at the fertility clinic reported that the demand for surrogacy was substantially lower after the ban. The hostel for the surrogates was running at less than half its capacity. She informed that many more women had resorted to ova donation as the increase in infertility in large cities had created a rising demand. Besides, after the ban on transnational surrogacy, the remuneration paid to the surrogates had not been raised despite inflation. This is also evident from the figures quoted by the surrogates who had gestated for the transnational clients earlier.

The micro-level qualitative phenomenological approach adopted for the study enabled the participants to narrate and impute meanings to their subjective experiences. A semi-structured and open-ended interview schedule was designed that allowed the participants to recount their motivations and justifications for undertaking surrogacy. Some of the issues that were explored during the interviews included: (i) the rationale for taking up surrogacy, (ii) the circumstances that influenced the decision, (iii) how were the requisites of surrogacy arrangements navigated, (iv) were the friends and neighbors informed of the decision or was it kept a secret, (v) lived experiences of surrogacy and were they different from pregnancy that birthed their own children, (vi) relinquishment of the baby, (vii) the bearing of the decision on their domestic life. Face-to-face interviews, which lasted up to 60-90 minutes each, were aimed at exploring the choices, constraints, and conditions that impinged upon the decision-making process of the surrogate mothers.

The interviews were conducted in an undisturbed room of the surrogacy hostel after obtaining verbal consent from the participants. All second-time surrogate mothers who were staying in the hostel of the clinic were interviewed as part of the study. Second-time surrogates were selected for several reasons. (i) Surrogacy arrangements made for a second time are often based on experience, leading to a more informed and thoughtful decision, (ii) second-time surrogates could assess the impact of the transnational ban, (iii) only the second-time surrogates could share their experiences of relinquishing the baby, (iv) with the monetary returns from the previous contract, they are better equipped to assess the advantages of surrogacy arrangement, (v) focus on second-time surrogate mothers offered a longitudinal perspective in understanding their perception of surrogacy and its ramifications on intra-family dynamics.

Phenomenological accounts of nine second-time surrogate mothers, including one attendant (who had been a surrogate twice) and a manager of the fertility center, were collected. They were assured of complete privacy and confidentiality. Therefore, pseudonyms have been used during the discussion. Further, their bios will not be discussed. All participants referred to as Hema, Usha, Jyoti, Maya, Kavita, Suman, Neena, Seema, and Gayatri are pseudonyms. Their stay in the hostel, maintained by the hospital, served to ensure constant monitoring of the surrogates' and the baby's health.

Barring Hema (50 years old), all other participants were between the ages of 24-33 years, married, and had children of their own. Except for Kavita and Sita, who had one child each, all others had two children. Except for Usha, who had completed her education till the tenth grade, others were either illiterate or primary school dropouts. Usha and Jyoti worked in a beauty parlor, Maya, Kavita, Neena, and Gayatri earned a living as part-time domestic help, Seema and Suman worked as unskilled helpers on farms, and Neena helped her husband with repairing and refitting garments before they joined the surrogacy program. Working as an attendant, assisting the surrogates in maintaining health and hygiene in the clinic, Hema had been a surrogate mother twice before. At the time of the interview, she was past the age when she could become a surrogate. The monthly earnings of the participants before joining the surrogacy program ranged from Rupees 1000 to 4000 (approximately US$11-44).

The interviews conducted in Hindi were recorded verbatim. Later, they were transcribed into English. Care was taken to capture the essence of the accounts. Some key statements and quotations used by the participants were retained to convey the crux of the meaning. Data were organized based on the main themes that emerged during the interviews.

Findings

Rationale & Justification: The Material and the Moral

Surrogate mothers in the study were neither educated nor skilled to find employment with an income that could contribute toward the improvement of their standard of living. Their spouses worked as painters and electricians, hawkers, and roadside tailors who repaired or altered clothes. Others worked as contractual daily wage workers on farms or construction sites. Their income was not enough to support the family, and hence, they had no funds to meet contingency expenditure. Three out of the nine surrogate mothers who were interviewed narrated that the prolonged illness and subsequent dip in earning capacity of their husbands pushed them toward surrogacy. In the absence of any other source of employment, surrogacy, they said, was the only route for them to earn a substantial amount in a lump sum. Almost all participants got interested in surrogacy after they witnessed a quantum jump in the living standards of their close relatives and friends who had divulged surrogacy as the source of their newly found wealth. Usha had seen an advertisement seeking a surrogate in the local newspaper, while Maya's tryst with the reproductive market began as an egg donor. She had visited the clinic earlier as an egg donor, and it was there that she was introduced to surrogacy work. All participants in the study expressed that it was their moral duty and responsibility to take care of the needs of their children. The care for the interests of their children weighed predominantly on the minds of all surrogates. Seema, in her thirties, strongly expressed that if children have been brought into this world, then it is morally binding on the parents to provide them with food and a roof over their heads. Furthermore, she added that it was the parents' responsibility to equip them with a good education to pull them out of poverty. The decision to work as surrogates was chiefly driven by the opportunity to earn money to educate children, improve their residential accommodation, especially in the case of those who had daughters, and to be able to save up for their daughters' marriages. As

mothers of two daughters each, Usha and Jyoti, felt, living in *kutcha* houses (mud houses) with adolescent daughters was predisposing them to the risk of being molested, and therefore felt impelled to provide safe accommodation for them and save for their wedding. In India, mothers are often castigated for not being able to marry their daughters (Pande 2010), and hence, saving for the weddings plays heavily on the minds of their parents.

The decision to earn through surrogacy was regarded as an ethical and morally upright one. The surrogates asserted that it was a "noble" way to earn without having to compromise on their values. "Mutual help" was the dominant rationale in nearly all narratives. Hema regarded surrogacy as a virtuous deed by arguing:

> We extend help to those who are not fortunate enough to have children on their own. The [commissioning] party returns the favor by providing the means to take care of the needs of our children. Both parties benefit by sharing what they have and, in return, receive what they need most. It's a fair deal of mutual help to help mothers and their children on both sides.

Maya expressed similar views:

> If I have the capacity to help someone, why should I not help? I have a womb and I have borne children out of it. It's now lying vacant and unused. What's the harm if it can be used to help childless women beget a child? It is a noble deed. People take rent for the most trivial things, we surrogates are nourishing life!

Usha elevated the discourse to a spiritual level by referring to surrogacy as *punya ka kaam* (good karma). Explaining further, she said that "children are a gift from God. If I can assist any woman to become a mother, then I am truly a blessed one." Neena argued that there are many immoral and illegal ways of making money, be it robbing or stealing. But surrogates have chosen an upright and lawful route to earn. She added that "while others shed sweat when they toil to earn, we earn by nurturing with our life and blood." The discourse on "mutual help" resonated with the views of Dr. Naina Patel, who is credited with making Anand, a small town in Gujarat, a global hub of transnational surrogacy. Rudrappa (2015:146) cites Dr. Patel's argument in defense of surrogacy:

> There is this one woman who desperately needs a baby and cannot have her own child without the help of a surrogate. And at the other end, there is this woman who badly wants to help her family…If this female wants to help the other one, why not allow that? It's not for any bad cause. They're helping one another to have a new life in this world.

Projecting surrogacy work as morally exalted, benign, and altruistic is consistent with the findings of Ragone (1996), Pande (2009), and Rudrappa (2015). The responses of the surrogates are influenced by the socialization and counseling imparted by the agencies and clinics that make surrogacy more acceptable and respectable. Rudrappa's respondents, surrogates based in Bangalore, also regarded surrogacy work as morally superior and "ethically impeachable," despite the community relegating them as "baby sellers" or "womb renters." They argued that the reproductive industry allowed them to be "moral workers" as the dormitory where they resided was a women-only space where they produced babies while abstaining from sex (Rudrappa 2015:96).

Negotiating Surrogacy: Mothers Straddling between Care and Contract

The Contract: Mothers' Relinquishing Children

The participants in the study had experienced pregnancy and childbirth when their own children were born. But experiences of surrogacy required re-orientation to the biology and sociality of reproduction. Since they were poor, when they had their own children, they could not afford medical care. They had delivered their biological children without having gone through antenatal check-ups, medically assisted deliveries, or C-sections. Childbirth was assisted by elderly women in the family or a *dai* (midwife). In sharp contrast, they narrated that surrogacy was steeped in medical check-ups, consumption of medicines, both oral and painful injections that preceded conception, and continued right through the pregnancy, culminating in "operation" (C-section delivery). Surrogates in Teman's (2010) study, based in Israel, contrasted their suffering during surrogacy to the relative ease and uncomplicated nature of their previous pregnancies. Some of them had chosen to become surrogates because of their earlier experiences of "easy pregnancy and uncomplicated delivery" (Teman 2010:43).

Narratives of the participants were replete with claims to being the *mother* of the child gestated by them. Each of them claimed that she is as much a "mother" to the child she was carrying as the commissioning woman. One surrogate mother, Gayatri, explained that a "mother is someone who gives birth and brings up the child. In the case of surrogacy, if there are two different women involved in birthing and bringing up, then obviously both are mothers!" Another surrogate mother, Seema, narrated:

> There is no doubt that both are mothers. Why take any stress on that front? But my duties and responsibilities toward this child that I am carrying are not the same as those that I have toward my own. Carrying this child is *my work*, and bringing up my own is my *dharma* [religious and moral obligation].

Seema further added that her surrogacy work was motivated by her desire to fulfil her duty toward her own children. While the surrogates claimed to be mothers of the child they were gestating, they were conscious of the contract and "agreement" that accompanied "mothering" in the avatar of a surrogate. They were well-versed with the code of conduct expected from them, including staying in the hostel, medical interventions, and, most importantly, the relinquishment of the child. Further, they added that the doctors and nurses at the fertility clinic socialized them into the code of professionalism, whereby they were counseled to take care of the fetus like a *mother* and to relinquish parental rights over the child in favor of the commissioning parents in a detached manner. Further, they were repeatedly counseled "to accept and acknowledge that the baby is not theirs, from the time it is conceived," informed Jyoti. Hema reasoned that "just as not returning your friend's valuables that she kept for you in safe custody is unethical, so also the baby that one is carrying is someone else's *amanat* [valuable kept in safe custody for someone else] and has to be returned to its rightful custodian."

Since all the participants were second-time surrogates, they were asked whether they missed the baby after relinquishment during their previous surrogacy. Neena did admit that during her first surrogacy, she was sad after giving the baby, but now "she is more experienced and wise." Suman expressed that she felt relieved at relinquishment be-

cause it marked the culmination of the agreement—that she had fulfilled her role as the nurturer and custodian of the fetus, successfully accomplished her target, and could get back home with the money she needed. The surrogate mothers rationalized that since they were mothers of their own children, they were not "troubled" at the relinquishment. As mothers, they were sympathetic toward the emotions of the childless. Neena said that if she did not have her own children, she would have had second thoughts about relinquishment. As a mother of two children, she admitted that she was struggling to bring up her own children and could not afford to bring up another child. Surrogate mothers were clear that their role was limited to gestating the child and that they were not interested in the child beyond that. Had they wanted to keep the child beyond gestation, they would have produced their own.

At the time of this study, the surrogates received Rupees four lakhs (approx. US$4600) for bearing one child and an additional one lakh, that is, a total of five lakhs Rupees (approx. US$5700) in the case of twins. It was the second time surrogacy for these women, and they had earned almost the same amount or more earlier, when transnational surrogacy was permitted. Hema had gestated a child in 2007 and 2010 for commissioning parents from the US and Japan, respectively, for which she received 4.5 lakhs each. After her first surrogacy, she bought a small plot for building a house, but ran into debt because the cost of construction surpassed her estimate. To pay off the debt and save money for her son's higher education, she undertook another attempt at surrogacy in 2010.

Women who had worked as surrogates before the ban on transnational surrogacy in 2015 were nostalgic about the "foreign party" who brought them expensive "imported gifts." Suman recalled with fondness receiving gifts and Rupees five lakhs from the *Londonwali Party* (commissioning parents were from London) in 2015. However, in 2019, as per her contract, she was to receive Rupees four lakhs only. She had used the money for educating her children and paying an advance for a rented accommodation, and now needed more money to pay for a house with an extra room so that her children could study undisturbed and also to save up for their higher education. Usha had borne twins in 2018 and received Rupees five lakhs, she fixed-deposited the entire amount in the name of her daughters. On average, surrogates receive Rupees four lakhs after a successful delivery. It would generally take about four years for their household to earn that amount, and many more years to accumulate it because most of the earnings are expended. Not all surrogates were lucky to receive the entire amount they were hoping for. Kavita recalled an earlier mishap when she had suffered a miscarriage after two months of conception. She received Rupees 25000 (US$287) only.

Navigating through Stigma toward Empowerment

It is evident that in any surrogacy arrangement, the child is the most coveted entity. Fetal health and development are contingent upon that of the surrogate mother. Therefore, as per the contract, the fertility center mandates that surrogates move into the hostel attached to the clinic to enable close monitoring of the maternal-fetal unit. Moreover, it proved beneficial for the surrogates who could escape from the disapproving eyes of the community and keep surrogacy under wraps. Besides these benefits, according to Pande (2010), hostels were spaces for the construction of perfect surrogates through counsel-

ing and socialization. In the construction of a perfect mother-worker, through counseling, Pande (2010:979) notes that the counselors paid particular attention to ensure surrogate mothers that surrogacy does not involve "immoral acts" like prostitution. Yet, the surrogates were disturbed about the negative public opinion regarding their work. Explaining the reason behind stigma, Suman said that people were still ignorant and associated pregnancy with sexual intercourse. For them, to be pregnant with another person's child is a slur on one's character. Jyoti said, "People who are ignorant of modern technology think that pregnancy is possible only by sleeping with a man, for such people, surrogacy is like prostitution. Others think we are 'baby-sellers,' so it is best not to reveal it to them."

Although the surrogates expressed that surrogacy was not immoral or unethical, they also confessed that they were doing it out of *majboori*, that is, a compulsion arising out of constraints of poverty, especially since they did not have any better options to earn. Those women who had daughters were asked whether they would encourage their daughters to become surrogates in the future. In response to this, all of them categorically stated that they would never want their daughters to become surrogates. Jyoti said the purpose of her surrogacy work is to ensure that after education, her daughter has "better options to earn." Usha stated she sincerely prayed to God that her daughters grow up to be better off and never have to take up this work because, "after all, it is not respectable."

The surrogate mothers circumvented stigma and negative public opinion by strategizing to maintain secrecy and concealing information regarding their engagement in surrogacy. Except for Neena, who had become a surrogate at the behest of her relatives, all the other surrogates kept their stint at surrogacy as a closely guarded secret from their children, larger family, and friends. To cover up the prolonged absence from home, they fabricated stories related to employment, training, or related assignments. Hema and Gayatri had informed their respective neighbors that they would be taking up a nanny's job in another city. Suman left home on the pretext of having found employment in a factory, and Seema had used the alibi of receiving training for work in a beauty parlor. Jyoti also concealed her surrogacy from her children and informed everyone that she was going to Mumbai to work as a live-in domestic help. Although their families could visit surrogates over the weekend, they did not permit their "grown-up" children, especially during the advanced stages of pregnancy. They said that they were embarrassed about their "work" and did not want their children to know about it. The fact that almost all women undergoing a surrogacy program had to keep it a secret from their extended family and friends is an indication that it is neither acceptable nor encouraged by the community and, therefore, derisive and stigmatizing. These findings are consistent with studies in other parts of the world. Berkhout's (2008) study in North America also confirms negative evaluation of commercial surrogacy and associated stigma. The surrogate mothers enjoyed their stay at the hostel as they got ample rest and good food without having to toil to cook. Gayatri referred to her stay in the hostel as *kamau chhuti* (paid holiday). However, she also added that she missed her family. Seema expressed a similar opinion, saying that "It is a win-win situation, we have no responsibility for domestic chores, there is plenty to eat, and we get to learn new things. Instead of paying for the luxuries, we are getting paid for our stay, but we miss our family, especially children."

On the positive side, since they were second-time surrogates, they reported experiencing enhanced self-worth and cessation of domestic violence within their respective families. Many said that they were treated better by their mothers-in-law and husbands. Neena stated that she was treated with dignity and respect by her husband, who no longer indulged in violence. Usha's mother-in-law stopped taunting her for not bringing enough dowry. Seema, Hema, and Gayatri reported having been involved in decision-making regarding important family matters after their first surrogacy. They reported better control over the money that they had earned, even though they said they decided to use it to further the interests of their children and family. Kavita said that after she was able to bring in the huge sum of money, she witnessed a role reversal. Earlier, she had to beg her husband for household expenditure, now it is the other way around—"Now, I control the purse strings, so he asks me for money." All the participants expressed that surrogacy had been a life-altering experience for them, as they felt confident and empowered due to their ability to earn. They narrated that staying in the hostel, living with other women, and interacting with doctors and nurses had been an incremental learning experience. Besides, the training imparted by the hostel, in skills such as running a parlor, stitching, spoken English, or computer literacy, added to their self-worth in the family and community. Hema narrated with pride about her ability to raise her natal and marital families out of poverty and educate their future generations by introducing womenfolk to surrogacy. For the Bangalore-based surrogates studied by Rudrappa (2015:96), the experience of surrogacy was both meaningful and empowering, which allowed them to assert their moral worth.

Discussion

Poverty often pushes women into surrogacy (Suryanarayan 2023). The COVID-19 pandemic introduced unemployment and resultant poverty, forcing more women to earn through surrogacy for the sustenance of their families and to pay off the debts. Since the pandemic, the fertility clinics in Hyderabad have reported an exponential rise in the number of women approaching for egg donation and surrogacy services. Enquiries at the fertility clinics have witnessed a tenfold rise. A survey among a hundred surrogates revealed that the majority had taken it up to tide them over the crisis generated by their husbands' loss of income (Chokhani 2021).

Surrogacy and Ethics of Care

Bailey (2011) regards surrogacy as an extension of care work that poor women have been providing to the rich. It is evident from the narratives of the participants that surrogacy is a medium through which surrogates extend care, devotion, and responsibility toward their family, with a desire to raise their children above poverty by educating them. In India, education is the most significant route to attain social mobility for the poor. Besides this, in the absence of a State-sponsored care mechanism for the aged, dependence on children during old age is their only security. Surrogates epitomize maternal care work doubly, first by birthing and nurturing their genetically related children and second, by gestating children for others.

Relationships of Care in Surrogacy Work and the Neglect of the Surrogate Mothers

From the vantage point of the surrogate, who is a mother before being a surrogate, there are three

main relationships that have a bearing on care. First, the relationship toward her own biological children, whose care and nurturance she feels impelled to provide for. Second, a complex relationship with the fetus whom she nurtures in her womb for the commissioning parents. Third, the relationship between the surrogate and the commissioning parents. In the first two roles, the mother's care-giving is one-sided and not contingent on reciprocity. The second and the third are imperative to the analysis of surrogacy. The relationship between the surrogate and the commissioning couple is the most extraordinary and an intimate one. The surrogate carries their gametes and nurtures them to life, fulfilling their dream of parenting. Such an invaluable relationship should ideally be premised on trust, gratitude, mutual care, and responsibility. Ironically, it is outsourced, contractualized, and mediated by commercially motivated interests, whereby the commissioning parents can completely shrug off all responsibilities by paying the agencies. In India, commercial surrogates are selected through a closed program, that is, the surrogate is selected based on her picture and bio-brief provided by the agencies. While the commissioning parents have all the information about the surrogate, including her picture and health status, the name and whereabouts of the commissioning parents are not shared with the surrogate, who refers to them as a "party." The surrogates referred to them as *Bengal ki party* (party from Bengal) or *Japan ki party*, depending on their country of residence. They meet only at the time of signing the contract and for the baby's handing over formalities (Ragone 1996:353). Rudrappa's (2015) study shows that many surrogates met their clients only after the fourth month, and in case they miscarried before that, they had no idea about whose fetus they were carrying. Commenting upon the surrogates "erasure" from the life of commissioning parents after the payment has been made, Rudrappa (2015:142) observes, "much as consumers often do not reflect on the labor that goes into making the products they consume in commodity production, the parents, too, did not ruminate on the surrogate mother's labor." The commoditization of this vital and delicate relationship that is managed and controlled by commercially driven agencies has left surrogacy bereft of interpersonal care.

Maximizing the care and promoting the development of the unborn child is the mission of all the stakeholders in surrogacy. Fertility clinics play a crucial role in ensuring and extending this care. As mediators between clients and surrogates, they engage with the surrogates to execute the contract between the two, whereby the surrogates are required to devote themselves to the care and protection of the fetus by moving into the hostels. Detachment and alienation are cultivated as a preparation for the relinquishment of the child. Surrogates are counselled to limit their interactions with the clients and remain detached from both the child and the commissioning parents (Hochschild 2015:43). This is advised for ensuring smooth relinquishment of the child, the ultimate objective of surrogacy arrangement.

Temporality, *transitionality*, and *transactionality* are critical aspects of the mother-child relationship in this arrangement, and hence relinquishment of the child to the commissioning parents marks the cessation of the relationship with the surrogate and commencement with the genetic and social parents. References to relinquishment are rendered in altruism in a bid to assuage the split of the dyadic unit. The discourse on "gift-giving" dissipates attention from the pecuniary nature of commercial surrogacy and contracts attaching a price to a child and

its gestation (Pande 2011). Though surrogates were socialized into believing that they were performing a "noble deed," the disdain and near horror expressed at the idea of their daughters engaging in it is revealing and insightful. More importantly, metaphors of altruism and "mutual help" are employed by the surrogates to present themselves in a position of reciprocity and equality rather than exploitation vis-à-vis the commissioning parents. Yet, having experienced surrogacy twice, they do not consider it "respectable." The homily on altruism is an attempt to dispel the stigma attached to surrogacy. It is the surrogate's attempt at assuming a moral position to combat her denigration. This "moral framing" (Rudrappa and Collins 2015:943) is cultivated by the surrogacy agencies to encourage their active participation as compassionate beings.

The surrogates fulfill the three dimensions of care postulated by Tronto (1993), that is, caring about, taking care of, and care-giving. They are mostly deprived of the fourth dimension that pertains to receiving care. Fertility centers and commissioning parents are interested in pursuing the interests of the child. Care in the form of food and medical care is extended to the surrogate because she embodies the baby, but not out of direct interest in her. Once the baby is relinquished, nutritious food and care cease to be provided.

Surrogate is the fountainhead of care for her own children and the care, safe custody, and relinquishment of the commissioned child. She not only assists the infertile couples in having a child, but also furthers the commercial interest of the surrogate agencies (Hochschild 2015:44). She is regarded as fungible and disposable, and the maternal-fetal dyad is marked by complications of alienation, relinquishment, and is corrupted by contracts.

From Contract to Care of the Surrogate Mothers

The maternal-fetal dyad of the surrogate demonstrates the primordial inter-corporeality. It is a relationship of dependence and survival, wherein the mother's body gestates the embryo to create a life and kinship relations. Dolezal (2017:325) emphasizes that pregnancy involves a prolonged embodied communication between the mother and the fetus, wherein the latter responds to the *in-utero* environment. This relationship is the foundation of post-partum intersubjectivities. In the case of gestational surrogacy, the surrogate plays a complex phenomenological and existential role in fetal development through "communicative inter-corporeal relations" that are vital to the future lived subjectivities. Therefore, any conceptualization that undermines the role of gestational surrogates as mere "carriers" or human incubators is unfounded and inaccurate (Dolezal 2017:315). Denying due acknowledgement to the care and nurturance provided by the surrogates during the foundational and formative period of the baby constitutes an injustice through instrumentalization of women as "baby machines" (Dolezal 2017:327).

Surrogacy arrangements in India are much cheaper compared to the US, Europe, and other parts of the world, owing to the prevalent poverty and illiteracy, both of which serve to reduce the employment opportunities and bargaining power of the surrogates. In the US, the provisions in surrogacy arrangements strengthen the surrogate's position by providing for health insurance to her and her family for maternity care. The surrogate is provided with a lawyer, who is paid for by the commissioning parents. More importantly, in the US, nearly 50% of the cost of surrogacy arrangements goes toward payment of the surrogate (Qadeer 2009).

Before the ban on commercial surrogacy was introduced, a report on surrogacy centers in Hyderabad, India, stated that the commercial surrogates received only 20% of the total cost of the surrogacy arrangement. That is, while the total amount paid by the clients is up to 25 lakhs, surrogates receive only five lakhs (Chokhani 2021). The fertility clinics and surrogacy agencies usurp a substantial amount. Parks (2010) applies care ethics to draw attention to the market competition involved in cutting the cost of surrogacy arrangements, which makes it risky and poorly paid for the surrogates. She warns the commissioning parents, especially in the case of transnational surrogacy, not to be party to such exploitative practices that offer competitive prices at the cost of depriving the surrogates of their dues (Parks 2010:336).

Surrogacy poses a health risk for the surrogates. The surrogate's work exposes her to painful medical interventions, injections, and C-sections. Besides this, feminists and reproductive health activists warn against the dangers of "artificial" pregnancy on the health of the surrogates, especially those resulting from multiple embryo transplants and the related abortions (Majumdar 2014:205). A study by Woo and colleagues (2017) has reported that surrogacy pregnancies are more prone to obstetric complications, such as a higher likelihood of caesarean section, gestational diabetes, hypertension, and placenta previa compared to "regular" pregnancies. Further, a comparison of surrogate and non-surrogate mothers during the prenatal and postnatal stages in India revealed higher levels of depression in the former. Hochschild (2015) observes in her study how women in India somehow managed their emotional turmoil due to their financial needs. Postpartum care over an extended period should also be part of the contract.

There is an urgent need for surrogacy agencies, fertility centers, commissioning parents, the community, law, and the State to extend care to the surrogate.

Parks (2010:338) suggests that viewing the commercial surrogacy arrangement from the standpoint of care ethics would imply that the "commissioning couple does not just enter into a *contract* with the surrogate, but rather embark on a *relationship* with her." In such a scenario, the responsibility will extend beyond payment for services, "to an expression of care and concern for the surrogate and her family."

Further, Parks argues that when one enters into a relationship, one assumes responsibility for the care of that person. The Surrogacy Bill 2020 proposes an insurance coverage for 16 months for the surrogate mother to take care of all her medical needs and emergency conditions/complications.

Paradoxically, though the surrogates command more respect and agency within the family after they add substantially to the family's earnings, their work is devalued, and surrogacy remains stigmatized. The secrecy that shrouds surrogacy is counter-productive and perpetuates exploitation as the surrogates are unable to come out in the open and bargain for their rights. Secrecy and stigma associated with surrogacy are a source of emotional and psychological distress among the surrogates. It is therefore crucial to disseminate factual knowledge about surrogacy to dispel false conceptions that are responsible for relegating surrogates' work as immoral, unethical, and stigmatizing. Qadeer and John (2009) suggest that the State should ensure an environment free of secrecy and anonymity associated with surrogacy. The surrogate mother should have all the rights of autonomy, privacy, and bodi-

ly integrity legally available to other women. Further, the surrogates' names should be included in the child's birth certificate and later transferred to the commissioning parents, who should be legally bound and responsible for the long-term care of the surrogate (Qadeer and John 2009:11). Dolezal (2017) recommends attributing kinship status to the gestational mothers. Ironically, in an effort to assert their self-worth, all surrogates in the study claimed to be "mothers" to children they had gestated and birthed, but such an acknowledgement is completely lacking on the part of the commissioning parents and fertility centers.

Commitment to the ethics of care by the State toward surrogates will make stakeholders more accountable and accepting of surrogacy work, eliminating the stigma attached to it. More importantly, the eradication of poverty and promotion of skill-based education to enhance employability among the poor sections of society will increase the bargaining power of those who wish to engage in surrogacy. The decision to engage in surrogacy should therefore not be compelled by financial constraints.

The limitations of the study include, firstly, a small sample size. On account of the stigma attached to surrogacy, it is hard to locate participants and encourage them to share their experiences. The study would have been enriched if the researcher could interview other stakeholders, especially the family members of the surrogates and the intended parents. This was not possible due to bureaucratic constraints and confidentiality issues.

Conclusion

The longitudinal perspective offered by second-time surrogacy was useful in cognizing the social and economic ramifications of the phenomenon. This is especially significant when the fertility industry was undergoing change on account of regulations introduced by the State. Interpreting the lived experiences of surrogates through the ethics of care not only helps in perceiving their motivations toward their engagement in surrogacy but also provides insights into ways to alleviate the denigration of their contribution. Caring is what mothers epitomize. Due to their sense of responsibility toward their own children, they feel obligated to provide for their needs. In the absence of other resources, their bodies and especially their wombs are their only resource to improve their plight. Although the surrogates provide an invaluable service to the commissioning parents and contribute immensely to raising the profit of surrogacy agencies, their work is devalued and considered lacking in dignity and respect. Though the money earned through surrogacy helped ameliorate their status within the family, the condemnation within the community resulted in sexualized stigma. The internalization of this devaluation is evidenced in the fact that they do not want their daughters to become surrogates. Though they tried to justify their engagement in surrogacy by claiming to be mothers to the commissioned child and using the metaphor of "mutual help," these remain failed attempts at elevating their position as equal to the commissioning parents. The application of the ethics of care perspective is directed toward promoting a responsible and humane attitude toward commercial surrogates. It is motivated by the need to uphold the dignity of the surrogates, their legal rights, and social recognition of their work. The application of care ethics can alleviate the neglect and oppression of surrogates.

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Citation

Bhardwaj, Ruby. 2025. "Labor of Care and Contracts: A Study of Surrogacy after the Transnational Ban in India." *Qualitative Sociology Review* 21(3):30-47. Retrieved Month, Year (http://www.qualitativesociologyreview.org/ENG/archive_eng.php). DOI: https://doi.org/10.18778/1733-8077.21.3.02