No strings attached: the expanding frontiers of low-cost transnational surrogacy



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Abstract

This thesis is about global low-cost surrogacy markets in India and beyond. It explores the so far largely unexamined role of intermediaries, mostly fertility doctors and international facilitators, in efforts to turn surrogacy into a streamlined industry and avoid regulation. In Part I, I analyse how industry practice and discourse is aimed at reducing surrogate women to their reproductive capacity as wombs and cutting them off from potential relationships with the babies or the intended parents. This discussion incorporates a critical examination of surrogacy as a part of the category of bioeconomies. I argue that while attempts to reduce the surrogate to a reproductive body make commercial surrogacy appear as a union of biology, technology and capitalism, the efforts needed to contain the potential for emotion, intimacy and relationships in surrogacy show its embeddedness also within economies of care. Part II traces the low-cost surrogacy industry's transformation after it's ban in India. It underlines the way the depersonalisation and control of surrogate women that I describe in Part I allows the industry to set up quickly in new destinations, and even move pregnant surrogates across national borders to avoid becoming subject to regulation. In the final chapter I identify in the representations of surrogacy doctors and international facilitators a discourse of entitlement to carry on providing surrogacy service despite criticism and regulation. Within this discourse, professionals see their work not as problematic but as reproductive activism of helping discriminated groups achieve parenthood while providing low-income women with the choice to lift themselves out of poverty. Overall, the thesis argues that attempts to curb low-cost surrogacy only through criminalisation are unlikely to succeed due to the ability of the industry to control surrogate women, move quickly

between countries and perpetuate a discourse of surrogacy as a mutually beneficial arrangement.

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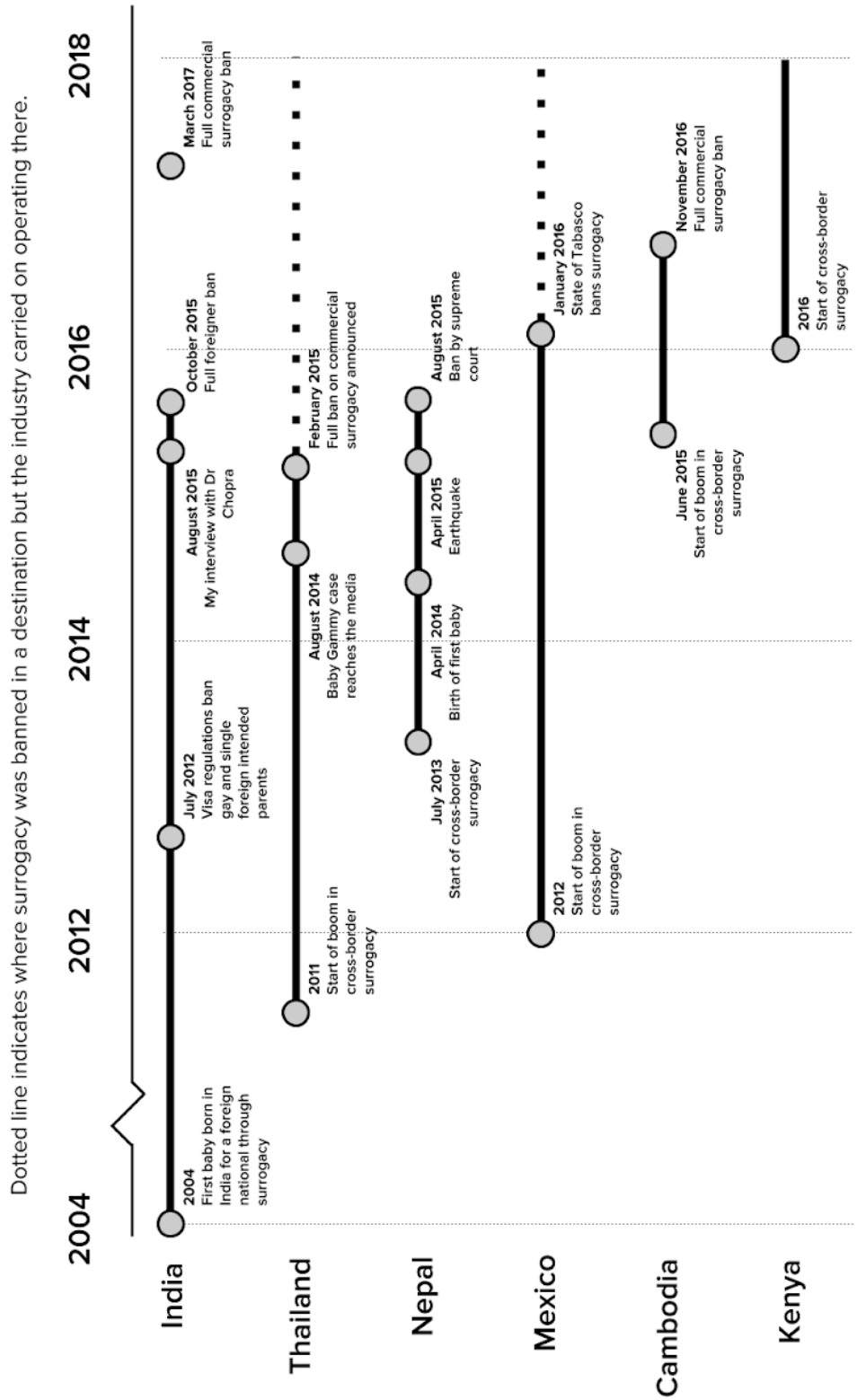
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Figure 1: Timeline of Surrogacy Destinations



1. Introduction

It was a busy monsoon season afternoon in an affluent business neighbourhood in Mumbai. I was running late, rushing around the streets hoping to find the surrogacy clinic before the next downpour of warm heavy rain would flood the streets. I was in the city to learn more about the business of low-cost commercial surrogacy, where Indian women are hired to gestate the babies of Western clients. Mumbai was one of the global centres for this strange and contested but burgeoning business, and I was on my way to meet the doctor of one of the city's top clinics. A personal introduction had secured this rare opportunity for me, but here I was, running late. I was certain I was in the right place, but there were no signs for the clinic anywhere. I decided to call the clinic receptionist. 'Yes madam, it's the right place, here are no signs. Just go behind the building, and in the hallway only you will see signs.' I followed her instructions leading me down a concrete driveway to what looked like a service entrance, but indeed, the signs were there, and they led me to the door.

As I sat in the waiting room enjoying the cool flow of the air conditioner, I had a look around. This was a beautiful modern clinic quite unlike what its entrance might suggest. The interior was painted in hues of green and dotted with carved statues of Ganesha, the Hindu god of auspiciousness. Relaxing music was playing in the background as nurses in pink scrubs came and went. I could begin to imagine the relief of anyone who walked through these doors to find such a place. The waiting room was busy, but quiet, with couples sitting together watching TV, talking among themselves or reading their medical files and brochures. It seemed that I was the

only non-Indian there, something I had noticed in all the clinics I visited, though nonetheless no one was surprised to see me, a young white European woman, sitting there.

After a while I was directed to the doctor's office. It was large and full of light, with Dr Chopra rising from her chair to greet me with a friendly smile. I told her about my research in more detail and asked if she had any questions to ask me before we began the interview. Dr Chopra gave me a long perplexed look and slowly spoke:

> I was surprised that you came to interview me and I am interested. What is your angle on this? What can you add? You are too late. Everyone came to write about this several years ago when there was so much of surrogacy happening. It's finished now. So I just want to ask you, why are you here, now?

Dr Chopra was referring to the surrogacy visa rules that were introduced in July 2012 by India's Ministry of Home Affairs, the details of which I discuss in in this thesis (Chapter 5). From then on, people travelling to India to make use of surrogacy needed to have a specific medical visa, the conditions of which excluded some of the industry's key client populations. While the full impact of this change is complex and debated, the rule did drastically reduce the numbers of foreign clients coming to India for surrogacy, leaving the boom-era multitude of clinics to scramble for what remained, which was roughly thirty percent of the former market. This was a period of widespread uncertainty and decline for those involved, and it was not a good time to be going around asking questions.

I was not sure what to say to Dr Chopra because her words confirmed what I had been starting to think myself. Was I really too late? Perhaps my morning of running

around the neighbourhood not being able to get to the right place was a good illustration of my fieldwork so far. While I eventually made my meeting at the clinic, I was hopelessly late for the surrogacy party in India. My difficulties in finding clinics prepared to participate in my research and the fact that many clinics who spoke to me told me they had very few foreign clients made more sense in light of Dr Chopra's straightforward description of the state of Indian surrogacy in the summer of 2015: 'It's finished now.'

Dr Chopra seemed genuinely interested in helping me, perhaps because she felt a bit sorry for me, so I took the opportunity to find out more. I told her that it was in fact change that I was interested in and that I would like to learn from her about the way the business had been adjusting to the end of the long boom that surrogacy had enjoyed in India. 'Well, maybe then your timing is actually good. Had you come a few years ago I would not have had time to even speak to you. You come when the surge is gone.' Indeed, the new rules meant that the doctors who agreed to speak to me actually had time for long interviews and that specialized lawyers and facilitators had become commonplace enough for me to find a reasonable sample to speak to. The Indian surrogacy business might have been in decline, but it was still functioning, being in fact transformed, rather than merely suffocated by the changing regulatory scene. New players, business models and revenue streams were already coming in to replace those who failed to adapt.

For Dr Chopra and others like her, the period after the introduction of visa regulations had been a process of adjustment to an entirely new market dynamic:

> Definitely the business has changed; it's something completely different now. So you will find now not so many clinics do surrogacy. Used to be many many

> more but now there are only a few of us left in this business who do surrogacy. Especially the smaller players I think just decided it was not worth the trouble with all these new difficulties.

Others were also clearly managing to adapt, and while many clinics had shut down, there were also new ones still entering the market. The boom in Indian surrogacy might have passed, but this meant that doctors had the time to speak to me at length about how the business had developed in India and showed me around their laboratories and the hostels where surrogate women were housed. Moreover, there was something else going on. The visa restrictions introduced in India had provoked the expansion of low-cost surrogacy on to a new global stage as the business moved out of India to other countries with fewer regulations. Thus some of the agents and facilitators I met had already set up their businesses in new destinations, from Thailand to Nepal and Mexico[1]. This situation of simultaneous crisis and opportunity provided a rare insight into the heart of the industry of making babies at cut prices. My visit, it turned out, was very timely.

Understanding low-cost surrogacy markets

This thesis explores the dynamics, causes and consequences of this new reality and the curious global arrangements that developed as a result. In doing so, it sheds light on many of the discourses and ideologies that underpin the business and complicate its successful global regulation. What started in 2004 as the isolated case of a British woman of Indian origin travelling to India for surrogacy grew, as a result of media

[1] Low-cost surrogacy started in India but from there it spread to other countries, with surrogacy sometimes being available several destinations in parallel. Due to the complexity of these developments, a timeline of these events (Figure 1) has been included as front matter for reference.

coverage and online communities, into a well-organised business where clients from Western countries could hire low-income Indian women to carry babies for them. Advertised as ‘wombs for rent’, the surrogate women did not have any rights over the child, nor in fact rights of any kind.

Even as it spreads, surrogacy continues to be as strange as it is everyday. Its driving motivation, the human desire for a family, is simple. In the global industry that this thesis explores, this desire is taken to a market where global emerging biotech powerhouses meet with structural inequality, flows of capital and people, intercontinental flights, travelling egg donors, mail-order frozen sperm and women who are willing to carry a baby for someone else so that in fulfilling the latter’s desire for a family they can make a better life for their own. At the end of it all, out of the intricate assembly of technology and people across continents, a child is born, a new human, a person, a brother or a sister, a legal entity.

The industry attracted significant academic interest for the many bioethical, sociological, legal and philosophical questions it raised. The scholarship that emerged from this interest is discussed in Chapter 2. Ethnographically these works are dominated by an interest in the perspectives of surrogate women (Deomampo, 2016; Pande, 2009a, 2010, 2014; Vora, 2013a) and those of the intending or commissioning parents who travel overseas (Blyth, 2010; Hudson and Culley, 2013, 2011; Inhorn, 2011a; Whittaker and Speier, 2010). Several of these works have been highly influential in providing understandings of surrogacy as a practice, its impacts on those involved and its broader implications for kinship, gender and identity, amongst other things.

However, the many questions I had about transnational low-cost surrogacy were of a different kind. How, I came to wonder, does a business like this, offering 'wombs for rent', come to exist? How can one person rent a part of another person half way across the globe? What are the business's local dynamics in both the producer and consumer countries and the global socio-economic and cultural formations that facilitate it? How does surrogacy fit in with a range of other markets that have sprung up around the commercialisation of human vitality and biology, such as those in organs and medical research? If the academic, public and legal debate on commercial surrogacy is to be relevant and helpful, then its evidence base needs to be expanded from involving the perspectives of the perceived victims and beneficiaries of the business – and who fills which role here remains subject to debate – to include the perspectives of its operators, including both the doctors and the various brokers who bring them together with potential clients.

While the clinics have been researched, so far very little attention has been paid to these various actors who actually make the surrogacy industry happen. As Inhorn and Patrizio observe, 'little is known about these CBRC [cross-border reproductive care] brokers, their services and their forms of remuneration, suggesting the need for further research in this commercial domain' (Inhorn and Patrizio, 2012, p. 160). The subjects of this thesis are therefore the fertility doctors, lawyers, agents and activists who together run the industry, explore new markets and ensure that those with the necessary means and determination will go home with a child of their own. Of this group, international surrogacy facilitators are of special interest to me because they connect the Western consumers of transnational surrogacy to surrogacy markets in

low-income destinations and thus traverse and link the two worlds of production and consumption that are otherwise so carefully kept apart.

While there are a number of fertility treatments on offer through arrangements of transnational reproductive care, my focus in this thesis is specifically on surrogacy. This is because surrogacy evokes with great clarity the complex relationships between surrogates as reproductive labour from the families they create for intended parents and provides a particularly potent field for inquiry into the socio-economic and racial inequalities that sustain the trade. The scope of the topics on which transnational surrogacy touches is broad, covering medical anthropology, kinship studies, gender, law, ethics and postcolonial studies, to name but a few. As it is not possible to cover all of them, in this thesis I have chosen to focus on surrogacy as a particular kind of industry and market.

Size of industry

There are currently no credible estimates available on the size of the low-cost surrogacy industry. Many scholars and news articles quote a report that estimated the Indian surrogacy industry to be worth 445 million US dollars in 2006, with a 150% rise in surrogacy cases from the year before (Ramesh, 2006; Sehgal, 2008; Smerdon, 2008). However, the rapid rate of the industry's growth is evident in the fact that in in the same year, the Indian Council of Medical Research at the time forecasted the market to grow to six billion USD by 2008 (Smerdon, 2008). The ICMR has not offered any further data on whether or not this prediction played out. Moreover, most clinics and facilitators estimated that the Indian industry shrunk by anywhere between thirty and sixty percent after the visa regulations were introduced

and since 2015 the commercial surrogacy industry has been banned in India altogether. Meanwhile, the new destinations that have come up are so fleeting, secretive and often involve so many countries as to make any data impossible to come by. The lack of information on the industry's size matched the vagueness of much of the information that circulates about cross-border surrogacy. It is a field where many participants prefer to keep their involvement secret, it is often hidden from state governments and there is no effective industry body to gather information.

I asked those I spoke to during my research to estimate the size of the industry but no one ever offered to guess. I was told that demand was large and growing, but that the size of the business fluctuated due to regulatory change. Several told me how many babies had been born through their agency in the last twelve months, or during the Indian industry's heyday. Those numbers ranged from a few dozen to several hundred, depending on the size of the agency. But no one had any idea how many children were being born in the many different countries low-cost surrogacy had spread to. If anything, I kept being told how hard it was to estimate, and how much the numbers could fluctuate.

Scenarios where concrete empirical data on matters that are often considered common knowledge is hard to come by has been described as 'empirical elusiveness', by Kristin Peterson (2009), in her research on capital flight and HIV rates in West Africa. Peterson argues that while attempts to gather evidence that relies on rumour, anecdote, stories and evasiveness and that can never hope to reach the kind of concreteness that we desire, are frustrating, they can also offer an analytical opening into something fascinating. Indeed, while I cannot offer an

estimate of the industry's size at different points in its history, the very fact that even industry insiders do not know its size is an important point in the context of this thesis. The vagueness and opaqueness of global surrogacy markets is part of what allows for it to function the way it does, its suppliers and its consumers often dodging the laws of their country or doing things they know to widely be considered morally suspect. The globally connected marketplace is a great place to hide for those who do not wish to be counted.

Methods

The choice to focus on the individuals who run this quasi-legal, morally contested and constantly changing transnational surrogacy industry has come with its own methodological challenges. Indeed, most of the decisions regarding methodology were not made in advance as a concrete plan, but emerged out of a combination of necessity and serendipity.

Studying up

My method in this thesis falls under what Laura Nader (Nader, 1974) has termed 'studying up'. Nader argued that, in order to revitalise the discipline of anthropology and allow it to fulfil its potential in addressing social and democratic issues, we need to study and understand power so as to meaningfully challenge it. This approach resonates with my decision to study surrogacy professionals. The absence of this group from debates surrounding a business that is as morally contested as low-cost transnational surrogacy made little sense to me. In outlining her vision for studying up, Nader also recognised the challenges researchers were likely to encounter,

namely the risk of anthropologists working close to home not being taken seriously, and issues with access and methodology.

It is worth noting here that much of the literature on the methodology of studying up conflates the practice with doing ‘ethnography at home’, of studying groups and populations close to one’s own. This assumption cannot be maintained in a world where, through the rise of non-Western economies, global relations of power and privilege are increasingly being renegotiated. Indeed, several of my research participants who most accurately fit the description of studying up were Indian doctors and lawyers by reason of their privileged upbringing and status as legal or medical experts with political connections. Moreover, what constitutes ‘home’ and ‘away’ was hardly straightforward in a situation where I found myself interviewing Americans and Australians in Delhi and German-educated Indians in London.

Accessing the multi-sited field

The location of the ‘field’ for my ethnography is so dispersed as to render the term potentially meaningless. The women gestating babies for money are located in hostels in various and constantly changing low-cost destinations, but those who broker their services, as well as those who commission them, are mostly located in Western countries. In order to capture this protean field, I carried out my research in various cities in India, as well as in London, with additional video calls to the United States, Australia and several European countries. This places my work in the category of what has come to be known as ‘multi-sited ethnography’ (Marcus, 1995,

1998). Rather than following the baby through surrogacy or ‘following the money’, I decided to locate and investigate the points where the two meet.

Multi-sited ethnography is not without its critics, with some arguing that splitting one’s time between locations can lead to a lack of depth, undermine relationships and make intimate knowledge of a particular site impossible (Englund and Leach, 2000), denying us the insights that come from long-term physical immersion (Hastrup and Hervik, 2003; Okely, 1992). Indeed, in our academic upbringing as anthropologists, we get taught to sit down and observe, to participate and write ‘thick description’ (Geertz, 1973). I feared that my description would run thin, but I took both courage and inspiration from the many powerful ethnographies of global connectedness, of ‘the system itself’ (Marcus and Fischer, 1999, p. 91), that have grown out of new approaches to ethnography by authors such as Kim Fortun (2009), Anna Tsing (2011, 2015), Kirstin Peterson (2014) and Adriana Petryna (2013).

Moreover, my movements across India and between India and the UK matched the way the international facilitators I was interested in travelled from one location to the next, causing overnight booms and then moving to the next destination as soon as regulations were introduced. My passing interactions with them were themselves illustrative of the way these actors interact with the locations they work in. To quote Mark-Anthony Falzon, in some scenarios ‘understanding the shallow may itself be a form of depth’ (Falzon, 2016, p. 9).

Most of my fieldwork was carried out in the various locations in India where the surrogacy industry had earlier thrived. These were mostly large cities like Delhi, Mumbai and Bengaluru, but they also included smaller and less urban locations. I

made arrangements to carry out research in Nepal, but the business had been banned there by the time of my visit. At the time of my fieldwork and interviews, India still occupied a strong place in the industry because many of its businesses and professionals had started there, the model of low-cost surrogacy had been developed there, and those involved in it had nostalgia for the relative stability and organised steady state it had reached. As a result, I decided to make India the centre of the surrogacy universe in this analysis, even though that universe covers many other destinations. The international facilitators I interviewed had worked at different times in Thailand, Mexico, Nepal and/or Cambodia. Some also took clients to Ukraine and Russia, where the treatment of surrogate women is considerably different and where only heterosexual couples can receive treatment. While some specialised in the low-cost sector, others also worked in the United States, where surrogacy is expensive and transnational clients are mainly from Europe and China.

The interconnected problems of access and methodology in studying up, as also outlined by Nader, were a constant negotiation in my fieldwork. The doctors, brokers and lawyers I sought to get to know were incredibly busy, worked in a field that valued privacy and that had grown suspicious of outsiders and had little motivation to speak to me. As Hugh Gusterson (1997, p. 115) has observed, ‘participant observation is a research technique that does not travel well up the social structure.’ Guesterson argues that a technique that worked well for the study of small-scale societies through face-to-face interaction may not be applicable to large multinational corporations where no one has time to speak to the anthropologist and there is the constant threat of being asked to leave their private property. Clinics and lawyers’ offices are closed spaces, with receptionists, nurses and sometimes even dedicated

security personnel to ensure that outsiders do not engage in exactly the kinds of activities that participant observation involves. Much of my time in the field was thus sent making calls, sending emails and waiting for responses in the hopes of gaining access to these closed-off spaces. I was fortunate to have some contacts from my fieldwork in London, without which my attempts would have been even more difficult.

My research efforts in many ways followed the journey of intended parents looking to start a family with the help of low-cost surrogacy, a fact that provoked in me a significant degree of compassion for them. After extensive online research, interactions with charities and advocates, and attendance at both professional industry and consumer surrogacy events in London, I spent most of my fieldwork in India visiting clinics, surrogate hostels and various other surrogacy professionals for tours of their facilities and interviews. Some welcomed repeat interviews and short stays, but requests to do longer fieldwork with them were declined. The surrogacy industry is aware of media and academic criticism that has resulted from the work of ethnographers and journalists and is thus careful in its interactions with outsiders. Access was thus an ongoing challenge in the research. Clinics and facilitators would often refuse to speak to me and acted as powerful gatekeepers for access to other clinic staff and surrogate women. Although I did manage to interview a few surrogates, I did so in a highly controlled clinic environment where the interaction was observed (indeed in one case even filmed) by clinic staff, and I was made to use a clinic staff member as an interpreter. My failed attempts at genuine contact with surrogate women ended up sparking my interest in the relationship between personhood and the bioeconomy, partly inspiring Chapters 3 and 4.

Reliance on interviews

As a result of the difficulty in securing opportunities for participant observation in the Malinowskian sense, most of this thesis is based instead on interviews with various surrogacy professionals. A total of 39 interviews were carried out. The core group of interviews, of which several were repeat interviews or came with opportunities for ethnographic observation, were conducted with ten doctors, three specialist lawyers, two clinic-based international patient coordinators and seven international surrogacy facilitators, as well as two support staff. Access was gained to some of the world's leading international facilitators and fertility clinics.

I also talked to two surrogate women, a few British and Indian intended parents, key charities involved in campaigning on surrogacy in the UK and in India, embryologists and Indian fertility clinics that did not offer transnational surrogacy, all of whom helped me to understand the core group and offered perspectives on the industry. From the core interviews, I chose a group whose voices I wanted to make heard by way of long quotes throughout this thesis. I felt that the words of these individuals were of special significance in understanding transnational low-cost surrogacy because of their well-articulated and reflective opinions or because the way they were positioned in the industry afforded them an especially revealing perspective.

The limited time spent on participant observation needs to be acknowledged. Long-term intensive fieldwork is often considered one of the defining features of anthropology, with participant observation as its central method (Gupta and Ferguson, 1997). However, according to Vered Amit, it is an epistemological tautology that even those scholars who approach it critically cannot let go of:

‘anthropology is validated as a separate discipline through a particular methodology, which, while valued for its open-endedness, is in turn legitimated through spatial and social encapsulation’ (Amit, 2003, p. 5). Many in the discipline consider immersion and long duration crucial to the development of the kind of all-encompassing understanding that ethnography strives for, culminating in ‘a total experience, demanding all the anthropologist’s resources, intellectual, physical, emotional, political and intuitive’ (Okely, 1992, p. 8). Indeed, some of the most powerful works of anthropology have come out of such immersion. But recognition of the value of participant observation to anthropological understanding is separate from a belief that research has value if, and only if, long-term immersive participant observation in its traditional sense of physical presence (see the section below on digital ethnography) has taken place. In a world increasingly on the move, continuing to insist on participant observation in all circumstances would limit the scope of anthropology severely as a discipline (Amit, 2003; Pande, 2014).

To overcome challenges of access and methodology, or what Gusterson has described as the dissonance between research projects, research sites and methods, he proposes a mixed method that he terms ‘polymorphous engagement’. Here interactions with those we study happen ‘across a number of dispersed sites, not just in local communities, and sometimes in virtual form; and it means collecting data eclectically from a disparate array of sources in many different ways’ (Gusterson, 1997, p. 116). Examples of such polymorphous engagement include interviews, sometimes by telephone and email, extensive reading of newspapers and even close attention to popular culture. Gusterson emphasises the need to

acknowledge virtual space as a real space of social interaction and to use virtual anthropology to follow our subjects there.

The resulting reliance on interviews, however, placed special significance on the willingness of my interlocutors to tell me about their world, or provide a narrative, rather than just answer my questions. This distinction has been identified by linguist Livia Polanyi (1985) as one between stories and reports. Stories, Polanyi argues, are about the speaker making a point or transmitting a message about the world they share with other people. In telling a story, the narrator takes responsibility for communicating that message and its relevance. A report, on the other hand, is a set of answers elicited by the interviewer, where the burden of interpretation therefore falls on the interviewer as well. If we are to use interviews to gain insights into the world of another, then we must find ways to use our questions to invite the telling of stories. This was not an easy task in an industry where secrecy and competition were prevalent. It was not so much the unwillingness of participants to tell stories, but their insistence on telling me particular stories that presented the industry and their role within it in a particular light. Such stories were nonetheless very useful in understanding the world of my interlocutors, the issues they considered important or contested, and the ways they wanted to represent themselves. The tensions between what is said and what is not said, as well as who has the power to speak and who does not, is an important thread running throughout this thesis.

My efforts to conduct meaningful interviews with some of the surrogacy industry's key actors were made easier by my knowledge of the technical, policy and industry aspects of surrogacy I acquired during time spent working with a policy and public

engagement NGO in London. My ability to converse in the specific languages of these expert communities about these issues and my awareness of them facilitated my access to surrogacy professionals in India and encouraged them to share their world, worries and plans with me, as well as a good measure of industry gossip. The importance of my own pre-existing knowledge of the industry can be understood in the context of the literature on oral history, especially Alessandro Portelli's (2010) argument that interviewing should be understood not as a unilateral transfer of information, but as two subjects apprehending one another as such in the context of the location and setting of the interview.

While both Polanyi and Portelli highlight the challenges of capturing the subjectivities of other persons through interviews, they both remain optimistic about the prospect of building genuine understanding of other people's worlds through narratives and interviews. Moreover, such challenges of are not unique to interviews, and there is no reason to assume that participant observation, especially when carried out in the context of groups or topics where information is divulged only very carefully, will automatically overcome or bypass issues of intersubjectivity.

Tone

Access issues were followed by the challenge of choosing the right tone and form of representation in writing up the data. The doctors and brokers whose perspectives make up most of the thesis are often seen as greedy and callous. They are blamed for the exploitation, fraud and illegal manoeuvrings of the surrogacy business. It has been my aim to humanise portrayals of international brokers without condoning or normalising the kinds of activities their work can involve. While anthropology has a

strong history of being a champion for the disempowered, the disenfranchised and the victimized, it has shown far less interest in those for whom it lacks sympathy (Waldram, 2009, 2015). During the write up, I found Harel Shapira's ethnography Waiting for Jose: The minuteman's pursuit of America (Shapira, 2017) on volunteer border guards policing the US-Mexico border, and - with even greater relevance for this thesis - Karen Ho's Liquidated: An ethnography of Wall Street (Ho, 2009) about investment bankers, to be useful examples of how to explore, take seriously and convey the world of those with whom we may not agree.

I have attempted to convey the complexity and nuance of the views held by the many actors in the surrogacy industry with some degree of fairness. This is not only because, as another consequence of studying up, my respondents will be able to look up, read and publicly criticise my work, but also because a negative portrayal would be simplistic and unfair. Many who are involved this business are acutely aware of its challenges and moral conundrums. They carry on because they believe that the business, with all its shortcomings, still has net advantages for all its participants. While one may not agree with all their views and actions, it is nonetheless important to appreciate just how different they are from the two-dimensional figure of the greedy broker they are often portrayed as.

Digital ethnography

My attempt to write about transnational low-cost surrogacy as a system would have been incomplete without the use of online ethnography. Because of the distances involved, the secrecy and the lack of information, much of the world of surrogacy happens online (Berend, 2016). Information and stories are shared in various blogs

and forums, and communication mostly takes place via email, WhatsApp and Skype. The internet not only offers a representation of the world of low-cost surrogacy, it is also the medium through which it actually takes place. In line with the method that Gusterson (1997) described as polymorphous engagement, publicly available clinic websites, industry forums, social media content and intended parent blogs were all used to gather additional information.

I chose to use quotes from intended parent blogs because, even though they are not the focus of this thesis, I wanted to convey the often very difficult position intended parents are in when they enter these markets. It was not realistic to do long-term fieldwork with the intended parents (although several of the facilitators I interviewed were themselves former intended parents), so blogs, coupled with academic research on intended parents' perspectives, helped create understanding of their actions and communicate the complexity and reflexivity of the often irreconcilable views they held.

My position in the field

My own position in the field was an ongoing negotiation. My whiteness, lack of Indian heritage and inability to speak the many local languages of the surrogate women placed me with the professionals and clients of the surrogacy industry, further complicating access to the surrogate women and local agents, drivers and clinic nurses. I always made it clear from the outset that I was there as an academic researcher. This did not cushion me from attempts by those around me to make me a part of their own agendas. Clinics would often present me with sales pitches in the

hopes that I would either bring them business directly or put them in touch with potential intended parent groups and international facilitators.

On fieldwork I quickly found out that, as a blonde Eastern European woman, I perfectly fitted the category of a commercial egg donor, who are often recruited from former Soviet states because of their combination of desirable physical attributes and economic precarity. Being an athlete studying in a world-renowned university meant that I was often faced with opportunities to become a part of the business I was studying and sell my ova (see Chapter 2 on the inequalities implicated by the recruitment of egg donors from college campuses). Offers ranging from an all-expenses-paid luxury holiday to Goa to absurd amounts of money were a window into just how well rehearsed the industry is in downplaying the risks of becoming a labourer in the bioeconomy and in talking up the possibility of easy windfalls.

Terminology

In large part, the terminology used in this thesis is also at the root of many of its key debates. The challenge to our conceptual categories in adjusting to new realms of reproduction and family as they have become intertwined with biotechnological forms of intervention and knowledge is obvious in policy debates, media coverage and regulation, but it also present in very personal experiences of confusion and anxiety for those affected by this uncertainty. Who is a parent? Who is a surrogate? The definition and ontological status of a parent is to a large extent up for debate, a matter which has very real consequences for those who have children through surrogacy and gamete donation.

In choosing which terms to use in my writing, I have tried to bear in mind the power of terminology and conceptual categories to have real life consequences. I have aimed to use language that seems to me to be most neutral and least contested, but that does not distort the nature of the phenomenon. Due to the debates surrounding many of my key terms, this has not always been possible. I have chosen to refer to the women who gestate babies for others as ‘surrogates’ or ‘surrogate women’, and not ‘surrogate mothers’ because in the context of assisted reproduction (as I discuss further in Chapter 2) gestation alone does not constitute motherhood. Apart from very rare and problematic cases, these women sign up as surrogates with full awareness that the child they will be carrying will not be theirs. I do, however, reject referring to them as ‘gestational carriers’, as is sometimes done to de-emphasise their maternity (Deomampo, 2016), for the term in my view exacerbates some of the potential de-personifying tendencies of low-cost commercial surrogacy. I use the term ‘low-cost surrogacy’ to emphasise the extent to which surrogacy, even in its commercial forms, can vary dramatically depending on the socio-economic and regulatory environment in which it is carried out. The experience of surrogates and intended parents in countries like the US or even in destinations in Eastern Europe, while similar in some respects, is nonetheless very different from that of Asian and African destinations, especially in matters relating to the amount of control and monitoring the surrogate woman is subjected to. As I elaborate further in Chapter 2, I have chosen to use ‘reproductive travel’ or ‘fertility travel’ rather than the common ‘reproductive tourism’ because the latter carries implications of triviality, leisure and choice that misrepresent the lived experiences of intended parents (Inhorn and Patrizio, 2009; Storrow, 2005a). The term ‘brokers’ was not used to refer to

themselves by the various intermediaries, facilitators and agents I encountered. However, since the term did not carry negative connotations for the participants in the same way the word ‘agent’ did, I use it as a catch-all phrase to describe the many roles these intermediaries fill, while emphasising their brokerage function. It is important to bear in mind that the international facilitators I describe as brokers, while similar in their role and work in most ways, nonetheless employ a broad range of approaches, especially when it comes to addressing the legal and ethical dilemmas of the industry.

Anonymisation

Privacy and even secrecy are important to many of the participants in this research. However, at least as many others insisted that they would welcome their real identities being used. Due to the small circle of people involved in this industry, it was necessary to hide all identities so as not to give away those who wished to remain anonymous. Anonymisation in this case involves not just the use of pseudonyms for individuals, but also changes in exact locations, names of companies and in descriptions of persons. Despite efforts to minimise the impact of anonymisation on the thesis, adopting it at this level has been a further challenge for ‘thick description’. However, considering the public profile of several participants and the nature of the industry and activities they are involved in, it has been a necessary measure.

Structure of the thesis

Following on from the introduction, Chapter 2 will introduce the history and context of assisted reproduction and surrogacy, together with some of the theoretical debates

the thesis engages with. The rest of the thesis is divided into two parts. The first, including Chapters 3 and 4, takes us to the heart of the industry, to the fertility clinics and surrogacy hostels in India, to probe the relationships between personhood and the bioeconomy and to ask how low-income Indian women become reduced to the status of reproductive bodies, losing their claims to bodily autonomy, personal freedoms and the opportunity to create relationships with the babies they gestate. Chapter 3 begins with my unsuccessful attempts to gain access to, or even locate, surrogate women in India and the realisation that the absence of surrogate women in my research is indicative of the absence of these women in the pregnancies that their own bodies are the site of. In order to streamline the business and control the women, surrogates become alienated from their pregnancies and deleted from the process. Drawing on literature on cadaveric organ donation and ethnographies of surrogate women's experiences, this chapter explores the causes, methods and impacts of this drive to reduce surrogate women from persons to wombs for rent. Chapter 4 looks at alienation of a different kind and asks how kinship, parenthood and intimacy are made and unmade in the surrogacy process to suit the needs to the surrogacy industry and its clients, the intended parents. It focuses on the importance of power relationships in this separation of roles and the extent to which the emotional costs of 'no strings attached' babies are borne by surrogate women. In taking much of its theoretical core from literature on adoption and care work, this chapter challenges the notion of surrogacy as a predominantly biotechnological industry.

The second part, consisting of Chapters 5, 6 and 7, moves the focus to the broader reproductive markets that have developed as a result of the reduction of surrogate

women to faceless, nameless reproductive bodies. It traces the movements of international facilitators – brokers who connect intended parents with low-cost surrogacy providers – as they build low-cost surrogacy into a global industry that is so far managing to outrun attempts to ban it, and it unpacks the shared discourse that makes their work not only morally acceptable, but laudable. Chapter 5 moves out of the clinical space to look at the way the industry needed to adjust to a challenge of a different kind, that of bridging the gap between the reality of where low-cost babies were made with the expectations of the industry's clients. The need to make the intended parents feel comfortable in India and able to leave the country without legal problems arising resulted in an expansion of the surrogacy industry into broader services of legal assistance, travel support and the emergence of various intermediary services. This change had impacts on the entire industry, increasing the number of people involved and making accountability for surrogate welfare harder to trace.

Of these new actors in the surrogacy industry, one group, the international facilitators, stood out and over time took control of the business. Chapter 6 identifies the causes of facilitator dominance in the combination of their role with the changing landscape of the surrogacy industry itself. Using Karen Ho's (2009) work on the global dominance of investment banks, this chapter explains why, after surrogacy was restricted and later banned in India, this group was best positioned to adapt to change. It takes a closer look at the different approaches that facilitators can adopt to be successful in the industry, and how their attitudes to risk and regulation have come to shape the moral, and not just geographical, frontiers of the industry. The impacts of their actions on low-cost surrogacy markets are the subject of Chapter 7,

which traces the cycles of booms and busts that are created when the seemingly insatiable demand for low-cost surrogacy meets the entrepreneurial resourcefulness of the surrogacy industry. A closer look at the kinds of locations the industry thrives in has important implications: the inequality and exploitation of surrogate women in low-cost surrogacy is not an unfortunate side-effect of the industry, but one of its foundations.

While Chapters 5, 6, and 7 describe how the industry works, they also speak to the kind of depersonalisation and deleting of surrogate lives addressed in Chapters 3 and 4. It is because the industry can ignore the needs of the surrogate women that it can function the way it does, with increasingly complex movements and arrangements. Chapter 8 brings together the debates raised in the previous chapters by asking how international facilitators, who in many ways run the global low-cost surrogacy industry, see the industry and their role within it. Out of their representations of surrogacy emerges an alternative view of mutually beneficial agreements, illegitimate regulation and the moral entitlement to benefit from surrogacy in its low-cost iterations, even where regulation has banned it.

2. Mapping a moment: the emergence of commercial surrogacy as a global business

Introduction

Transnational surrogacy has become such an established way of making families that it can be easy to forget how recent and contested it is. But how does such a peculiar business come about in the first place? This chapter attempts to answer that question by introducing the literature, both ethnographic and historical, and the theoretical frameworks that can help us understand this phenomenon and place low-cost transnational surrogacy in a broader context. What were the historical, social, ideological, political and technological developments that led to a moment in time when intended parents could travel across continents into low-income countries in pursuit of families? What dynamics sustain it in its current format? This thesis has the Indian surrogacy business – site of the first big transnational boom – as its subject matter, but it is ultimately about mapping out the histories and presents of a very particular global economy. Doing so brings it into conversation with a wide range of theoretical and ethnographic work on Indian surrogacy specifically, but also on broader topics such as technology, gender, labour markets, modern kinship, intersectional inequalities, governance and globalisation.

Miracle babies

The technology

The surrogacy business is about making babies. Crucially, not just any kinds of babies, but ones that meet the criteria that make them appealing to the intended parents who commission them. As such, the technology and expertise that produces such babies is central to an understanding of global surrogacy industry. The roots of the development of gynaecology and later assisted reproduction are twofold, involving agricultural livestock-breeding on the one hand and human population control on the other (Clarke, 1998; Cooper, 2011; Franklin, 2007). In vitro fertilisation (IVF), cryopreservation and hormonal superovulation were all first developed in farming, to allow for the reproduction of livestock on an industrial scale by removing it from the inefficiencies and unpredictabilities of nature and bringing it into the controlled environment of the laboratory (Cooper, 2011). This history of maximising productivity, control and manipulation remains at the core of assisted reproduction.

The key technology of IVF allows extracorporeal conception. The egg and the sperm are joined under a microscope in a petri dish by highly trained embryologists, and the resulting embryos are then incubated until they are ready for implantation or cryopreservation (freezing). By moving conception outside the body, IVF separates sexual intercourse from reproduction. The option of freezing allows embryos to be kept on standby until they are needed, facilitating complete expert control over the reproductive process. The first human IVF baby, Louise Brown,[2] was born in 1978 to

[2] Despite growing up in the spotlight and experiencing both interest in and criticism of her existence, Louise Brown has always insisted she had a normal childhood and never felt different from other children.

significant public fascination (Franklin, 1999, 2002). Despite the ongoing debate about the nature and impact of assisted reproduction, it has nonetheless become established as a rapidly growing field of medicine that is increasingly normalised, publicly talked about and common (Markens, 2012; Poote and van den Akker, 2009).

Assisted reproduction involves a host of technologies and medical procedures that have evolved around IVF. Due to the way IVF separates conception from gestation, it is possible to delegate each of them to different women. Genetics, in the form of ova, can come from one person, the gestation being provided by a separate surrogate woman. Neither of them will necessarily have any parenting role, which is reserved for the intended or commissioning parents in what has come to be known as third-party assisted reproduction. In this thesis I will be focusing on surrogacy, the most intrusive and arguably also most controversial of these techniques, where a woman agrees to carry a baby to term and hand it over at birth to the commissioning parents. The first reported case of surrogacy took place in 1986, and the practice has been growing in popularity ever since. Most surrogacy today is gestational surrogacy, where the eggs of the intended mother or a separate egg donor and the sperm of the intended father or a sperm donor are used to separate out gestation from biogenetic connection. The most complex arrangements can involve large groups of people, with donors, carriers, doctors, lawyers, embryologists, geneticists, case managers and surrogacy brokers all coming together to make a baby.

The demand

The reason for surrogacy's rapid expansion has been the existence of widespread demand. Infertility, most commonly defined as 'a disease of the reproductive system

defined by the failure to achieve a clinical pregnancy after twelve months or more of regular unprotected sexual intercourse', is a common problem worldwide (Zegers-Hochschild et al., 2009, p. 1522). The condition predates its medical definition, but before the advent of assisted reproductive medicine there was little people could do other than accept a life without one's own children, remarry or adopt. The availability of young babies for adoption, however, has dropped sharply as use of contraception spread and single parenthood became more acceptable (Briggs, 2012). Rising infertility rates due to, amongst other factors, lifestyle changes, delayed parenthood, environmental pollution and health issues nonetheless mean that the demand for babies remains high. The increasing social acceptability of gay families has in many cases opened up the possibility of adoption for these groups. As a result, waiting lists for adoption are long, costs high, and eligibility criteria strict, making it an unattainable option for many aspiring parents. The value placed on genetic blood ties in Western kinship (Schneider, 1980) also means that many never even consider adoption.

As medical technologies for the treatment of infertility have been developed, the condition has become increasingly medicalised, developing into an ecosystem of monitoring, hormonal manipulation and biomedical intervention in the reproductive process, with IVF at its apex (Inhorn and van Balen, 2002). Right from the beginning, before the safety of these procedures was proven, there were people willing to take the chance, put their faith in a science that sounded more like science fiction and have their children made in a petri-dish. Such pioneers were driven by the hope of finally having a family of their own. Even as children become less central to a normal life course in the West, infertility nonetheless has the potential to carry deep

personal, emotional and social consequences[3] (Becker, 2000; Melhuus, 2012). Not being able to conform to the expectations of parenthood affects women and men in different ways. Women, who are often assumed to be the cause of the infertility, can develop a negative identity and a sense of personal failure (Becker, 2000; Nachtigall et al., 1992; Ulrich and Weatherall, 2000). Men can struggle to find ways to express and achieve recognition of their sense of loss in a culture that downplays their role as nurturers (Melhuus, 2012; Pruett, 1998) and expects 'real men' to embody infallibility and virility (Throsby and Gill, 2004).

Another way of thinking about infertility is as a social condition of involuntary childlessness, the inability to achieve a desired social role of parenthood (Becker, 2000; Greil et al., 2010). This approach highlights that IVF is not in itself a medical cure. Unlike uterine transplants or hormonal treatments, IVF will not make someone medically fertile or undo the damage left by cancer treatment or genetic conditions. Instead, it bypasses the problem with the help of technology and additional human parties. This approach allows the inclusion into the sphere of fertility treatments of those who are childless due to their sexual orientation or the lack of a suitable partner, two groups for whom third-party reproduction has also opened up the possibility of genetic parenthood (Agigian, 2004; Bryld, 2001; Melhuus, 2012). While such individuals cannot have babies of their own without technological assistance, they nonetheless do not suffer from a medical condition. Their quest for parenthood is thus more fully understood as a matter of reproductive justice and the right to a

[3] Not all those who are unable to have children seek medical help. Population research suggests that the characterization of infertile women as desperate to conceive only describes treatment seekers, ignoring those who choose not to seek help (Franklin, 1990; Greil et al., 2010).

family life than of health care (Robertson, 2004).

These non-heteronormative families now fall under the expanding category of arrangements termed alternative parenting. Especially relevant for this thesis is the so-called Gayby Boom of gay men having babies through the use of egg donors and surrogates (Drescher, 2014; Mitchell and Green, 2008; Norton et al., 2013). Their experience of surrogacy can be very different from that of medically infertile heterosexual couples (Riggs et al., 2015). They do not have the same sense of failure, as they never expected to be able to conceive without a ‘facilitating other’ (Mitchell and Green, 2008). Nor have they typically been through years of failed IVF cycles before turning to gamete donation or surrogacy, as is usually the case with heterosexual couples.

Assisted reproduction around the world

The fertility industry welcomes all these different groups as patient-clients because it is directed at making babies, the end result that all of its clients yearn for. Clinics make parenthood seem within reach for anyone provided they can afford to pay for another cycle of the ever-expanding package of the medical miracle of IVF (Sandelowski, 1991). As assisted reproduction spread globally, anthropologists followed to document the ways this new technology and expertise are being employed, articulated and accessed in a variety of cultural and socio-economic contexts.

Indeed, the global response to ARTs has been anything but uniform. Ethnographies on assisted reproduction in the Middle East have focused on the cultural, religious

and legal responses to the challenge of third-party assisted reproduction, mainly egg donation and sperm donations. The context here is one of concerns about adultery, the management of relationships and the proximity of non-related males and females, the issue of masculinity in the face of the growing prevalence of poor sperm quality and the tension of a culture that values children highly but is particularly concerned with appearances and religious restrictions on reproduction (Buchler and Kayasseh, 2014; Clarke, 1998; Inhorn, 2003, 2011a). Not only have these studies identified significant differences in Shia and Sunni Islam's respective approaches to assisted reproduction, they have also highlighted the often significant willingness of religious scholars and leaders to try to accommodate the needs of their followers as much as possible in relation to assisted reproduction.

Studies of IVF in Africa have revealed unique challenges of combined structural and religious constraints on its operation (Hörbst, 2016). In Elizabeth Roberts' (Roberts, 2006) work on IVF in Ecuador, a country dominated by Catholicism and its firm anti-IVF stance, assisted reproduction nonetheless claims to happen under God's blessings, becoming a site of struggle between fertility experts and the Church over who gets to control miracles, or harness the power of God to effect material change on earth. The growing number of ethnographies on assisted reproduction in South Asia is wide in its interests, ranging from the rise of the middle classes and the interactions of old beliefs with new encounters with biotechnology. Some highlight the emphasis on large families and the reluctance to adopt as among the reasons for the success of fertility industries in India (Bharadwaj, 2003), while others (Simpson, 2004; Simpson and Dissanayake, 2005) focus on attitudes towards genetic testing in Sri Lanka, highlighting the mismatch between support for prenatal genetic testing

and pre-existing regulation against the termination of pregnancies (Simpson, 2004; Simpson and Dissanayake, 2005).

The legal debate surrounding access to assisted reproduction and the impacts of restrictive regulation in many European countries has become the subject of several key ethnographies in the field (Melhuus, 2012; Shenfield et al., 2010). If socio-cultural factors or preemptive regulatory restriction have stifled the growth of ARTs in some countries, others saw them flourish with state support. Israel has embraced the use of assisted reproduction through the creation of unprecedented centralised state-sponsored ART programmes for the creation of more babies and families, but only of the kind it considers desirable for the state and the Jewish nation (Birenbaum-Carmeli, 2007; Birenbaum-Carmeli and Inhorn, 2009; Teman, 2010).

Of all the countries to embrace assisted reproduction, however, India has possibly been the most surprising and most dramatic. Despite initial resistance by the Indian government to the use of IVF (Deomampo, 2016), assisted reproduction quickly became a special success in India. The country's pronatalist culture and a preference for male children, coupled with rising numbers of affluent middle classes and a well-established network of fertility specialists (albeit trained to restrict fertility through population management programmes), made for a rapidly growing fertility sector (Bharadwaj, 2003). The timing was also perfect to coincide with India's powerful entry on to the global stage of technology and biomedicine. Meanwhile, India's well-established medical tourism industry began offering IVF to foreigners for a fraction of the cost of such treatment in their home countries, quickly attracting significant numbers of patients and setting the scene for what later grew into the

world's first low-cost surrogacy boom.

New Kinship

Making children in these novel ways through the mediation of technology and with the addition of third parties has not been without its impact on kinship and family systems, creating new forms of relatedness and highlighting unexpected features in existing ones. Anthropologists have noted that assisted reproduction creates new conceptions not only in the procreational sense but in the imaginative and cultural sense as well. Thus, 'not only are new individuals being conceived but new conceptions of kinship and relation are also born' (Franklin, 1999, p. 163). Euro-American kinship, which is especially implicated here, since most commissioning parents come from white Western backgrounds, has traditionally been based on taken-for-granted natural facts and biogenetic connection, despite the latter constantly being reconfigured (Carsten, 2004; Edwards et al., 2005; Johnson et al., 2013; Schneider, 1980; Strathern, 2005). Strathern (1995) has extrapolated from this the idea that biogenetic kinship is fundamentally also a kind of knowledge about who is related to whom and how. Without such knowledge, the social relationships built on assumed biogenetic substance can be contingent. Medical technology, or the way people use the information it provides, has come to feed the resulting need for this kind of knowledge so that it can be used to connect people, separate them and create desired relationships (Strathern, 2005). This 'new' kinship, mediated by bio-medical and commercial interventions, has been shown variously to both challenge and reproduce, obscure and make explicit, established gender and reproductive normativity, as well as the emphasis on genetics, race and eugenics

(Carsten, 2004; Edwards, 2000; Edwards et al., 2005; Franklin, 2002; Strathern, 1992).

Charis Thompson (2005, 2009) has described what she calls an ontological choreography by means of which biological kinship can be configured in multiple ways to emphasise certain aspects and deemphasise others depending on the specific circumstances of the people involved. In her study of intended parents pursuing surrogacy in India, Daisy Deomampo observed how different views on kinship and relatedness were played out in ways that could complicate relationships for everyone involved, from personal dilemmas to disputes within the family and miscommunication between surrogacy professionals (Deomampo, 2016). Studies of surrogates and egg donors, in India and elsewhere, as well as of sperm donors, have shown that perspectives on the nature of relationships vary greatly (Daniels and Daniels, 1998; Orobitg and Salazar, 2005; Pande, 2009b). There is, Deomampo concludes, no uniform 'unique template for kinship within the context of transnational surrogacy'; rather, it is 'a complex chain of events, something located in everyday practices' (Deomampo, 2016, p. 94). In the world of opportunity of ART kinship, 'there is little now to be taken for granted' (Strathern, 1992, p. 20).

Governing access

Imaginaries of miracle babies and the promise of biomedical prowess make of surrogacy a world of opportunity where science and technology allow one to take control of one's destiny. But not everyone is convinced. Surrogacy of any kind is a category of medicine that remains highly controversial and contested despite its long

use. For many, IVF, and especially surrogacy, comes too close to playing God or creating science fiction cyborgs, while Christian pro-life groups and some religious denominations worry about the large numbers of embryos that are created, only for many of them to be discarded (Franklin, 1995, 1999, 2002; Strathern, 1992). Other cultural and religious groups may also be concerned about matters such as religious prohibitions (Clarke, 2013) or the maintenance of ethnic purity (Kahn, 2000). The rapid advance, hope and progress that are conveyed by the iconic images of gene helixes and intracytoplasmic sperm injection constitute for others an abomination and an existential threat, eugenic slippery slopes and exploitation (Habermas, 2003; Scheper-Hughes, 2002; Scheper-Hughes and Wacquant, 2002; Wahlberg and Bauer, 2012). Assisted reproduction is at the centre of debates over the nature and extent to which biotechnology is changing how we think of ourselves and relate to others through kinship, thus touching on the basic fundamentals of what it is to be human in the world and to organise ourselves as societies. By creating life and families in such novel contexts, assisted reproduction unsettles and denaturalises what constitutes not only parenthood, but also personhood, individuality and the beginnings of life, making gestation culturally ambiguous (Birenbaum-Carmeli and Inhorn, 2009; Strathern, 1992, p. 22).

Assisted reproduction has also animated the debate over human enhancement due to the option of, ostensibly at least, choosing the genetics of one's child. If in the past one had no control over the genes of one's child, and instead had to direct all efforts towards bringing up the child with tutoring, the right diet and environment in a way that would bring out the best in them (Miller, 1997), then assisted reproduction has opened up new possibilities for improving the perceived quality of one's offspring.

Whether scanning the market for deluxe gametes, sex selection and genetic testing for disease is substantially different from choosing the right school is matter of ongoing debate, probing and redefining the line between eugenics and reproductive choice and the nature and limits of human enhancement (Daniels and Heidt-Forsythe, 2012; Hanson, 2001; Sandel, 2004; Ylönen, 2016). Perhaps not surprisingly, the commercial market for gametes seems to have taken on some of the characteristics of the adoption business where demand and therefore price has always been greater for lighter skinned, healthier and younger babies (Rothman, 2000).

Some of those who broadly support assisted reproduction can nonetheless oppose access to it by certain categories of people, mainly gays, singles or older individuals (Agigian, 2004; Bryld, 2001; Melhuus, 2012; Pennings, 1995; Thompson, 2005, p. 7). Gay and single-parent access to ARTs is especially contested because of the way gay parenthood can be seen to challenge the naturalness of core heteropatriarchal institutions and the heterosexual family ideal. Even societies in America, Western Europe and Scandinavia that otherwise appear to support gay rights and women's rights have seen various forms of mobilization for the defence of the embryo from the non-normative family (Bryld, 2001; Mamo, 2007). On top of direct opposition, laws that are not intended to restrict access to assisted reproduction can also have indirect impacts. The removal of donor anonymity had at least a temporary negative impact on the availability of donor gametes in the UK (Blyth and Frith, 2008), while laws dealing with the recognition of parenthood or donor compensation are blamed for the shortage of women signing up to be surrogates in the UK (Sauer, 1997).

Such anxieties about the potential impact of assisted reproduction on society have led to widespread legal restrictions and even total bans on surrogacy and donor conception. Research on these legislative approaches highlights the tension between law's morally simplifying and universalising property as a primary technology of government and the wide range of individual attitudes towards assisted reproduction, especially in culturally and morally pluralist societies (Kroløkke, 2012; Melhuus, 2012). When it comes to assisted reproduction, advances in technology far outpace legal responses, meaning that the law is necessarily always trying to catch up with change, often being dominated by the fear of a 'slippery slope' from which there is no turning back (Warnock, 1985). As a result, regulation of ARTs has often followed the precautionary principle, where the premise that technologies have the potential to cause irreversible and unpredictable harm and must therefore be subject to strict regulation, even in the absence of evidence of such harm, guides the imposition of blanket bans in order to keep these technologies under state control (Melhuus, 2012, p. 13).

The various forms that surrogacy regulation assumes globally can thus reveal, in legislation, an account of the increasing state control and disciplining of human reproduction (Clarke, 1998). Indeed, in its articulations with biotechnology, medicine and reproduction, ART regulation powerfully demonstrates the extent to which the body has become a medium on which power operates and through which it functions to discipline and control populations. Thus, the governance of assisted reproduction can fruitfully be analysed in the context of Michel Foucault's concepts of biopolitics and biopower, which can be applied to the various strategies and techniques of intervention by governments for the governing of life processes of individuals and

populations (Foucault, 2012; Lemke et al., 2011; Rabinow and Rose, 2006; Rose, 2009).

Such attempts at control have not been without resistance. In public political activism, as well as in private choices of modes of resistance, the intended parent community emerges as a kind of biosociality, a community of shared biological characteristics (Rabinow, 1996), precisely in response to biopower, to attempts to prevent it, to prevent access to treatment, and through the efforts of intended parents to resist and circumvent these restrictions. Nikolas Rose and Carlos Novas' (2007) work on biological citizenship describes the political manifestation of biosociality in the emergence of activist communities around advocacy, care provision and shared identity for various medical conditions, and demands on the state and the general public made by such groups. Research in other contexts has shown that biopower can indeed be socially productive, as it creates the conditions of possibility for the formation of identities and communities of resistance, such as deaf communities (Friedner, 2010), parents of children with disabilities (Rapp, 2004) or people living with HIV/AIDS (Comaroff, 2007; Nguyen, 2005). It is important not to overstate these developments. Aditya Bharadwaj (Bharadwaj, 2008), on the basis of his research on Indian fertility patients, argues that a biological condition can only lead to the development of a politically active identity under very specific privileged conditions that do not apply to many, if not most, subjects. For most people, he argues, entering the realm of biomedicine as patients is a matter of becoming bioavailable for the medical industry with limited agency. In this scenario, biosociality is less about identity issues and more about demands for and the pursuit of treatment and resolution. Still, activism and resistance have seen the circle of people who can

access parenthood and reproductive care widen gradually in most countries, shifting the goal of assisted reproduction to ‘making parents rather than making babies’, in line with an increasing emphasis on reproductive privacy more generally and rights to family life (Thompson, 2005, p. 7).

Crossing borders

Due to this regulatory environment, many continue to lack access to surrogacy in their home countries. For them, the activist framing of state regulation as oppressive and discriminatory and resistance as morally acceptable - even laudable - has been crucial in opening up a new path to parenthood: cross-border reproductive care in countries where these procedures are legal and/or accessible. The decisions of large numbers of people to take back control over their reproductive lives by contracting surrogacy and donor conception abroad has facilitated the development of widespread reproductive travel (Pennings, 2002). Its drivers extend beyond restrictive regulation and are varied, complex and intertwined. Restrictive regulation is common, but so can be the lack of regulation and thus legal protection, religious and ethical restrictions, the unavailability of specific services or equipment, the availability and affordability of donors or surrogates, the cost and level of care, and privacy concerns (Blyth and Farrand, 2005; Brazier et al., 1998; Deech, 2003; Inhorn and Patrizio, 2009; Pennings, 2002).

Surrogacy has become a part of the growing field of medical tourism (Connell, 2006; Wilson, 2011), though this term is contested. While those critical of the phenomenon like to use the term ‘tourism’ to highlight its consumer emphasis on five-star hotels,

private hospitals and sightseeing, others consider tourism to be an inaccurate representation of the realities of the financial and emotional stress of reproductive travel, arguing that cross-border reproductive care or even reproductive exile are better terms (Inhorn, 2011b; Inhorn and Patrizio, 2009). The role of the Internet is crucial in facilitating such travel, both as a source of information and as the actual site of the existence of many surrogacy brokerage services (Berend, 2016; Shenfield et al., 2010). State governments have employed various methods, from prosecution to the denial of citizenship for the child, to restrict reproductive travel, a complex challenge and often a losing battle in an increasingly globalised world (Knoppers and LeBris, 1991; Kroløkke, 2012).

As intended parents cross borders in search of fertility care, they join other global flows of technology, expertise and finance to become part of what Inhorn, building on Arjun Appadurai's (1996) language , has called a complex 'reproscape' – a kind of meta-scape combining numerous dimensions of globalization and global flows:

> reproductive tourism occurs in a new world order characterized not only by circulating reproductive technologies (technoscapes), but also by circulating reproductive actors (ethnoscapes) and their gametes (bioscapes), leading to a large scale global industry (financescapes), in which images (mediascapes) and ideas (ideoscapes) about making lovely babies while 'on holiday' come into play. This reproscape entails a distinct geography traversed by global flows of reproductive actors, technologies, body parts, money, and reproductive imaginaries (e.g., the birth of 'miracle' babies) (Inhorn, 2011b, p. 87).

These reproscapes, of which surrogacy is an important part, are becoming ever more complex, as socioeconomic change, migration and political processes weave constantly shifting trajectories for both consumers and providers. While much of the

travel happens between wealthy Western nations and less developed economies of the global south, alternative trajectories also exist, such as return travel by members of a diaspora to receive treatment in their country of origin, in addition to travel to the US, where surrogacy is expensive but widely available, by elites from all over the world (Hudson and Culley, 2011; Inhorn, 2011a; Whittaker and Speier, 2010).

What is reproduced?

The focus on miracle babies downplays the role of gender and class inequalities in surrogacy arrangements (Inhorn, 2011b). Indeed, while the US remains a popular fertility destination for those who can afford the prices, there has been an increasing move towards low-cost destinations in Eastern Europe, Russia, Asia and Africa. Third-party assisted reproduction, with its high labour costs and regulatory challenges, was always going to be attractive for global outsourcing, and today it is indeed not uncommon to have the egg donor come from South Africa, the sperm from the intended parents in, say, the US or Australia and the surrogate from somewhere in Asia or Eastern Europe. Patterns in the dynamics of which groups predominantly provide the reproductive labour of these arrangements and which groups receive the majority of its benefits have not gone unnoticed.

Human reproduction, even in its biotechnological form, relies on the bodies and labour of women. Many scholars have noted how, even without third-party involvement, assisted reproduction can work to essentialise women's bodies as a site of reproduction, commercialise women's reproductive capacities, overemphasise women as natural reproducers and shift control over women's bodies to the

patriarchal medical establishment through IVF technologies (Dahlem, 1992; Gupta, 2006; Lieber, 1992; Martin, 2001; Raymond, 1993; Robertson, 1996; Rothman, 2000; Storrow, 2005b).[4] Assisted reproduction involving third parties as reproductive labour, as in egg donation and surrogacy, has given rise to concerns about dystopian futures in which some classes of women are turned into a breeder class for the elite (Atwood, 1986; Busby and Vun, 2010; Corea, 1985; Roberts, 1998).

The rise in male gay couples using egg donor surrogacy to have children has further fuelled the discussion of this problematic, given the stark contrast between wealthy Western men and the underprivileged women who carry their babies in exchange for a long shot at a better life (Cory, 2015; Riggs and Due, 2010). Others, however, see gay surrogacy families as a positive feminist development that works to separate the biological and social roles (Cory, 2015). This highlights how the feminist response to surrogacy has been all but uniform, with many scholars pointing out that to insist on speaking for all women in opposing surrogacy is paternalistic and inconsistent in its implication that those who enter surrogacy arrangements are incompetent to make decisions about their own bodies and reproductive lives, contradicting the crucial stance that women have both the right and the ability to control their own bodies (Bailey, 2011; Jackson, 2001; Macklin, 1988).

Transnational surrogacy is also imbued with problems of racism,[5] as race-based inequalities often provide the business with its producers as well as its consumers.

[4] See (Inhorn and van Balen, 2002) for a detailed account of the development of feminist discourses in relation to assisted reproduction.

[5] Race is both a problematic and a complex term. I use it here, rather than alternatives like ethnicity, to reflect usage by the authors I cite and to highlight the political and historical context of surrogacy debates.

Worldwide, even domestic reproductive markets see patterns of darker-skinned providers of reproductive services and lighter-skinned consumers, a distinction even more pronounced in global markets (Harrison, 2016; Speier, 2016). While some of that distinction is down to class, race plays a major role independent of class as well. Indeed, comparing surrogacy markets to those of egg donors highlights the way race and genetic essentialism interact in assisted reproduction. It was the severing of the genetic link between the baby and the surrogate that has facilitated the cross-racial and global spread of surrogacy:

> As a result of the advent of gestational surrogacy through in vitro fertilisation, the surrogate, no longer a genetic contributor to the child, need not match the characteristics or desires of the intended parents, including their race and ethnicity. This means that according to contemporary racial logic, women of colour who act as surrogates for white families are sharing a biological connection (the 'environment' of the womb and more) with the fetus, while still giving birth to babies who are understood to be white (Harrison, 2010, p. 5).

The thinking behind gestational surrogacy is simple: if a child inherits its genetics from the egg donor, then it is important to make sure that donor is of the best possible stock so that genes of intelligence, health and good looks can be passed down. The surrogate, by contrast, who is seen to have no lasting contribution, simply needs to be able to carry a pregnancy to term. In such understandings, cultural meanings and symbolisms of the gene become conflated with scientific knowledge to form a genetic essentialism where DNA becomes framed as the sole arbiter of the 'true self' (Nelkin, 2004). As long as the genes are desirable and white, so are the children.

As a result, egg donors are often recruited from college campuses and chosen for

good looks, talent and achievements, whereas surrogates tend to come from lower income, less educated backgrounds (Deomampo, 2016; Harrison, 2010, 2016). Globally, ova markets tend to develop in locations where the desired (generally lighter-skinned) phenotypes are widely available. Thus, the race to the bottom that has dominated the spread of surrogacy markets (Bailey, 2011; Jackson, 2001; Macklin, 1988) is kept in check by geographical limitations on where fair-skinned donors are available, with low-cost ova markets ending up mainly in South Africa and the post-Soviet bloc of Eastern Europe (Cooper and Waldby, 2014). The result of these dynamics is what Daisy Deomampo has called ‘racial reproductive imaginaries’, framings of the world where different categories of people are seen to have different naturalised roles in reproduction (Deomampo, 2016, p. 4).

Due to the lack of a genetic link to the child, therefore, gestational surrogacy does not fall within the same recruitment and market limitations of race, appearance and education that egg donation does, allowing markets to spread to wherever the prices are lowest and regulation most absent (Schurr, 2016). If anything, the racial difference between the surrogate and the intended parents can be welcome and emphasised. ‘Intended parents Other the nation of India and Indian women’s bodies as excessive, exotic and fundamentally different in order to naturalise kinship narratives that normalise this means of family formation’ (Harrison, 2010, p. 182). Media accounts often use representations of excessive Indian fertility against deserving but barren western parents to argue for the benevolence of the practice, its inherent fairness and acceptability.

More specifically, the surrogate’s racial difference from the foetus (and her attendant

class difference) also evidences her status as a temporary caregiver, a reproductive labourer without a valid claim to kinship (Harrison, 2014, p. 155; Ragoné, 1998). In cases where the citizenship and national belonging of surrogate children come into question, such details can become crucial. In one example, Krolokke (2012) has documented how presenting her Indian-born surrogate children as fundamentally different from the country, people and culture of India helped a Norwegian woman bring them home against Norwegian law. The case sheds light on the complexity and fluidity of race in these scenarios: the children were successfully framed as out of place and too frail to live in India, despite an Indian egg donor and surrogate having been used.

While the comparison of egg markets and surrogacy markets is useful for their revealing contrasts, race also interacts with ART markets in more subtle but equally potent ways. In fact, as Daisy Deopampo (2013) has observed in Indian transnational surrogacy, even positive representations of race can serve to other and exoticise Indian women, culture and society in a way that justifies the inequalities of transnational reproduction and reinforces their place as the rightful parents. Equally, issues of race can be coded in seemingly innocuous talk of likeness and difference. The intended parents could become very attached to their baby's Indian origin story, but in a romanticised and exoticising way that flattens it out, positioning it as opposite to Western sensibilities (Deomampo, 2013). This is another point at which transnational surrogacy has come to resemble transnational adoption (Fonseca, 2011; Frekko et al., 2015; Howell, 2006). Deomampo (2016) has argued that such 'racial reproductive imaginaries' are crucial, as they allow consumers to envisage their reproductive endeavours in ways that conceal the operation of race while

benefitting from it.

Surrogacy is no doubt a highly gendered and racialized trade, but it is important to note that women of all colours may be its consumers as well as its producers. Older women can use sperm donation surrogacy to bypass the need for a man and overcome the limitations age sets on female fertility, while African-American intended parents commission surrogacy from low-cost destinations, and wealthy Chinese elites increasingly travel to the US for surrogacy. All these groups will receive treatment as long as they can pay for it. It is hard to overstate the extent to which access to assisted reproductive technologies, domestic or international, is for all groups highly mediated by income and socioeconomic class, with other factors, such as race, gender and age, being important mainly for their impact on income. The consumers of assisted reproductive technologies tend to come from middle- and upper-class backgrounds, have lighter skin and live near urban centres, whereas the providers of fertility services – the surrogates and egg donors – tend to be of lower socioeconomic backgrounds. Barriers of price, location and awareness mean that 'some individuals, communities and nations have had better access to the fruits of reproductive globalisation than others' (Inhorn, 2011b, p. 91).

Baby trafficking, or a beautiful gift?

Despite the practice being deeply rooted in socioeconomic inequality, proponents and professionals of commercial surrogacy systematically play down the significance of money. The insistence on altruistic motivations may be a part of the effort to dispel unease over the interests and welfare of children being birthed and handed over in

such highly commercialised exchanges. The impact of surrogacy on children is a debated matter even in altruistic arrangements. Ethicists and social scientists have raised concerns over the psychological impact on the children of some forms of assisted reproduction, especially surrogacy and gamete donation (Crawshaw et al., 2017). The idea of women premeditatedly giving up babies sits uneasily with much public and academic opinion because it challenges the concept of unconditional maternal devotion. Elly Teman (2008) has shown how even surrogacy research approaches its subject matter as an anomaly, assuming that normal women would not become pregnant with the intention of relinquishing the child at birth. Constructions of motherhood devalue surrogate women as failed mothers for giving away the children they give birth to even as they simultaneously value their work as surrogates (Riggs and Due, 2012). Approaching surrogacy from the perspective of the best interests of the child also raises additional issues concerning the consent of the child and the disclosure of information about their heritage (Readings et al., 2011; Roberts, 1993).

When babies are handed over in an extremely commercialised market context, then the arrangement begins to intersect with concerns over baby-selling and human-trafficking (Davies, 2017; Hanna, 2010; Spar, 2006). Indeed, Western notions of the immorality of money mean that commercial transactions around children and motherhood are met with discomfort and suspicion (Howell, 2003a, 2006). The distinction between gifts and commodities has a much older and broader history in philosophy and social science. It is important to note here some of the ways in which this intellectual history feeds into contemporary debates about the nature of the relationship between the providers and the receivers of human biological substance

in which surrogacy is entwined.

Bioethics discussions regarding surrogacy often conclude that only a purely altruistic gift relationship is acceptable and that any monetary remuneration will carry both direct threats of exploitation and broader social consequences of the devaluation of human dignity. Such analyses pick up from previous debates around the use of human bodies to increase the vitality of others, the most influential of which is perhaps Richard Titmuss' extensive comparative look at the procurement of donor blood (Titmuss, 1970). Titmuss, an advocate of the welfare state, makes a powerful and resonant case for altruism in blood donation by arguing that sharing between the citizens of a nation is a crucial part of the broader collective social values that must be kept away from market forces.

Much of the elevation of the gift relationship above that of commodities in moral and social terms rests on the premise of the gift as the antithesis of self-interested commercial exchange, a purely altruistic and benevolent act. Anthropologists have complicated this premise and the assumptions behind the separation of gift and commodity, together with the moral values attached to each. They have highlighted the way gifts can equally be part of elaborate economic systems of reciprocity and prestige (Gregory, 1997; Malinowski, 1926; Mauss, 2016; Strathern, 1988) or in fact carry consequences of social debasement, ritual impurity, condemnation or asymmetrical dependence if left unreciprocated (Parry, 1986; Raheja, 1988).

Despite such arguments, altruism remains for most the morally superior format, and commercial arrangements are viewed with suspicion and concern. To counter any moral uncertainties or perceived judgements about what they are doing constituting

baby-selling, those involved in surrogacy, whether as surrogates, intended parents or professionals, downplay the commercial aspects of surrogacy and emphasise altruistic motives. Surrogacy is framed through a selfless or altruistic idiom, as the ultimate gift of love (Ragone, 1994). Even surrogates who openly discuss their financial motives can see themselves similarly as being on a heroic journey to give someone else the gift of motherhood, detaching themselves from the pregnancy and shifting it to the intended mother through a bond of friendship (Teman, 2010). Amrita Pande (2011) has observed a similar emphasis on gift and sacrifice in Indian surrogate mothers, who negotiate the anomaly of surrogacy by emphasizing their altruistic motivations towards the intended parents and the sacrifice they are making for the benefit and future security of their own children.

In light of the layered and complex inequalities that create the conditions of existence for global low-cost surrogacy markets, notions of friendship and gift between the providers and recipients of babies come to look more suspect. Marilyn Strathern has noted the way discourses of altruism can work to distort the dynamics and processes at play and that ‘the language of the gift conceals the commodification of the body’ (Strathern, 2012, p. 401). Indeed, the report of a government-commissioned investigation into surrogacy payments in the UK discovered that, despite a legal and discursive insistence on altruism and the exclusive remuneration of pregnancy-related expenses only, average sums paid out to UK surrogates within the altruistic system were not drastically different from those paid to US surrogates in the context of a fully commercial system (Brazier et al., 1998).

Importantly, there is no evidence to support the belief that a relationship based on

altruism is somehow a guarantee against exploitation. In fact, various court cases have shown the lack of binding contracts to be a source of potential vulnerability for surrogate women (Sama, 2012). ‘The ethical insistence that the biological should not be waged only serves to facilitate atavistic (yet fully functional) forms of labour contract and desultory forms of compensation’ (Cooper and Waldby, 2014, p. 7). The bioethical insistence on non-commercialisation has, according to Cooper and Waldby, placed clinical labour – under which they also place the reproductive labour of surrogacy (see below) – under an exceptional regime of labour that justified various important exemptions from the standard protections of twentieth-century labour law.

The moral stigma of commercialised biolabour has been felt most strongly in the reproductive industries, namely surrogacy, where economic need is framed as an alarming, culturally illegitimate reason to carry a child. The notion of women receiving remuneration for their reproductive abilities already leaves them positioned as morally suspect in the eyes of the public (Cannell, 1990; Markens, 2007; Pande, 2011). As a result of the expected ideal of altruistic motivation, surrogate women are limited in their capacity to negotiate wages and challenge contracts due to the threat of being portrayed as greedy, heartless monstrosities. The discourse of altruism and gift can thus be one of the further disenfranchisement of surrogate women by denying them the protection of contract and negotiation. The beautiful gift of motherhood, in its interactions with multi-layered complex inequalities, can thus become a vessel for further exploitation.

Labour between biology and intimacy

The shortcomings of the gift metaphor and the framework of altruism in understanding the global commercial industry that is surrogacy have led to the latter becoming part of research on labour. Scholars in this field argue that, rather than looking at human bodies as commodities, which is often the way alternatives to altruism are presented, we might be better off approaching surrogacy as a kind of labour (Pande, 2014; Vora, 2015). But what kind of labour?

The socioeconomic and gender dynamics of reproductive markets – their tendency to employ low-income young women with few alternative income options and to serve the needs of predominantly white men, entailing implications of exploitation and escaping global regulation – have provoked comparisons to global markets in prostitution (Boris, 2010; Sera, 1996; Storrow, 2005a). Any lines between surrogacy and prostitution need to be drawn with care, not only because the two businesses are, for all the similarities discussed here, fundamentally different, but also because comparisons with prostitution can be used to stigmatise surrogate women as sex workers, as is sometimes the case in India (Pande, 2010).

But these parallels nonetheless highlight the broader economies within which surrogacy exists and possibly also to which it belongs analytically, where the worlds of rich and poor are invisibly bound through chains of care, of emotional, physical and intimate labour, that fill the need for nurture, domestic work and sexual services (Ehrenreich and Hochschild, 2004; Hochschild, 2011, 2012; Parreñas and Boris, 2010). Ehrenreich and Hochschild trace the spread of this care-work economy in the

care-work deficit left in Western households once women entered the formal workforce, while men refused to pick up their share of domestic chores that the women were no longer able to perform. This gap has been filled by low-waged female migrant workers:

> The globalization of childcare and housework brings the ambitious and independent women of the world together…it does not bring them together in the way that second-wave feminists in affluent countries once liked to imagine — as sisters and allies struggling to achieve common goals. Instead, they come together as mistress and maid, employer and employee, across a great divide of privilege and opportunity (Ehrenreich and Hochschild, 2004, p. 11).

This new global division of labour, the authors argue, is a scaled-up version of a much older division of labour between men and women within the household. The West has taken on the role of the old-fashioned male – entitled, pampered, unable to care for himself, and dependent on the female role of the self-denying, nurturing and patient migrant workers from poorer regions (Ehrenreich and Hochschild, 2004).

But who will care for the reproductive futures of the women who make up the production line of these reproductive markets and nurture their families? Several authors (Colen, 2009; Hochschild, 2000; Parreñas, 2002) have traced these care chains to their less visible end, to where, in distant villages thousands of miles away, the families and children of migrant care-workers are left to bear the emotional and social costs of such migration. Colen saw in the transnational commodification of childcare work a window ‘in which global processes are evident in local, intimate, daily events, and in which stratification itself is reproduced, as childcare occurs across class lines, kin lines and oceans’ (Colen, 1995, 2009, p. 78). Colen’s concept of ‘stratified reproduction’ (Colen, 2009, p. 380) captures the way access to physical

and social reproduction is mediated by hierarchies of class, race, gender and migration status, granting some groups access to opportunities to parent, while denying them to others. Rayna Rapp and Faye Ginsburg (1995a, p. 3) developed the concept further in their work on reproductive inequality and have expressed it as ‘arrangements by which some reproductive futures are valued while others are despised’. This starker definition is especially powerful in understanding low-cost surrogacy in India, where the business of making babies for wealthy foreigners has developed in the context of, and sometimes out of the expertise and technology of, efforts to control the reproduction of lower-class Indian women through often coercive sterilisation campaigns (Pande, 2014).

What emerges from analyses of these various intimate, emotional and reproductive markets is a kind of racialized and gendered economic precarity that drives its assembly line. It is not that the technology itself is inherently racist or elitist. Rather, when intended parents confront its possibilities within structures of racial and socioeconomic inequality, their actions end up foregrounding with particular clarity the broader social forces and ideologies that make up the context of global surrogacy. The way issues of race and class overlap and become intertwined in assisted reproduction is a reflection of, and an insight into, the ways these two spheres of inequality reproduce each other on both domestic and global scales (Ginsburg and Rapp, 1995b; Harrison, 2016). As such, analysing low-cost outsourced surrogacy presents new challenges as well as opportunities for feminist scholars due to the interaction of gender and class in the multilayered relationships of power within which surrogate women and the other actors that make up the

industry live (Gupta, 2006; Ryan, 2009).

Labouring Bodies

Representations of surrogacy by the industry, as well as the treatment of surrogate women and their exclusion from meaningful connections with the families they help create, work to reduce the practice down to a simple biological function of reproduction. This view situates surrogacy in the context of theoretical approaches – expressed variously through concepts such as biovalue (Waldby, 2000, 2002), life as surplus (Cooper, 2011), biocapital (Franklin and Lock, 2003; Rajan, 2006) or bioeconomics (Rose, 2001) – that seek to understand the connection between biotechnologies and capitalist world systems. These concepts all describe bioeconomy as a vast and growing field of research, industry and politics that involves anything from genetics and agriculture to defence and pharmaceuticals. There are important differences in these approaches (Birch and Tyfield, 2013; Helmreich, 2008), but they all take as their starting premise some idea of an emerging public and private enterprise geared towards the accumulation and extraction of latent value in biological matter or processes in the forms of genetics, cells and tissues.

The economic promise of biotechnology is of crucial importance to the survival of a growth-oriented industrial capitalist system that is coming up against the limits of growth set by the limits of the planet and our environment (Cooper, 2011). Biotechnology is one of the key technologies (another being space exploration) touted by post-industrial thinkers, and thereafter also by general neoliberal orthodoxy, to provide a solution to both economic decline and environmental crisis by

‘internalising, and thus overcoming, all limits to growth – from the waste products of industrialism to the very finitude of the earth’ (Cooper, 2011, p. 18). As those limits have become ever more pressing, biotech industries have taken over as the primary field of expansion. As a result, the biotech revolution, according to Cooper, is the result of a whole series of legislative and regulatory measures designed to relocate economic production at the genetic, microbial and cellular level, so that life becomes, literally, annexed within capitalist processes of accumulation’ (Cooper, 2011, p. 19).

One way of approaching surrogacy, then, is as a case study of these emerging ‘markets in life’, a line of analysis offered, in the Indian case, by Sharmila Rudrappa (2015). The aim of biotechnology ‘to gain traction in living processes, to induce them to increase or change their productivity’ (Waldby, 2002, p. 310) resonates powerfully with IVF with its roots in industrial farming and prominence in the medicalised management of human fertility. Indeed, the human biological body has become a crucial site of these developments, having been transformed by contemporary medicine into a source of instrumental and commercial value (Campbell, 1992). The surplus value created in the bioeconomy, or biovalue in Waldby’s terms, can take the form of either intellectual property or the vitality of consumers as

> [...] a surplus value of vitality and instrumental knowledge which can be placed at the disposal of the human subject. The surplus value is produced through setting up certain kinds of hierarchies in which the marginal forms of vitality—the foetal, cadaverous and extracted tissue, as well as bodies and body parts of the socially marginal—are transformed into technologies to aid the intensification of vitality for other living beings. (Waldby, 2000, p. 19)

Recognising these patterns links theories of bioeconomy to class hierarchies in surrogacy, where women use their reproductive capacity or vitality to aid that of

others in a form of unskilled embodied labour. A focus on gestational surrogacy as a ‘miracle of technocratic medicine’, a term coined by Leslie Sharp in relation to organ donation (Sharp, 2006, p. 9), obscures the fact that, both as a technology and as an establishment, it still relies in huge part on human bodies and human labour, most obviously surrogate women, but also doctors, embryologists, nurses and lawyers, only coming alive in the human networks that operate it and that it in turn operates on.

Surrogate women, egg donors and the other socially marginal labouring subjects of this new global market are variously referred to in its different forms as biolabour (Fumagalli, 2011), clinical labour (Cooper and Waldby, 2014), reproductive labour (Rudrappa, 2015) or experimental labour (Cooper, 2008). These new forms of employment, ‘the way in which the in vivo biology of human subjects is enrolled into the post-Fordist labour process, through either the production of experimental data or the transfer of tissues’ (Cooper and Waldby, 2014, p. 7), are becoming increasingly important in the global expansion of biotech industries. Indeed, hiring out or selling the biological regenerative capacity of one’s body for wages is a broader and growing phenomenon that follows the same divisions of class and race as surrogacy (Cooper, 2011). Other examples of biolabour include participation in clinical trials (Cooper, 2008; Petryna, 2007, 2009), the sale of tissues or blood (Mitchell and Waldby, 2006; Rosemann, 2011), the provision of sex cells (Almeling, 2011; Cooper and Waldby, 2014; Waldby, 2008) or, most controversially, the sale of organs (Cohen, 1999; Scheper-Hughes, 2002). This literature highlights the extent to which these different industries vary in their approach to this labour, but also how their interactions with local and global racial, gendered and socio-economic inequalities

run across industry lines. Women's reproductive labour is in especially high demand due to the need for embryonic tissue in stem-cell industries on the one hand and the assisted reproductive markets on the other (Waldby and Cooper, 2008, 2010). Biolabour is very different in nature and in remuneration to the labour of the various experts and specialists involved, for it does not rely on skills or knowledge but on embodied human biological capacities, tissues and processes.

The subjects of biolabour are, in a curious apex of the theory of neoliberal human capital, encouraged to think of themselves as entrepreneurs of their own biological capacities. Following Foucault, 'in this model, the wage labourers are no longer the employees dependent on a company, but are autonomous entrepreneurs with full responsibility for their own investment decisions and endeavouring to produce surplus value; they are the entrepreneurs of themselves' (Lemke, 2001, p. 199; Rose, 1998). Such framings deemphasise or even justify the reality that biolabour rarely if ever constitutes secure employment.[6] Instead, it is recruited contractually as and when there is demand, is underpaid and is made to suffer the risks of biomedical innovation without a stake in its intellectual property:

> ...the life science business model is organised around a classical (Lockean) labour theory of value which identifies the cognitive labour of the scientist as the technical element necessary to the establishment of intellectual property in living matter. [...] In this account, the bodily contribution of tissue providers and human research subjects appears as an already available biological resource, as res nullius, matter in the public domain (Cooper and Waldby, 2014, p. 9).

The same patterns have been observed in assisted reproduction, especially its

[6] In their discussion, Cooper and Waldby (Cooper and Waldby, 2014) place the emergence of biolabour firmly in the context of an overall move towards labour precarity. See (Standing, 2011) for a detailed discussion of the precarization of work.

global low-cost forms, where the doctor and the broader technocratic medical establishment is credited with the birth of the baby and any gamete donors or surrogates often all but erased (Bharadwaj, 2000; Inhorn, 2011b). Such treatment of people in biomedical industries as effectively ‘dumb biological materials’ (Cooper and Waldby, 2014, p. 9) has made some scholars interpret what is happening more as the extraction of reproductive resource (Nahman, 2013) or the transfer of vitality (Vora, 2015) than as labour.

For surplus life or vitality to be extracted into the bioeconomy, it first needs to be defined as such and potentialised (Vora, 2013b) for marketing and consumption. It is the market that has come to define aspects of the human body and its biological capacities as surplus. According to Lesley Sharp, in the US the definition of brain death was constructed in direct response to the need for brain dead individuals’ organs to be harvested in hospitals so they could be used to save other lives without ethical and legal objections (Sharp, 2006). Such designations of waste play a central role in the circulation of human tissues through for-profit laboratories because identifying them ‘as valueless or dangerous before their entry point into the revivifying space of biocommerce is a crucial move in securing the intellectual property rights and profit margins of the biotechnology industry’ (Mitchell and Waldby, 2006, p. 29). Equally, the second kidney in living humans only becomes ‘extra’ or ‘spare’ (Vora, 2015) in the context of a demand for them – desperate for those who lack them, and lucrative for those who trade in them – as potential donor kidneys in the bioeconomy. Central to the harnessing of Indian labour and vitality has been the colonial idea that India has surplus reproductivity that can be used for economic gain (Vora, 2015). It is in such dynamics that the connection between ideologies of race

and class and the global realities of stratified reproduction interact with commercial markets to naturalise and justify bioeconomic arrangements as beneficial for all.

Kalindi Vora, who has used the emergence of biolabour, namely surrogacy, to point to the dehumanising ways in which outsourced labour is treated in other economies, shows that the distinction between humans as labour and as biological resource, or biolabour, may not be empirically useful (Vora, 2015). Her examples of Indian IT engineers and call-centre agents show how outsourced labour can work to extract vitality as emotional or low-level professional labour in similar ways to surrogacy. Human biological processes are for Vora merely the latest edition of the exploitative nature of outsourced labour: 'The conditions, technologies and sensibilities that engendered outsourcing have become more complex and have extended in ways that have enabled the rise in markets in biological commodities and services' (Pande, 2016; Vora, 2015, p. 2). In a similar vein, the Indian surrogate women in Sharmila Rudrappa's account found the work of surrogacy, for all its faults, to be better remunerated but also personally more meaningful to them than their experiences in the only alternative available – the outsourced garment industries (Rudrappa, 2015). Surrogacy in countries like India, then, is tightly enmeshed in broader local and global structures, dynamics and histories that have created the conditions for its existence. Within such realities, biolabour, factory work, care work and even professional employment all stand as different expressions of the intersection of global inequality and capitalism.

The arguments raised by Vora and Rudrappa speak to emerging criticism of the growing range of bio-concepts and their fetishisation of everything 'bio'. Kean Birch

and David Tyfield (2013) have argued that STS scholars like Cooper and Waldby have adopted Marxist terminology, such as value and surplus, without adequately addressing their original formulations, nor accounting for the increasing financial and economic restructuring of the economy. In short, Birch and Tyfield conclude that these theories do not make clear the need for a specific 'bio-' prefix for the understanding of emerging life-science industries. They go on to argue that the focus on capital, value and labour obscures the more important insight from these industries – that they are underpinned by a rentier regime where the value generated by the bioeconomy is not in revenues from the sale of commodities, but in the financial asset value of knowledge and the resulting intellectual property.

Arguably, this latter point does not apply to commercial surrogacy, where the industry is focused on producing babies as commodities, rather than on assets in intellectual property, as evidenced by the fact that the clinics and mostly also the surrogate women are paid extra for the delivery of multiples. Cooper and Waldby's (2014) appreciation of both the mining of intellectual property and the sale of biotechnological commodities is thus more applicable to commercial surrogacy, an industry that still relies on human bodies to make its product. This does not make the criticism of Birch and Tyfield irrelevant to this thesis, however. If anything, it might point to the problem that prominent bio-concepts are too broad to be analytically useful. Alternatively, perhaps we need to reevaluate whether commercial surrogacy indeed belongs in this category. As this thesis suggests, tempting though it is to think of the creation and gestation of babies for money as an example of the kind of extraction of latent vitality that these theorists of bioeconomy and biocapital describe,

this might not in fact be the case.

Conclusion

The success of industries that combine biotechnology, marginalised populations and industry is its combination of something old and something new: colonial histories of the exploitation of undervalued labour in economies such as Indian tea plantations or Atlantic chattel slavery, or more recently in migrant care-workers or the global sex trade, have become reanimated and reimagined through the possibilities afforded by globalisation and biotechnology (Vora, 2015). Low-cost outsourced surrogacy, with its regulatory and labour-cost race to the bottom, finds a place in these uncomfortable histories even as it orients itself towards the speculative futures of progeny and wealth. For all its curiosity, surrogacy may not be either as new or as scandalous as it appears. In many ways it is a fresh, biotech-mediated iteration of an older and broader dynamic whereby the vitality and the emotional and biological capacity of low-income women is put to use to raise the standards of living of local and global elites. Nonetheless the bioeconomy is a new frontier of the exploitation of disenfranchised bodies for the benefit of powerful bodies that therefore deserves attention in its own right. The fresh market shape that this old dynamic is assuming, as well as the various actors, subjects and discourses it creates in tandem with globalisation and biotechnology, is what this thesis seeks to explore in the context of reproductive outsourcing to India and beyond. Looking at bioeconomies through surrogacy's entrepreneurs can also work to foreground cultural values and beliefs that become materialised in the uses to which assisted reproductive technologies are

being put, holding up a mirror to both its producers and its consumers.

The emerging global assemblages (Ong and Collier, 2008; Sassen, 2006) of the bioeconomy can be both open-ended and brimming with the unexpected: revealing of new lucrative extractive markets, but also of shifting global relations, biopolitics and human trajectories in the making. As Cooper (2011, p. 4) concluded, drawing on the work of Kaushik Sunder Rajan, 'The politics of a country such as India, with its unique history of drug production and patent laws, bring an end to the idea that the emerging biotechnologies of the 21st century will be organised around rigid dividing lines between imperialist winners and postcolonial losers'. While many of the surrogacy industry's outcomes were predictable from its histories, the processes of bioeconomic futures are by no means a mere extension of the past. Moreover, if the techno-scientific representations of surrogacy work to reduce reproduction to biology, the challenges of the industry that are outlined in this thesis, to which I now turn, show that the task of disentangling conception from care, intimacy and emotion are far from being achieved.

Part I. Wombs for rent

3. Bodies and Persons

‘the invisibilising... They invisibilise the entire body of her. I mean, the entire woman! They talk about just her body and how her uterus is et cetera... (women’s health activist from Sama, interviewed August 2015).

‘I see her shape and his hand in the vast networking of our society, and in the evils and oversights that plague our lives and laws’ (Gordon, 2008, p. 6).

Introduction

‘You want to meet the surrogates? Make sure they are taken care of and everything? No problem!’ said Amit enthusiastically, as he got up from his large black leather chair, his small, young, smartly dressed frame emerging from behind tall piles of document folders and post-it notes. I had, in fact, not asked about the surrogates. I had not asked about anything. But as I had by now realised, people in the Indian surrogacy business had learned through news articles, researchers and journalists, as well as through interactions with their clients, exactly what it was Westerners wanted to know. They also knew about the criticism that the treatment of surrogates in Indian clinics was subjected to in the West, as well as the concerns of potential clients over the medical and living conditions in which their babies were being gestated. Each clinic and agency I visited insisted that they were the exception and cared well for surrogate women. Clinics would arrange long, if highly sterilised tours of facilities for me where they could promote their business while making sure I never set my eyes or ears on anything outside the script.

Indeed, Amit refused my request for extended fieldwork at his agency and hostel, but was nonetheless determined to show me around his discreet operation on the outskirts of Mumbai. I soon found myself on a tour of the well-concealed suburban house that was home to dozens of surrogate women during their stint in the global bioeconomy. As I followed Amit from the office part of the building into the dormitory, the feel of the place changed from a business to a strange kind of domestic space. The walls here were covered in stained white paint interspersed with cheerful children's drawings: 'You can't help it with kids around, so we just gave up trying to clean it!' said Amit with a smile. He did not seem to mind. We squeezed past racks with colourful flowing sarees drying on them and made our way downstairs. It was darker and warmer there, with the relentless whirl of ceiling fans in place of the air-conditioning. It was almost eerily quiet, a combination, I thought to myself, of the ill fortunes of the surrogacy industry at the time of my visit and the hot afternoon sun having chased everyone into their rooms for a nap under the cooling breeze of those same humming fans.

Amit walked down the hallway, stopping every now and again to knock on doors. Surrogate accommodation here looked little like the rows of beds in large shared dormitories that are often portrayed in the media and that I myself had witnessed elsewhere. Most surrogates had their own room or shared a double. The rooms were basic but comfortable, indeed likely more so than the housing many of these women normally resided in. Each room was equipped with TV sets to help the women ward off boredom during their long and isolated stay here. When a woman came to the door and invited us in, Amit told me a few words about her: how far along her pregnancy was and who the child would go to. He then turned to the woman and

asked questions in Marathi. The woman nervously smiled and nodded. Amit turned to me and exclaimed: ‘see? They are happy!’ and continued on along the corridor, only to stop at the next door and replay a version of this odd routine. A few of the women had young children with them, some had visitors. These things were pointed out to me as further evidence of the good care these women received. Amit pointed to a bottle of Coke on a bedside table: ‘If they want a Coke or some snacks, then we bring them, everything we bring them; they live like royals.’

As we reached the end of the row of rooms and Amit disappeared for a moment to arrange for us to visit the kitchen, I looked around me in the long dark corridor, where door after door led to a small room with a bed, a table, a small television and a woman alone sitting on a bed waiting for her next hormone shot, next set of medication, next invasive and uncomfortable scan. I let the word ‘royals’ echo through my mind and bounce off the walls of this strange place and realised I had entered the world of what Sharmila Rudrappa (2015) has called the ‘production line’ of global markets in life.

These were the surrogate women I had been trying to speak to. I had finally managed to get inside these walls, and for a moment all watchful eyes were busy elsewhere. As I waited, I suddenly got the urge to seize this opportunity, break protocol, open that first door again and ask from the woman inside all the questions I had. I did nothing of the sort and instead just stood there. I could have opened the door, but the wall separating me from the woman behind it would have stood as firm as ever. On a practical level, we did not share a common language. More importantly, we both knew that her place in the reproductive market and any hopes of

accessing its rewards to break out of a life of chronic economic precarity was contingent on her obedience to those who run the surrogacy industry and her presence in their eyes only as a womb, never as a person with things to say to the world.

As I discussed in the methodology section, my approach of working with the professionals of the surrogacy industry set limitations to the scope of my research. There is no doubt that entering surrogate spaces chaperoned by doctors and agents, the gatekeepers of the industry and people who hold significant power over surrogate lives, separated me from surrogate women in ways that other formats of contact would not have. However, my own experiences of having my requests for fieldwork in surrogate spaces be repeatedly denied and of having any contact with surrogate women closely monitored or even recorded, coupled with the descriptions of other ethnographers such as Sharmila Rudrappa (2015) of the kinds of maneuverings they had to engage in to be able to hear surrogate stories, shows a more deliberate attempt by the industry to exclude surrogate women of its self-representations of technological prowess and unproblematic surplus Indian fertility.

Indeed, surrogate women were not just hidden away from my questions, they were conspicuously absent from Indian surrogacy. The women whose bodies carried the children were somehow excluded from discussions about the pregnancy, from contracts and negotiations, from updates and decisions and from communications with doctors, intended parents and even the very child they were carrying. What I first perceived as a matter of me not being able to access the surrogates was in fact

equally a matter of these women not being able to access me, to access doctors and intended parents, to enact agency over their bodies, to communicate their own views or to find recognition for their suffering and their achievement. The seemingly contradictory absence of surrogate women in surrogacy was the result of a system that allowed them presence only as bodies, rather than as persons. It is this system that this chapter explores, using a variety of sources, including my own interviews with fertility doctors, surrogacy lawyers, local agents, international facilitators and women's health activists, as well as excerpts from intended parent blogs and secondary sources such as reports and ethnographies. The very absence this system creates is key to understanding the system itself.

The importance of absence is powerfully advocated in Avery Gordon's work on haunting as a sociological method of inquiry (Gordon, 2008). That, which appears to be absent can, in Gordon's words, be a seething presence. Gordon begins by discussing a passage from a book by Patricia Williams, a descendant of a slave woman and her owner, Austin Miller. In researching family history, Williams comes to realise that the lack of power the slave woman ancestor had over her own life, coupled with the lack of interest history has shown in the powerless, means that she cannot come to know her great-great grandmother in the way she can get to know Austin Miller through his writings and documented actions. Instead, Williams is left to look for 'the shape described by her absence in all this' (Gordon, 2008, p. 6).

Avery Gordon took that search for those who are not there but whose absence screams of social injustice and expanded it to a sociological imagination through the

metaphors of ghosts and haunting. Haunting is so powerful, Gordon argues, because it

> is one way in which abusive systems of power make themselves known and their impacts felt in everyday life, especially when they are supposedly over and done with (slavery, for instance) or when their oppressive nature is denied (as in free labour or national security) (Gordon, 2008, p. xvi).

It is this latter form that is significant for surrogacy, which, in its exploitative forms, can only exist due to the many injustices lower-class dark-skinned women are subject to in India and in the global economy (Pande, 2014; Rudrappa, 2015; Vora, 2015). The ghosts Gordon talks about are not dead or missing persons. Rather, they are social figures, haunting being 'an animated state in which a repressed or unresolved social violence is making itself known' (Gordon, 2008, p. xvi). Gordon's work is mainly focused on historical social injustice, yet her argument very fittingly captures what I felt standing in the hallway of that house in the Mumbai suburbs on a hot summer's afternoon – what I felt, in fact, throughout my fieldwork in India. The haunting absence of the surrogate woman in the low-cost surrogacy industry was not just frustrating for my research, it was illuminating in its own right.

Moreover, taking inspiration from Patricia Williams' search for her great-great grandmother, even if I could not reach the surrogate woman herself, what could I find if I made it my aim to look for the surrogate woman's shape in the contours of industrialised reproduction that have been drawn out by the wealthy and the well-educated who hold power over her? If it was not going to be possible to speak to surrogate women directly, I would try to find out what I could by looking for her shape

in the accounts of others, in adverts for surrogacy packages, in commissioning parent accounts, and in the physical spaces and operational procedures of clinics.

When these women signed up to be part of the global bioeconomy as surrogate mothers and entered the hostel, they ceased to have full control of their lives and bodies for ten months. They took on a very particular and peculiar role as biolabour, a role that sees value extracted out of the worker's embodied processes and biological potential (Cooper and Waldby, 2014), rather than a working person with skills. In commercial surrogacy, as has been shown to be the case with other similarly embodied labour such as that of clinical trial subjects and tissue donors, the combination of the need for extensive control over the labourer's body and actions, coupled with their recruitment from often socio-economically marginalised populations, can lead to situations of disproportionate control of the labourer's existence by the industry they serve. Surrogacy adds to those challenges the matter of pregnancy, which as I discuss below, already brings often severe limitations on the personal freedoms and bodily integrity of women in India and elsewhere). In the context of Indian surrogacy, biolabour is not intended to have a voice, to live at home surrounded by family and friends or to speak to curious researchers. To ensure compliance with this role, surrogates in the hostel were constantly policed by various caretakers (Rudrappa, 2015). The system was so good at locking these women into their roles that a successful global business had developed out of it. India became the global surrogacy hub for a number of reasons, but largely due to the availability of cheap, docile, fertile bodies. What, I wondered, does it take to turn a woman into a

body that produces value with minimal disruption. What is lost, and what is gained, in the process?

I first began thinking about surrogacy in terms of biolabour and bioeconomies when i visited Indian surrogacy clinics and hostels. There was something about the way surrogate women were treated and spoken of as bodies with nutritional needs, hormone levels and procedures, rather than persons who should have some say over or at least knowledge of what happens to their bodies that struck me as reductive of their personhood, beyond what could be considered biomedicine's general Cartesian approach to the person. As I discussed in the previous chapter, scholars have looked at several emerging biotechnology industries, such as medical trials and stem cell research and found that same kind of novelty and strangeness. Their efforts to describe these new fields of commerce have resulted in the terms bioeconomy and clinical labour or biolabour that I utilise here, and provoked debate about the significance and ontological uniqueness of the phenomena they refer to. The novelty and strangeness, critics argue, might be deceiving, hiding the fact that there is not much new in the employment of individuals for their embodied biology (Birch and Tyfield, 2013). But while that surrogacy hostel in the Mumbai suburbs and the local and global production lines of commercial surrogacy that it belonged to might not have constituted a revolutionary, or at least significant, shift in the structures of global capitalism, it was nonetheless something new, especially when it came to the industry's relationship to the various kinds of labour that sustained it. This newness was politically powerful and analytically significant.

Patients, clients and pregnant bodies

Commercial surrogacy might in some ways be considered a special triumph of biomedicine because the practice moves beyond merely enhancing existing bodies or extracting value out of them: it allows the creation of entire new living humans in a union of production and reproduction. Biomedicine plays a dual role in commercial surrogacy: it provides those who commission surrogacy with the power to gestate a baby while at the same time allowing the surrogate woman to turn her body's biological capacity to bear children into a source of income. However, for the actual medical treatment, such third-party addition complicates the doctor–patient relationship, adding the roles of client (the commissioning parent), surrogate and the unborn child. The position of the patient can no longer be taken for granted here.

The body of the surrogate woman is the site of the biomedical intervention, but she is hardly the beneficiary of it. If anything, the heavy hormonal treatment, implantation and later selective reduction of numerous embryos and the generally premature Caesarean birth that follows can reasonably be argued to be against the medical welfare of the surrogate woman. Indeed, in Indian and other low-cost surrogacy, the woman carrying the child is not treated like a patient but rather like labour or even a resource akin to the donor eggs or sperm that the IVF industry also relies on.

The goal of the treatment is to produce a healthy baby and any discomfort or medical risk this might involve for the surrogate is regarded as a necessary, if unfortunate part of signing up for the job. Negotiating the potentially conflicting interests of mother and foetus in doctor-patient relationships is an issue not unique to surrogate

pregnancy. Abortion restrictions, forced medical interventions and the policing of pregnant women through socially or even legally enforced lifestyle adaptations are only some examples of the many ways the welfare of unborn children is prioritised over the women who carry them (Kirkham, 2004; Maier, 1989). The increasing medicalisation of pregnancy can exacerbate this tension because of the additional scope for monitoring and intervention they facilitate (Martin, 2011). Irma van der Ploeg (2001) has argued that in the discursive practices that surround the treatment of infertility and foetal surgery, such as in discussions about treatment options, the couple and the foetus, rather than the woman whose body will be subjected to the treatment, have emerged as the patient. Women's bodies and experiences in the medical interventions that can be painful, invasive and potentially dangerous are absented and deleted in the process. These technologies represent for van der Ploeg a threat to the recognition of women's autonomy and worth:

> Feminism has been precisely about the effort to establish that women are individual persons in their own right - not just spouses and mothers. By contrast, reproductive technologies, and the biologies or body ontologies they generate, show female bodies configured not as individual women's bodies, but as 'prosthetic devices' instrumental in the medical care for other bodies that, in the same movement, are construed as self-realising individual entities.' (van der Ploeg, 2001, pp. 124–125).

While it might seem as if the entire surrogacy process focuses on the health of the baby rather than the surrogate (whose health is only considered in relation to how it might affect the baby), this does not necessarily mean the baby's welfare is paramount. A closer look at the practices involved in IVF and surrogacy reveals unsettling complexity. Specifically, the acceptability and even popularity of multiple

pregnancies in surrogacy places the baby, too, in a strange relationship with the surrogacy procedure.

If the imagined not-yet-born or even conceived baby was considered the patient, then all reasonable efforts would be made to avoid a multiple pregnancy, one of the most serious and best documented risk factors in any pregnancy (Braude, 2006).[7] This, however, is not the case. Indeed it is common for the commissioning parents to opt for a multiple embryo transfer, often at the recommendation of their doctor, in order to maximise their chances of a live birth or even twins.

One could argue that in medical treatment choices often have to be made that balance out acceptable risk with the optimisation of a desired outcome. However, increased health risks for the baby due to the prevalence of complications or congenital disorders in multiple pregnancies do not bring any medical benefit for that particular baby. All they do is supposedly (there is a lack of medical consensus on the matter) increase the chances of a baby being born – an important difference. Neither the surrogate nor the baby can thus be considered to fulfil entirely the traditional biomedical role of a patient. It is the commissioning parent whose social need for a child rather than any other party's medical need that governs and takes priority in the medical procedure of surrogacy. This can potentially be said to be the case for biolabour in other contexts too.

[7] Multiple pregnancy increases the risk of serious medical complications, especially preterm birth. The World Health Organisation has identified IVF treatments as a leading cause of preterm births in many countries and argued for the importance of policies aimed at promoting single embryo transfer (World Health Organization, 2012). Guidelines issued by the European Society of Human Reproduction and Embryology (2015) have indeed recommended single embryo transfer in most cases, and discouraged the transfer of more than two embryos in order to reduce the incidence of multiple births.

There is no evidence that these novel medical relationships are necessarily negative in themselves. However, as Indian surrogacy has shown, a single-minded focus on delivering for the client can sometimes leave other parties vulnerable. In fact, by risking the health and life of the infants though potential complications, multiple pregnancies can also leave the commissioning parents themselves with heartbreak because their babies might be born with congenital health conditions or even die due to the risk of premature birth.

It is important to recognise that the position of the intended parents themselves can be very difficult in choices around assisted reproduction. Despite the lack of conclusive evidence of multiple embryo transfers necessarily leading to more successful pregnancies, the decision of how many embryos to transfer is nonetheless often presented to the intended parents as a simple matter of numbers – more embryos equals better chances that one will attach and grow into a baby. The associated risks are played down or ignored altogether. Getting two babies in one go can be an all too powerful image for those who have come so far to have even just one. In the following quote from the online blog[8] of an intended mother commissioning surrogacy in India, even high-order multiple births are compared to winning the lottery:

> Think of it this way: One baby… decent chance; Two babies… less of a chance; Three babies… is even less of a chance; Four babies… is like winning the lottery (meaning nearly no chance...not dreaming of it happening). (“Taj Ma Baby Blog”, n.d.)

[8] Documenting one’s journey on a public blog is common in surrogacy. I use quotes from some of these blogs throughout this thesis to provide an insight into intended parent experiences and perspectives. I did not interview any of the authors.

Fixated on what appears like an impossible dream, the intended parents can make seemingly indefensible choices. It is one of the industry's truisms that the most important thing one needs for a successful fertility journey is positive thinking and hope. Those are the qualities that enable aspiring parents to keep trusting the doctors and the process through the highs and lows of IVF treatment and to keep trying. But when it comes to medical decisions, this blind focus on positive thinking can become dangerous: imagining how wonderful a pair of twins would be and how great it would be never to have to undergo the surrogacy process again often overshadows the medical warnings against multiple pregnancies. Indeed, even activists who condemn planned multiple pregnancies have a lot of understanding for those who choose to commission them because they still remember a time when they themselves or people close to them were making those same decisions.

An analysis of the medical practice of surrogacy in India thus reveals that, of all the parties involved, the intended parents, the clients of the transaction of commercial surrogacy, emerge as the best match for a description of the patient role: they commission treatment, give consent, make decisions. The entire process is designed to fill their desire for a child, even at the expense of the health of others. This remains the case even in donor gamete surrogacies, where the commissioning parents themselves never undergo any medical treatment at all. This level of abstraction of the clients from the actual treatment makes surrogacy an especially intriguing case study of bioeconomy. Indeed, unlike the organ trade where the client still needs to undergo invasive surgery to receive the organ and remain on lifelong

medication, surrogacy's clients can in some cases simply pick up the desired end result, thus possibly enjoying the purest form of the extraction of life as surplus.

Liminal beings

The fact that the person on whom the interventions are performed is not the person who will benefit from them, commission them and pay for them is at the heart of the union of modern medicine with the bioeconomy. One person's body is put to the service of another person, who is, depending on circumstance, in dire medical need (in the case of live kidney donation), with better chances of ever living a full life (in cadaveric organ donation from brain-dead donors), in possession of research funding (in medical research) and, more often than not, from a wealthier socio-economic background and with a lighter tone of skin colour. Surrogacy blurs even those comparisons due to the fact that infertility, single parenthood and homosexuality are not medical emergencies, but rather, depending on definition, somewhere on the long continuum of socio-medical conditions.

Commercial surrogacy shares with practices like organ donation or human subject medical research the fact that, in order for the industry to operate, it needs to rethink its human capital as a source of embodied value rather than a collection of individual persons. Lesley Sharp's (2006) analysis of organ procurement, where she explores and analyses the role of the donor body in the transplantation process, offers insightful approaches for thinking about surrogate bodies. Comparisons between organ donation and surrogacy are problematic and should be made with great care. This is partly because of the often instant association made between organ donation

and organ trafficking, two rather different if intertwined lines of business. Donation seeks to make use of the life-giving potential of brain-dead donors, while trafficking is a brutal and bloody global business that preys on living, healthy but desperate bodies in the world's most poverty- and catastrophe-stricken areas. But comparisons can also be simply misleading because they imply a loss of organ on the surrogate's side, thus unfairly misrepresenting the practice and devaluing the labour of surrogate women. There are nonetheless some important parallels in the way the bodies involved in both surrogacy and organ donation can come to inhabit a liminal status as not-quite-patients, despite being treated by medical professionals, and in the kind of depersonalization that needs to take place for them to be able to fill this liminal role effectively.

Once a hospitalised patient is pronounced brain-dead and put on the track to potentially becoming an organ donor, care for his or her body does not stop (Sharp, 2006). The donor at this point still has a heartbeat and looks and feels like they might wake up any minute, even when that is not the case. The fact that on a biological level organ donors are still alive means that they must remain under careful respiratory and other support to keep their organs from deteriorating. The purpose of these life-sustaining interventions, however, is no longer geared towards sustaining and enhancing the life of the donor but to keep precious organs viable for transplantations so that they can support and enhance the life of the recipient.

This shift represents the fact that the donor, once identified as one, stops being seen as a person, a loved one, a member of society, and starts being seen as a source of precious organs. Sharp argues that the brain-dead organ-donor constitutes a kind of

liminal being (Sharp, 2006), caught somewhere between being a patient and a cadaver. In order for organ procurement to be possible, the patient must successfully make the shift into donor status in the minds of everyone involved. Crucial here is a process of depersonalisation that is played out in the hospital setting. Nurses and doctors stop addressing the donor body by name or speaking to it as they normally would, and the life-support systems that keep the body breathing are re-classified as ventilation to remove confusion over the fact that there is no longer a life to support. Brain-dead patients are no longer talked about in terms of their survival chances and instead become known through terminology relating to the value and quality of their organs. Indeed, they are no longer patients at all. These processes of depersonalisation can be very difficult for the medical staff involved but they are necessary for transplantation and its life giving capacity to be possible.

While no one would suggest that surrogates are part-cadaver, there is a similarity here to the kind of depersonalisation that takes place in Indian commercial surrogacy. Rather than being somewhere between patient/person and cadaver/donor, surrogates occupy a liminal space between patient/person and body/resource. This comparison between organ donors and surrogates can be far less straightforward in countries such as the UK, where, despite using their bodies for the benefit of others, surrogate women nonetheless retain control over their bodies and lives, remaining involved in the medical process through ongoing procedures of consent.[9]

[9] However, this exclusion is not exclusive to low-cost surrogacy. Court cases in the US have upheld the rights of the commissioning parents to make decisions about the bodies and pregnancies of commercial surrogates (Rowlands, 2015).

This liminality was felt by surrogate women as exclusion and as a denial of their presence and personhood. Below is a quote from an Indian surrogate, taken from a report by a local women's health charity, describing her experience of medical appointments:

> Here the thing is you can neither talk to the doctors nor to the couple [commissioning parent]. You have to keep your thoughts to your own self. Whatever they say, you have to do it. Madam said 'Do this, do that.' And you have to do it. You can't talk freely. She [doctor] just asks 'everything is fine, is there any problem, eat this, eat that.' They will ask all the things they are concerned with as part of their work. The rest comes in the report. The doctors look at the report in front of them. They won't share experience with a human, but they will do it with a file and that is it. They won't look at you. They will look at your file. 'How are you? Do you feel fine? Are you eating? Is movement okay? … That is all they say. Even if you try to talk to them, they will say 'I don't have just one patient to see, I have many.' They are all meethi churri [sweet knife]... [...] They only talk to the family [commissioning parents], as if it is them and not us who are pregnant. (Surrogate SD2, emphasis mine) (Sama, 2012, p. 76)

In line with Sharp's (2006) observations about organ donors, the processes of depersonalisation in surrogacy are both unintended and intentional. The practicalities of the business itself can leave surrogate women's needs last and work to reduce them to their physical bodies without anyone's direct intention to do so. Biomedicine, even in its more conventional treatment of patients has been widely criticised in medical anthropology for its preoccupation with the body at the cost of the suffering person (Kleinman et al., 1992; Lock and Gordon 2012). Doctors in India are also very busy, often working long hours and with huge caseloads, performing procedures in large batches and as a result, rushing through appointments and cutting time where they can. Indeed, I discuss the problems such clinical relationships created with intended parents in the following chapters. As a backdrop, the cycles of reproduction,

even when manipulated, still set their own restrictions. Moreover, the demands of a highly client-focused private health-care system bend the needs of surrogate women to fit those of the commissioning clients and the primacy of profit.

Still, present in Indian surrogacy are also distinct strands of a more focused effort to limit, if not erase surrogate personhood in the transaction because interchangeable docile bodies are easier to work with than people. In my fieldwork, doctors and other industry professionals seemed to like the surrogate best when she was neither seen nor heard, coupled with a fear amongst surrogacy professionals, one that they sometimes communicated to me directly when discussing the contact between intended parents and surrogates, that the women might begin to feel too special and thus become difficult to manage. If a surrogate started feeling too important or making requests (identified by professionals as illegitimate demands), she was seen as making trouble and interfering with hospital matters.

Such an attitude has been identified by Suze Berkhout (2008) as the objectifying 'denial of subjectivity', where surrogates are treated as

> …something whose experiences and feelings (if any) need not be taken into account. The denial of subjectivity occurs when the surrogate's experiences in pregnancy are subordinated to the physician's, contracting agency's, or the feelings or desires of the biological father and social mother. (Berkhout, 2008, p. 106)

The economic argument is straightforward: overlooking the needs and unique identities of surrogates can help streamline the production line of low-cost surrogacy by maximising the women's biological capacity to birth desirable babies while minimising the cost per baby born. In a process as drawn out and with as many

moving parts as transnational surrogacy, doing away with complexity wherever possible was important for doctors.

The extent to which surrogate care is aimed only at enhancing the pregnancy becomes immediately apparent in the context of postpartum care or its conspicuous absence. I spent time with doctors and agents discussing medical care and surrogate welfare, and yet it somehow never came up. My questions on the matter were, for the most part, quickly brushed off as unnecessary concerns. ‘No, after the delivery that’s it, they go because they miss their family,’ I was told. Ethnographic accounts of surrogate lives resonate with such statements, showing this lack of care to be a normalised part of surrogacy in India (Rudrappa, 2015). The surrogate’s welfare is only important, and thus medical care is only provided, as long as she is still carrying the baby alive in her uterus. If she miscarries she will become worthless, and all medical efforts will be directed towards creating another pregnancy in a different surrogate, rather than helping her deal with the loss (Mitra and Schicktanz, 2016). Medical care also ends if all goes well and there is a live birth.

Apart from very rare cases, as soon as she gives birth the surrogate loses all support from the clinic, the agency and the intended parents. According to a specialised Indian lawyer, even those intended parents who express genuine care for the surrogate during the pregnancy often do so only as a way to care for the baby and thus stop once the child is born or are simply too preoccupied with their new family to think of the surrogate:

> In some cases probably the commissioning parents do care about the surrogate and everything, but at the end of the day what they want is a child.

> Surrogate they are caring about as long as she is carrying their child. Once the child is delivered, there is no care. (Arun)

Despite having just borne a multiple pregnancy, been on large quantities of medication, bed rest and a managed diet, all then finished off by the serious surgical procedure that is a caesarean, the women are quickly sent home without any medical provision or domestic help to ease their transition back into the physically arduous work of being an Indian housewife. ‘We offer for them to stay and recover, but they are all in a hurry to get back home to their families,’ noted one fertility doctor. While in many cases that is likely to be the case, in others, the cost of such care would be taken directly out of the surrogate’s earnings, thus making the option unaffordable. The Indian women’s health charity Sama argues in its report that surrogate women often suffer long-term health consequences from surrogacy, ranging from pain and incontinence to faintness and infections (Sama, 2012). These go untreated and often cause long-term issues and loss of earnings. The world of high-tech medical care that they were a part of as gestational carriers is, however, closed to them as soon as the contract ends, with some doctors offering simple painkillers and others not even that.

This position of the surrogate as a liminal body, half-patient, half-resource, was not accepted with equal ease by all the professionals involved. Some of the fertility doctors, especially those who had come to assisted reproduction from a long career in gynecological and maternal care found it hard to look at a surrogate and not see a patient whose best interests they should always keep in mind. They were used to being concerned with women’s reproductive health first and birth rates second. In the

context of the competitive surrogacy industry, this attitude could prove problematic. Suveera, one such fertility doctor who had in the past specialised in high-risk pregnancies, told me that her insistence on putting what she considered the surrogate's or even the baby's health first could be a source of professional tension:

> We only do single embryo transfer. Just put the strongest one in. If that won't grow, then the weaker ones wouldn't either. As soon as you get a multiple pregnancy, the risks also multiple. We have to worry about everyone involved, not just the parents. The baby could have congenital disorders, low birth weight, premature birth, foetal growth stagnation, a million things. And the surrogate, she is our responsibility, the risk of complications, bleeding, scarring, everything. Also the burden of carrying triplets for nine months. It will drain her, and it will be very tiring and unpleasant for her. I stick to that: even if Swetesh [her husband and business partner] tried anything, I say no, I have a responsibility to the baby and the surrogate, I stand my ground even if Swetesh is pushing for it. So we only do single transfer, but also we have never had premature birth.

She made that statement with special pride. For Suveera, everyone's health and welfare, including the surrogate's, had to trump other considerations. Her words show consideration for the surrogate in both the short and long terms. In her comment about premature birth, Suveera ties the welfare of the unborn child to the welfare of the surrogate and thereby implicitly also to the wishes of the commissioning parents. This, however, was a rare conviction, and it was often tested by those around her. In that liminal space between person and fertile body, commercial pressures ensured that surrogates were always being pulled towards the latter.

Limits of alienation

Issues over surrogate welfare and consent reinforce the fact that Sharp's analysis of cadaveric organ donors is only partially relevant to the case of Indian surrogacy. Even amongst other bioeconomic industries, surrogacy occupies an especially complex position because it constitutes a profoundly embodied and emotionally engaged long-term conscious involvement by the surrogate woman. As I noted in Chapter 2, this difference has prompted many scholars to move away from an analysis of surrogacy as kind of commodification of the body and approach it more as a novel type of labour, or rather the inclusion of the category of reproductive labour into the realm of the free market, where it has become alienated from the women themselves so as to be allowed into the flows of market capitalism (Pande, 2010; Rudrappa, 2015; Vora, 2015; van Zyl and van Niekerk, 2000). While this approach has generated important insights into surrogate's needs and rights, and has profoundly informed my own thinking about surrogacy, it also raises its own questions.

Indian surrogacy, indeed, is a very particular kind of labour, which, in its articulations with medical intervention, kinship, emotional work and complete control (or aspirations for it) of the labourer's biological existence, complicates the process of the worker's alienation from her product. The limits of this alienation and the resulting contradictions can have far-reaching consequences for surrogacy arrangements. Working with living, feeling, family-missing, injection-fearing pregnant women who have lives, personalities and social networks over the course of roughly ten months can be significantly more complicated than working with brain-dead organ donors,

short-term research participants or tissue donors (which is not to say that these industries do not come with their own complications) or indeed with labourers in more conventional fields. So whether we look at surrogacy as a form of organ commodification or a form of labour, we cannot escape its embodied and emotional nature and long-term involvement.

The producer or surrogate and the product or baby of this labour process are so intimately tied together, quite literally, in flesh and blood as to render any straightforward alienation during the pregnancy, either as a rented womb or as wage labour, problematic. In the surrogacy process, both in clinic practices and in the depersonalising work of surrogate agencies and hostels, surrogate women thus become truly liminal bodies caught between the statuses of rented wombs, reproductive workers and caring mothers. Indeed, surrogacy, which I described at the beginning of this chapter as a triumph of the bioeconomy, has in practice turned out to be stubbornly complicated and tied up in the ineffective realities of human emotion and connection – a matter I explore in more depth in the next chapter – causing endless headaches for those who are trying to make babies as a streamlined biotech business.

Wombs for rent

The rhetoric of surrogacy as ‘renting a womb’, used widely by the industry, its clients and often, perhaps unaware of its implications of erasing the women whose wombs they refer to, also by its critics, is one attempt at containing this complexity of surrogacy within the bounds of bioeconomic exchange. It portrays the surrogacy

arrangement as a simple business transaction in which biotechnology and its experts take centre stage as they create miracle babies out of India's fertile biological resource.

Such attitudes towards surrogate women are continuously recreated and reaffirmed through the language used in everyday clinical practice. In the clinic, in conversations between doctors, nurses and other professionals such as lawyers or facilitators, or in correspondence with intended parents, the surrogates are rarely referred to by name.[10] Even as simply 'the surrogate', the women are rarely spoken of at all, and it is only through references to their body parts, various test results and scans that surrogates have a presence in the clinic at all. The condition of her uterine lining, the levels of hormones in her blood or images in her scans are talked about as if they existed in themselves and not as part of a woman undergoing an invasive medical procedure.

As I discussed above in relation to the complexities raised by pregnancy and biolabour when it comes to medical care, and the implications this has on surrogacy, biomedicine can place its subjects in a liminal position of existing between personhood and biological existence. Indeed, the issues I discuss here issues are not exclusive to surrogacy and might in fact be an important, if contested, part of the ability of biomedicine to function. However, the depersonifying of surrogate women was extreme even in the context of biomedicine because the women were not considered patients or subjects of treatment, and they were not considered to have

[10] This is different to surrogate hostels, where the agents who oversee and care for the surrogate women over several months (and often live in the same areas can get to know the women well (Rudrappa, 2015). My argument is based on the clinic space and communications between clinical staff, international facilitators and intended parents.

any right to make claims or demands, to hold doctors accountable or to ask questions. Even if surrogacy can in part simply be a case of the biomedical focus on the mechanistic, Cartesian body being allowed to function without the hindrance of consent procedures and other patient involvement, it seemed as if the drive to make surrogate women all but invisible also served a separate purpose of making the surrogate easy to manage by reinforcing her disposability and limiting her agency in the surrogacy process.

This was especially apparent in the period of surrogate preparation and embryo transfer, before a pregnancy was confirmed. Surrogate bodies needed to remain interchangeable and easily replaceable for as long as possible. Indeed, while surrogate women carrying confirmed pregnancies for intended parents became highly valuable bodies, expressed in the high levels of care they received and control they were subjected to, this stood in stark contrast to how surrogates were treated prior to a pregnancy being confirmed.

Clinics would offer to prepare - that is, to subject to hormonal manipulation in preparation for IVF - several surrogates at a time. Two or even three women or however many the client wanted and was willing to pay for could be prepared in this way. In some clinics the client could then meet the prepared surrogates and choose the one they liked best, in others the one with the best uterine lining was chosen, or embryos were implanted into several surrogates at the same time. This way, the chances of a pregnancy were doubled, and if too many embryos developed, some could always be aborted later.

Clinics were interested in keeping this purely medicalised approach intact in the face of any personal or emotional connection the intended parents may develop. An Indian fertility doctor explained to me the need to bracket off the surrogate as a person from the potential fertility of her body in order to keep the process focused on biomedical factors:

> They [intended parents] never even meet the surrogate before the pregnancy, the reason being that we don't want them to choose a surrogate based on some non-medical reasons. We prepare several surrogates and then choose the one who has the thickest lining and is most likely to get the pregnancy. We only choose based on medical reason, not her face or something, and we don't want parents to start to prefer one surrogate for some other reasons. Only when there is a pregnancy do we tell the couple that we had several surrogates prepared and show the surrogate. (Swetesh)

Dr Swetesh's comment illustrates the ideal scenario of the evaluation of surrogate women based only on their medical and reproductive potential, a system to which personal, non-clinical relationships could pose a threat. This focus on clinical factors is important for identifying and capitalising on the potential of surrogate women to create desirable healthy babies - the end goal for everyone involved, including the surrogate.

A similar tension between medical and non-medical factors can manifest itself in the selection of egg donors. Indeed, it is useful to think of the two types of reproductive contribution together here in the context of the way the bodies of those who become a part of the production line of the bioeconomy come to be seen and treated differently. Fertility specialists prefer to work with egg donors who are young and healthy, especially if they already have a history of producing high numbers of healthy, viable eggs. At the extremes of this focus on productivity, some doctors are

willing to risk the donor's health or even life with high doses of hormonal medication aimed to maximise the number of eggs retrieved. It was common for doctors to proudly state the number of eggs they retrieved. Other doctors would share, often also with with criticism, stories of incredibly high numbers of retrieved eggs, sometimes several times over numbers that are considered medically safe. In 2010 a young woman in Mumbai died from ovarian hyperstimulation syndrome, a dangerous potential complication of egg donation (Mumbai Mirror, 2014). The investigation found that the woman had donated several times within a very short timeframe and was only sixteen when she first underwent the procedure. At the time of writing the case is still not settled in court. Meanwhile, the practices of maximising reproductive production in many Indian clinics remain unchanged.

If the medical side of uterine linings and follicle counts provides a relatively straightforward framework within which to evaluate the reproductive potential of surrogates and egg donors, the women's overall reproductive market value is more complex to estimate. It takes into account other, non-medical factors that sometimes frustrate the doctors but that are nonetheless important for clients. As noted in Chapter 2, for both surrogates and egg donors, clients generally value women who are either similar to them or possess characteristics which the clients deem important. As cultural values play a role here, both NRI (non-resident Indian) and domestic Indian clients often pay extra or wait longer for upper-caste, fair surrogates and donors.[11] Depending on their background, both international and domestic clients may have preferences and restrictions relating to the surrogate's faith and

[11] Amrita Pande (Pande, 2014) discusses the importance of caste in Indian surrogacy in her book Wombs in labour.

vegetarian diet. What specific expectations for the surrogate and donor the clients have depends to a large extent on their country of origin, religion and culture. Western clients, I was told, are generally less concerned with the surrogate's skin colour, caste or religion, focusing more on medical factors, personality and availability in order to begin the process as soon as possible.

The existence of a genetic tie to the child means that such non-medical aspects are especially important in the selection of egg donors. Indeed, while many overseas clients, even those of Caucasian heritage, are happy to opt for an anonymous Indian egg donor (often the entry point into reproductive markets for women who later end up becoming surrogates), others have high demands for the donor's looks and social characteristics. Across the board, many clients request a donor who matches their own ethnic characteristics so that the child will grow to look like their own. For example, flying in Caucasian egg donors from Ukraine and South Africa is a popular, albeit expensive option for white Western clients. Others, however, are willing to pay large amounts to obtain a physically attractive 'deluxe' donor with, depending on the ideal of beauty the clients subscribe to, can mean blonde hair and blue eyes, a wheatish complexion and dark hair or tall stature and slim build. Such genetic essentialism is not limited to looks can lead to the pursuit of eggs from women who are employed in a specific field - with doctors and engineers for example being most popular among domestic and overseas Indian clients - enrolled in a specific university or talented in sport and music. The resulting arrangements might be peculiar, especially considering the clients' wide range of socio-cultural backgrounds, but clinics are usually happy to accommodate them:

> Darsh: For egg donation, the patients [domestic, NRI and international], they care about religion somewhat but mainly looks and education. Everyone wants a doctor. We did have one [NRI] case where the donor was flown in from Croatia. They wanted a child with blue eyes so they flew her in. It cost the same to fly her in as all the rest of the treatment together.
>
> E: But isn't the child going to look European? Won't they want to keep it secret and pretend it's theirs?
>
> Darsh: Yeah but it's such a hot look, people are willing to pay and figure things out. [laughs] As I said, we get all kinds here, every case is unique. [emphasis mine]

In surrogacy agreements class, race and caste thus intersect with women's perceived reproductive worth and market value in ways that insert genetic essentialism into social difference and devalue the reproduction of lower class women. It is telling here that deluxe donors can be paid orders of magnitude more than regular donors and can be flown in from abroad and housed in luxury hotels. For surrogacy, the concept of a deluxe gestational carrier does not even exist, highlighting the relative value of gestation and care in relation to perceived superior genetics.

Depersonalisation in practice

The depersonalisation of surrogate bodies as wombs for rent was not pre-given, but the result of careful planning and continuous processes of rhetoric and control. Over the course of the entire surrogacy from recruitment to post-delivery arrangements, the clinic has opportunities to shape the role and position of surrogates. The interconnected practices of acquiring consent, screening of candidates, and the

ongoing counselling and monitoring of surrogate women during their pregnancies emerged as important for creating good profitable surrogates.

Consent

As regular practice, Indian surrogates are excluded from any kind of decision-making about their pregnancies. Women are not consulted or sometimes not even told about things like multiple embryo transfers, foetal reductions, caesarean sections or any other matters arising during the pregnancy and are discouraged from asking questions. Accordingly, my enquiries about consent, even if at times preempted, were most often brushed off by doctors and other professionals as a non-issue. I was not allowed the opportunity to observe consent procedures so my analysis is based on their representations of the matter. However, many doctors seemed happy to give their opinions and appeared candid in their answers. I asked various industry professionals, including, doctors, lawyers and international facilitators, about consent as a procedure and as a Western bioethical ideal. The surrogates, I was told, were simply too ignorant to understand what they are being told or too interested in the money to care about anything else. Indeed, some doctors who did value consent procedure, mainly those with experience of working or studying abroad, argued that, despite their best efforts, it was difficult. Dr Sid explained to me that this was a combination of educational issues and the fact that most women were desperate enough to agree to anything:

> There's a problem in that [consent]. If you look at the ICMR [Indian Council of Medical Research] guidelines you have to have a psychiatrist on panel. I do. After me counselling them they fill in a form that my nurses explain to them in their native language - Hindi, Marathi et cetera - then they go to the psychiatrist who talks to her and her husband and explains everything: 'This is what's gonna happen, this is gonna be the baby, you don't have to do

> anything for the baby, you just take your money and you have to go. The baby will not be shown to you, you will not be breastfeeding the baby.' All these things which probably is going to have a psychological effect on the mother, the psychiatrist explains all of that. Some do understand it and engage, some are not bothered, they go 'OK, I just want the money.' None of them are educated, so you try your best in explaining and then hope that they have followed it. (Dr Sid)

Dr Sid considered the husbands of the surrogates, who are a party to the consent process in India, to be equally equally clueless and often overtly greedy: 'The husbands usually don't understand it (consent) either; most of them are stupid, they are only here for the money' (Dr Sid).

The lawyers I spoke to in India shared this opinion. When I asked one seasoned Indian surrogacy lawyer how realistic genuine informed consent was in India, her response summed up many of the opinions I had heard on the matter:

> No!!! The surrogate will not understand! She has no education, she just wants the money, and she knows other women have done it, so she doesn't understand or care. For example, if she has some disease and goes to the doctor and the doctor said that it is malaria and spends time explaining that this is a parasite and this is what it does in your body and this is how the medication will help, then in the end she will walk out and say, I have malaria and the doctor gave me medicine. These things like IVF, they don't even understand the terms that are used to explain. You can do it in their own language and we do that, we get it explained in their language, but it doesn't matter because it is not a language issue, it is an education issue. (Sindhu)

Yet despite this presumed inability to understand what was involved, the surrogate's consent in the clinical context is seen as a one-off all-inclusive agreement that clears the clinic for all future procedures and decisions. Obtaining consent was about convincing the woman to agree to sign the surrogacy agreement, and within it commit to handing over the baby. From then onwards everything was in the hands of

the clinic. A comment by Dr Chopra, from New Delhi implies that surrogates' lack of knowledge of the details of what they would be undergoing actually made the process of getting consent easier:

> It isn't very hard to convince women to become surrogates. They get married so early here and have lots of babies, so for them pregnancy is something natural and easy, it's not difficult or scary. We here know all the things that can go wrong and dangers, but they don't so they don't worry. (Dr Chopra)

When issues of surrogate consent did arise, it is often in relation to bureaucratic necessity, and one that made little sense, rather than an important practice in medical care. Consent was often lamented in the context of British intended parents requiring a consent document in order to be able to obtain papers for the baby. Rajesh, another Indian surrogacy lawyer, explained the frustration at having to deal with consent within the realities of surrogate women's lives in India:

> All these things the foreign courts want we have to provide here in India! So they want a document – they don't care that the surrogate's house flooded. Or they want consent, but how will we make sure she understands everything truly? Paperwork in India is a mess. I always say India is full of stupid people! It's also full of very smart people like everywhere is, but also idiots. Doesn't help that the surrogates are usually the lower end of society so they don't understand any of this and spell their name one way on some papers and a different way on other papers, so contract reads Seethu and consent form is Seeta, and then the parents take these to the authorities who of course won't accept them... (Rajesh)

Once the surrogate signs the contract, and a surrogate pregnancy is confirmed, her body comes to be at the disposal of the industry. From the perspective of the smooth running of bioeconomic enterprises, this is not necessarily a problematic approach. As long as the surrogate signs all necessary papers and is desperate enough for

money never to raise any issues, then doing away with a genuine consent procedure is an appealing option in making the recruitment process simpler and quicker.

According to critics, it is this economic appeal, rather than the surrogates' fundamental lack of interest in or ability to comprehend the process, that motivates professionals to overlook or even avoid proper consent procedures:

> The surrogate mother, she might be uneducated, but she's not dumb. There is a lot of difference between the two. Her IQ could be really good, she can understand and analyse and come up with logical conclusions, even if she doesn't know what is H_2O. But there's a difference between knowledge and the logical part to it. She will be able to understand and appreciate things if it is told to her. But it's dealing out that information that's the whole point. Surrogates in the US who are writing blogs about it, posting photos of their pregnant tummies and all those things. Here the surrogates are not even able to meet the IPs in many cases. (Arun)

In this comment, Arun brings together issues of education, of the stereotyping of the poor and of the lack of agency or even presence Indian surrogates have in the process.

This is an important link because, while the surrogates' apparent lack of interest in their own medical treatment was brushed off by most professionals as resulting from the women's greed or lack of education, ethnographic accounts of surrogates suggest otherwise. In fact, the report by Indian women's health charity Sama that I mentioned above showed surrogate women to be deeply critical of how the extent of the intrusive medical procedures they had to undergo had been hidden from them (Sama, 2012). The following quote from this report, where an Indian surrogate surrogate discusses her experience of foetal reduction (a partial abortion of unwanted or unhealthy foetuses), sheds light on how the lack of understanding of

biomedical procedures, further exacerbated by the sometimes complete absence of communication from clinic staff and the denial of surrogate interests, can make for traumatising medical procedures:

> They had transferred four eggs (embryos) inside me, and I was not told about it. One day I got a call asking me to visit the hospital. They told me that one of the children did not have a heartbeat and that one has to be taken out by surgery. I was very scared. I didn't understand how you could take one out. What if something happens to me? I called my husband, but before he could reach they had taken me inside for surgery. That night there was too much pain in my stomach. (Sama, 2012, p. 66)

The issue of consent in Indian surrogacy, as in many other forms of bio-labour, is less about the individual and more about the structural violence that places workers in a position where consent procedures become irrelevant. Talk of consent is problematic in the context of Indian surrogacy for the same reasons as is talk of choice: with enough economic need, consent is a matter of agreeing to undergo any procedures necessary, whether the person actually finds the risks acceptable or not. A passive approach to the details of medical procedure on the part of some surrogates can thus also be seen as simple resignation to a system that, even if it exploits, nonetheless holds out the promise of reward.

However, while the lack of genuine consent procedure in Indian surrogacy can be seen as an issue for the industry and a symptom of their disregard for the welfare of their biolabour, these same structural pressures add complexity to the matter. Indeed, Cooper and Waldby (2014) have argued that the fact that in the context of clinical labour such as participation in clinical trials, tissue donation and also surrogacy, the position of economic precarity that largely characterises the

populations from within which these industries recruit means that whether they are fully aware of the risks or not, labourers are likely to sign their bodies up for the task, turns consent into a tool for the bioeconomic industry, rather than a protection for its subjects. Consent in this context can be far removed from the bioethical ideology of protecting the welfare of those undergoing treatment and instead become a tool for biomedical industries to protect themselves against potential litigation or claims to compensation, thus removing all responsibility from themselves and make the clinical labourer the sole bearer of risks. Much as Indian surrogacy might seem like an easy target for criticism on consent procedure, it might in fact be the case that challenges around consent in India are merely highlighting the problematic nature of consent in highly unequal transactions, bodily or otherwise, in many more conventional and far less criticised industries and contexts.

Screening for productivity and docility

The process of creating the easily managed biolabourer, or ‘perfect mother-worker’ (Pande 2010) begins long before the pregnancy is even conceived, in the recruitment and screening that form the gateway into the reproductive assembly line. All women who apply to become surrogates are screened by the surrogacy agent and the clinic. The selection of caring, strong, well-nourished and healthy surrogates is important for clinics, as it improves the chances of a successful delivery. A rigorous screening process is crucial for identifying any issues the surrogate may not know about or may wish to withhold. Anaemia and tuberculosis are common due to the women’s socio-economic backgrounds. I was told of instances where the surrogate had hidden serious known gynaecological or other health disorders from

the clinic and the agency, confirming to doctors the need to carry out medical screening in addition to questionnaires:

> There is a waiting list to get a surrogate because they have to pass screening first. They have to test everyone because once the agency sent them a surrogate who had tuberculosis. So they don't trust the agency and run all their own tests, which many of the surrogate don't pass. (Dr Rasheed, Fertilitum)

The local agents who bring potential surrogates to clinics have also been known to hide issues from the clinic in the hopes that nobody would check. Dr Sid, the young doctor from Delhi, showed me files of some of his recent surrogate screenings and explained:

> Same with the surrogates [as with egg donors]. We get them from the agency and do our screening here, big time! [...] We do a diagnostic hysteroscopy of every surrogate mother. In the last fifteen surrogates I screened I have had one unicornuate uterus. The surrogate never told me. She has only one fallopian tube! And the shape of the uterus is like this [draws the banana shape of a malformed uterus with only one horn]. She knew and she never told me. That's amazing, you know? If you're desperate for money you'll do anything just in case the doctor accepts it. (Dr Sid)

A thorough screening would generally include both medical and lifestyle aspects. The medical screening would cover the surrogate's previous deliveries and test for infectious and sexually transmitted diseases, as well as general health indicators. There was significant variety in the levels of screening, but procedures were nonetheless always advertised as comprehensive. Indeed, the website of one internationally well-known Delhi clinic ambitiously promised 'FBI, Child Protective Services, and state police records checks in any state where the surrogate and her partner have lived for the last ten years' ("Intended Parent FAQ", n.d.).

Indeed, the screening of surrogates goes beyond just their medical health. Lifestyle screening is aimed at establishing the character of the surrogate in relation to trustworthiness, morals, religion, family arrangements and overall reputation. But just as important is the clinics' interest in identifying and excluding women who might give them trouble with demands for money or attention. The surrogate's economic background is important here, as it has impacts on the medical health of the surrogate - an ill and malnourished woman can hardly be relied on for a successful surrogate pregnancy - as well as her perceived trustworthiness and submissiveness. It was an Indian surrogacy lawyer who spelled out the importance of that last factor to me, acknowledging that, while surrogate mothers tend to come from lower socioeconomic classes, they nonetheless should not be too poor:

> We are not looking at working with an illiterate group or slum people, or people who don't care about anything else other than money. We don't want to work with people who do not have anything to lose. (Arun)

The thinking behind such socio-economic selection is that, while the financial need of surrogate women is an important tool in controlling them and subjecting them to the demands of the surrogacy process, excessive economic despair can, in the view of many surrogacy professionals, create its own complications. It is feared that destitute women will not be able to present themselves in an acceptable manner either physically or in terms of their behaviour in the clinic and in front of clients and that they or their husbands may cause problems with additional demands for money.

As a result, surrogates are rarely as poor as they are made out to be. The common reference to surrogates as coming from urban slums or backward villages, a

necessary part of the 'surrogacy as charity' narrative that I discuss elsewhere in the thesis, sometimes distorts perceptions of their economic situations. The lives of surrogate women are no doubt of significant economic precarity, but by Indian standards these women are by no means the poorest of the poor. As a slum charity in Mumbai explained to me, with rents of around 5000 Indian Rupees a month (£60) and constant competition over housing, living in a central Mumbai slum can, in fact, be aspirational.[12] Even slum-dwellers thus often have regular employment or a combination of odd jobs that bring some form of steady income. Rudrappa (2015) has made the same point about Bangalore's garment production neighbourhoods where the surrogates in her research lived. The cost of living in the urban areas of modern India is high, even if the quality of life on offer is not, creating a large pool of people who just about manage to get by. Those who need extra cash due to a sudden expense or who have aspirations to move up in the world through educating their children become an ongoing flow of perfect candidates for the production line of the global low-cost surrogacy business.

Perceived character, however, involves more than just the surrogate's background. Recruiters are looking for a broader combination of factors that agents and doctors believe will give them a desirable reproductive worker. A good surrogate is someone who will subject herself to the demands of the industry and the intended parents without question. According to research on surrogate recruitment criteria (Saravanan, 2010), submissiveness and inertness constitute important qualities in the screening process because it is hoped such a surrogate will be easier to

[12] In her book Behind the beautiful forevers, Katherine Boo (Boo, 2014) provides a compelling and accurate account of the daily realities of India's urban poor.

manage. Clinics thus prefer a certain character type of surrogate who knows her place, yet comes across as friendly.

The result is that the intended parents often describe their surrogates as sweet and shy or friendly and kind, but always delighted by their presence. There is no mention of the surrogate taking any kind of initiative in the conversation nor, indeed, doing anything other than standing there and answering questions. This blog post written by a heterosexual American couple about their experience is a good example:

> We shuffled back to Dr S who then brought our surrogates in to meet us. We have a young surrogate and an older gal, both medically fit and emotionally signed up for this. Our young surrogate was full of life, excited to meet us and all smiles. Our older surrogate was shy and quiet but equally as lovely. We chatted with the girls for a bit then they were on their way. ("Mark and Kerrie's Journey Blog", n.d.)

Several intended parents even noted in their blogs that the surrogate appeared worried or intimidated by them. While this is partly a result of the counselling of surrogates and instructions on appropriate behaviour, it is also due to a general recruitment strategy that has been shown to favour as surrogates women who display a character of submissiveness and quietness while excluding on polite medical grounds those who are seen to be overly assertive (Saravanan, 2010).

Once they have been selected as surrogates, women need to be matched with their intended parents. It is common at that stage of the agreement for clinics to invite the intended parents to choose 'their surrogate' from a selection of pre-screened women. They come to the clinic, meet the women and sign contract papers. While some intended parents welcome the opportunity to choose a woman they like, others are

less enthused. One American woman wrote on her blog that, although she was happy with the result, she found the selection an ‘agonising task’:

> On the surrogacy front, we have selected our surrogate. This is an agonizing task. The idea of lining up women to select the so called best...ugh. Well, anyway, it is done and we feel very good about our girl. She apparently cooks the best biryani so we of course hope to be lucky enough to try this and borrow the recipe. (“Taj Ma Baby Blog”, n.d.)

From that initial meeting, the surrogacy process officially gets underway. As excited and hopeful intended parents departed for their flights home, the surrogate began undergoing preparation for embryo transfer. From this point on, her life was entirely under the control of the clinic, her days and her body both subjected to the needs of the IVF miracle.

Risk and control

Having full control over surrogate women at all times is not a trivial concern for clinics. A lot can go wrong when one is trying to create a baby in a petri dish and grow it in a working-class Indian woman while convincing Westerners across an ocean that everything is going to plan, even if it is not. The technology can be capricious, bodies can react in unprecedented ways, and emotions run high, all across language and cultural barriers (a matter I discuss in More detail in chapters 5 and 6). Even smaller, everyday things can refuse to go according to plan. As an example of how an egg retrieval can quickly become stressful, the anaesthetist might be running late at the other clinic they work at, but the embryologist needs to leave soon to go to her next procedure at her other job. The eggs, however, need to be harvested that day because the follicles have formed and the surrogate has been

prepared. Days like that were all too common in my time at different clinics. Indeed, with so many moving parts, on some days doctors may feel as if the whole enterprise was constantly trying not to work out. For business to be profitable, however, it needs to be streamlined so that time and resources are not wasted. The last thing doctors want in that situation is a surrogate woman asking questions or making demands about the medical treatment she is subjected to. From the clinic's perspective the depersonalising and objectifying treatment of surrogates is thus a necessary side effect of needing to control and police the production line of surrogacy to ensure efficiency, reliability and predictability.

This desire for control was rationalised in different ways, often with reference to quality control. The clinics' task is to produce healthy babies, and they want to maximise their chances of doing just that. With so many moving parts, this is not necessarily an easy task. Even surrogate agencies who specialise in recruiting women and caring for surrogates during their pregnancies cannot necessarily be trusted not to cut corners. Dr Sid explained to me the importance of checking everything:

> Once they [surrogates] are accepted and pregnant, they are taken care of by the [local surrogacy] agency. But I have verified where they are keeping them. I have seen the surrogate home facility myself. The medications for the surrogates and the donors go from my clinic, they don't go from where they want to buy it from.

Small details like where the medication comes from and how it is stored can have a huge impact on a clinic's success rates, making it a significant factor for the clinic to manage. Indeed, some clinics even advertised to me the fact that they had managed

to bypass the separation between surrogacy agency and clinic by bringing the agency role in-house, thus guaranteeing a uniform system and quality across the reproductive production line. Pranav, the head of a small chain of corporate clinics that grew out of an ART bank, said he considered it a key advantage to have the 'back-end work' side of surrogacy under his control:

> Our surrogate agent is all in-house — Hope Life and Fertilitum [the clinic's major competitors] depend on agents and this adds complications. We started out first with an ART bank, the back-end work [of the surrogacy industry], and when the clinic came all of that was in place. So we control the whole process. It makes us confident.

According to India's ART guidelines, fertility clinics needed to be separate organisations from the ART banks that provided them with ova, sperm and surrogates. But in reality there are often varying degrees of connections between the two sides to the surrogacy process, a fact that gives doctors peace of mind. Surrogates are the crucial link in the chain of making a baby. Their bodies are, after all, the site of the transaction, so managing what they do and who they speak to can help manage the others, hide failures or generate additional profits. As I discuss in Chapter 4, the clinic's drive to be in full control applies to all parties to the surrogacy arrangement, including agents and intended parents. But in huge part the fact that surrogate women become the central target of such controlling practices is simply because they can be controlled due to their vulnerability as of lower class and their situation under contract. It is far easier to control surrogates who have been screened, contracted and coached to be submissive than it would be to obtain the same level of cooperation out of intended parents.

Surrogacy providers themselves, however, often argue that practices of surveillance and control in surrogacy are not for their benefit and instead something their clients value and demand. Indeed, for some clients, control was one of the things that most attracted them to India. In a quote published in an article on Indian surrogacy in The New York Times, Julie, an American intended parent, explained she had come to India partly because she could not get the same kind of surveillance and control in the US:

> [in the US] You have no idea if your surrogate mother is smoking, drinking alcohol, doing drugs. You don't know what she's doing. You have a third-party agency as a mediator between the two of you, but there's no one policing her in the sense that you don't know what's going on. (Warner, 2008)

Gabriella, a parent turned facilitator through surrogacy whose surrogate had continued to live at home, told me that she later realised she had been in the minority in not worrying about it:

> Our surrogate was not housed with the twins until the sixth month. But this woman was a nurse. So that's a different story. Do I think all surrogates need to be housed? Absolutely not! [...] I'm like an oddity. Most international parents definitely want their surrogates housed. They feel... that's something that they definitely want, they want them housed. A lot of probably older parents or people who are more like me with a New Age thinking will be happy not to have them in special housing. I don't necessarily think that they all need to be housed 24/7.

But as we discussed the topic further, it eventually emerged that not insisting on housing was conditional on her trust in the clinic's recruitment process:

> Do I feel that depending on certain clinics they should be housed? Of course. The clinics that are run by businessmen who are not doctors, who may hire doctors to work for them, I think that those surrogates probably should be housed because they are probably surrogates from very poor areas of the metros, and if they're living in slums, it's probably not the best situation.

> They're probably not getting the nutrition they need, they're probably not being monitored the way that they really should be for an international couple. (Gabriella)

Gabriella was not carefree. Instead, she was very practical and experienced so her approach to the control and monitoring of the surrogate was more nuanced and holistic. If the clinic could be trusted to recruit surrogates based on their suitability for the job, rather than their willingness to work for a smaller fee, and the clinic had the network[13] and structures in place to monitor surrogates in their own homes, then there was no need for a hostel.

Anxious Representations

The concerns of intended parents that, without proper monitoring, surrogate women would lead unhealthy lifestyles, contract disease or in some other way harm the pregnancy often made them full supporters of the practice of keeping surrogates housed. But while some clients, like Julie, would come with preconceived ideas about the dangers of unmonitored surrogacy, others needed convincing.

Medical risk

To justify full control of the surrogate's behaviour, industry professionals make use of the representation of surrogate pregnancy as always in some way at risk and in need of management. Clients are told of the multitude of medical risks that can result from a bad diet, sexual intercourse or work, as well as the threat of infectious disease. As Gabriella explained, 'the clinics I work with all have housing. There are cases of

[13] Such informal networks of surveillance and control are explored by Sharmile Rudrappa (2015).

babies being born with chlamydia and other issues, and that's clearly from the surrogate not being housed or monitored'. Stories of what could happen if surrogates are not kept under supervision become subtle yet powerful arguments for the need to do so

> At that time [beginning of Indian surrogacy industry] also we didn't have a house for the surrogates. They were just living in their own homes. But then we had some complications and miscarriages, and so we came to think that we needed more care to be available. Because they live far and they don't have access to medical care or they don't come for help and so we started housing them. (Dr Chopra)

The argument for keeping surrogates under supervision was often presented as a safeguard in case things go wrong and there are complications, such as a premature birth or a miscarriage.

Even Suveera, who otherwise believed the surrogates were best off living with their families, agreed that having surrogates under supervision towards the end of the pregnancy was a necessary precaution: 'We haven't had any premature births so far, but they have the surrogates stay in the hospital in the final weeks before birth just in case. Otherwise they live in their homes if possible.' If things do go wrong, having surrogates under control also helps the clinic to control who knows what, mainly when it comes to communications between surrogate women and intended parents. Anything from failed attempts to the allocation of payments can be kept under wraps, while ensuring that any discrepancies between advertised standards of care and the reality remain unknown to the intended parents. The message here is that keeping surrogates in highly monitored hostels is a necessary measure for the health and safety of the baby, as well as the surrogate woman. Such comments, set against the

backdrop of the extreme monitoring and awareness of potential failure that accompanies assisted reproduction (Becker, 2000), can have a powerful impact on the minds and decisions of the commissioning parents.

Surrogate as a risk factor

It would be hard to overlook the fact that underlying such medical concern was more often than not a more general representation of surrogate women as a lower class of people who could not be trusted to take care of a pregnancy. I asked one doctor from a high-end fertility centre why she insisted the agency kept surrogates under full surveillance. She answered: 'Agencies have to monitor them because it's not their baby, so they might keep doing work or be having sex or something, not eat well…' She then went on to work through a long list of ways in which these women would not take care of a pregnancy. Her face went through a series of ugly grimaces as she spoke, describing the dirt, lifestyle and potential for sexual intercourse, with its associated risks of disease and undesired genetic input.[14] For her and many like her, surrogates were a lower class of person, dangerous to themselves and the precious babies they were carrying.

Surrogacy professionals' personal opinions on the nature of lower class life no doubt shape their attitudes towards housing and surveillance. But it is also important to remember that these are people who make an income out of mitigating these very risks that they themselves keep emphasising. In selling their services, doctors,

[14] Concern over the sexual conduct of surrogate women was common. It was justified by reference to the threat of sexually transmitted disease or the chance that the surrogate will become pregnant with her husband's child rather than the intended parents'. The fact that the latter remains a perceived threat even once a successful surrogate pregnancy has long been confirmed, coupled with the language used to discuss the matter, implies that racial, class and caste prejudices about the sexual conduct of lower class dark-skinned women might account for some of the concern.

agents, lawyers and surrogacy facilitators can thus further exacerbate anxieties about surrogates. Arun, a Bangalore based surrogacy lawyer who has a keen interest in the social and ethical side of the business, argued that creating mistrust for the surrogate was good for business not just because it helped justify additional services that were charged to intended parents, but also because helped industry professionals consolidate full control of the arrangement,

> And who is actually trying to give this impression that they can't be trusted? Somebody is giving them the idea. The doctors and these agents or intermediaries, all these people are basically looking for controlling everything. They want everything to be in their control. (Arun)

Representations of surrogates as bad mothers can be further strengthened by insisting that the surrogate is only interested in the money, and thus does not care about the baby's health. An example of this framing was Dr Sid's answer to my question about the need for surrogate housing: 'In India the reason women want to be surrogate mothers is for the want of money. There is no altruistic or philanthropic initiative in their mind. She is only doing it for a genuine want of money.' Others agreed, one Mumbai lawyer stating: 'The surrogate only has three concerns: carry the baby, deliver the baby healthy, get money for the baby.'

These negative representations of surrogate women have a significant impact on the intended parents. The latter's common insistence on surrogate's being housed is an excellent example of the kinds of concerns and mistrust that underlie the surrogacy contract as a result. Arun expressed this contradiction in respect of relationships:

> Here you have surrogate hostels where surrogate mothers are put in a particular place, they are fed. The whole thing is about mistrust, they are

> looking to work with people who they don't really want to trust. They are growing their children in someone who they don't trust at all! (Arun)

Control as guardianship

'They are fed' perfectly captures the extent of the total institution that confines Indian surrogates to an existence where every moment becomes standardised, streamlined and subjected to the aim of producing babies. It is neither ubiquitous nor inevitable in low-cost surrogacy, but it is commonplace and a powerful symbol of the developing dynamics of the bioeconomy in a laissez faire market environment. Yet many in the Indian surrogacy business would resent my interpretation of the management and surveillance of surrogate women as objectifying. They would instead argue that the management surrogate women are subjected to for the duration of their pregnancies is good for them. Dylan, an international facilitator who spends long periods of time living in India and regularly visits both clinics and agencies, argued that one could actually observe the objective benefits in terms of health and well-being of health checks, nutritious diet and a long break from daily hard work during the course of the pregnancy:

> Surrogacy is good for them! Their health improves! They gain about five years in life expectancy here. These women come from some incredible poverty, they have never seen a doctor before, and here they get all kinds of check-ups and medicines and food and supplements. You don't recognise them after nine months.

In my tours of various surrogacy facilities, I came across different ways in which this message was communicated by the staff who were showing me around. One doctor kept telling me how many kilograms each surrogate had put on during their stay. If he

did not know, he asked the women themselves. ‘Seven’ or ‘ten’, the surrogates would proudly state, and I, not knowing how to respond, cheerfully congratulated them, to everyone’s delight. There was something profoundly strange about these situations, but everyone involved seemed to consider it all perfectly natural. The cheerful patting of these women’s shoulders and the counting of their accumulated kilos was a way to emphasise their suitability as reproductive workers at the same time as proudly showing off the result of the clinic’s micromanagement of their lives and diets. But it was also intended as a way to rinse out any lingering sense of exploitation or harm, presenting to anyone who was ever a party to such discussions clear physical evidence of the fact that keeping surrogate women in highly monitored environments was not only good for the clients but also for the women themselves.

These various representations form a powerful narrative that makes surrogacy as it is practised seem like a morally acceptable way to have children. In order to justify the depersonalisation, isolation and relentless control of surrogate women, they are represented as potentially dangerous and as becoming suitable mothers only through management by the clinic. This surveillance and control is presented as both necessary and indeed beneficial to surrogate women, erasing any doubts over its nature, and thus opening the door to the clinic’s near-absolute power over the relationships that evolve out of surrogacy, together with the commercial and emotional potential they hold.

Counselling

Getting surrogate women to understand and accept their depersonalized role in surrogacy is important, achieved through ongoing counselling by clinic and agency

staff. When I use the term counselling, I am referring to a focused combination of convincing, explaining and mentoring that aims to create efficient and docile surrogates. I learned about the aims and practices of counselling from Indian fertility doctors, for whom it was an important part of ensuring surrogate women filled their role with care and without making trouble. I have here supplemented these accounts with other authors' ethnography on surrogate perspectives and experiences. This is very different from the kinds of counselling that surrogates in countries like the UK or the US receive.[15] According to Arun, this difference in counselling has broader implications for surrogate women. The lack of understanding and information is, according to him, an important part of the industry's ability to control the surrogates throughout the arrangement:

> In comparison in the US things are in no way comparable to India because the surrogate mothers there are involved in what they are doing, they are made to understand what they are doing, given the counselling and everything, they understand what's happening. (Arun)

Counselling in the Indian surrogacy context is less concerned with supporting women in working through the meanings and emotions around what they are doing than in providing an opportunity for agents and doctors to get the women to see surrogacy in a way that best matches the needs of the industry, thus potentialising (Vora, 2013a) surrogates as reproductive workers.

[15] Although outside the scope of this thesis, it is interesting here to think about the ways in which surrogate counselling in India and the UK or even US are different in nature, yet similar in their aims to get women to see their position in the transaction in a particular way, whether as low-level workers or altruistic angels.

The process begins with an explanation of what surrogacy is. Most women will have some idea about it from recruitment, but breaking down the biotechnology can nonetheless be tricky. As Amit, the director of a surrogacy agency explained, this can take quite some effort because the women often lack the education to understand the technology involved: ‘Counselling! Lots of it. We find someone who speaks the language and use pictures, videos. So we say [points at bindi forehead sticker and laughs] ‘baby is so small! Like that we explain in their terms.’ The surrogates are also told about their relationship to the child, as one of a temporary carer, and the need to hand over the infant immediately after birth.

The overarching focus of counselling is to get the women to accept the functioning narrative of low-cost surrogacy: that they are not mothers, they are merely renting out their wombs, they will never see the baby or have any relationship with the intended parents, and that they must behave as is appropriate for someone who is renting themselves out for money - that is, follow instruction and not make trouble. It is through counselling that the discourse of rented wombs, a key premise for the inferior positioning of surrogates, is introduced and instilled in the women. The rhetorical reduction of the surrogate’s role works to ease surrogate women into the depersonalising experience they are about to undergo by emphasising the irrelevance of their own persons: they are needed for their wombs. It is thus a useful tool for creating and maintaining discipline in the surrogates, turning them from housewives and factory workers into reproductive biolabour.

Representations of medical risk are, again, important. Surrogate women are told that their pregnancies are inherently at risk due to the use of IVF and that they should

thus take extra care even if their own pregnancies had been without complications. This risk is then placed firmly on the surrogate. ‘It all depends on you’, is how the medical complexity of pregnancy loss was presented to one surrogate without any further explanation (as quoted in Sama, 2012, p. 81), so as to encourage surrogate women to subject themselves to the clinic’s control. Pregnancy loss was a serious matter for these women because it meant losing out on the payments, potentially coming out of the entire ordeal with nothing (Mitra and Schicktanz, 2016).

This kind of negotiation is an important supplement to the industry’s more direct forms of surrogate management because the women are carrying precious babies. Comments by Indian surrogacy professionals revealed that in order to ensure that they always act in the best interests of that precious baby, it was not enough simply to control them: they need to be convinced to want to look after it as if it was their own, a matter covered in more detail in the next chapter. In discussing surrogate counselling with Indian industry professionals, I came across additional, parallel approaches that were aimed at the development in the women of a kind of ‘entrepreneurship of the self’. I borrow this term from Cooper and Waldby’s (2014) analysis of biolabour in the context of the neoliberal Chicago School’s theories of human capital. In commercial surrogacy, surrogate women are encouraged to begin to see themselves as economic actors and their capacity to bear children as a source of economic value that they need to look after (see my discussion in Chapter 2 above). This approach is built on the women’s own recognition that exposure to global bio-markets through surrogacy allows them to make a small fortune out of something women usually do for free. Manju, a surrogate woman from Delhi quoted in a newspaper article, said she joined the industry because she had seen others

make ‘good money’ out of it and wanted to get the same for herself. ‘Any fool can have a baby,’ she said; ‘it takes a smart woman to get paid for it’ (Roy, 2011).

Counselling aims to build on surrogates’ recognition of themselves as ‘smart women’ and begins to develop in surrogate women a kind of entrepreneurship of their own reproductive bodies: they were no longer mere housewives but breadwinners. If counselling is successful, the surrogates begin to monitor themselves in ways they never did for their own pregnancies, such as agreeing to dormitory stays and following diet and other lifestyle prescriptions, because they would come to see themselves and the babies they were carrying as valuable investments. Dr Sid told me that, in his experience, surrogates were happy to move into housing and follow other instructions if they were ‘counselled’ to understand that the potential value of their bodies can only be unlocked if a healthy baby is born, and that the best way to achieve that was for the women to do as they were told:

> Really it depends on how you counsel them. It’s not their decision. You have to understand that in India the reason women want to be surrogate mothers is for the want of money. There is no altruistic or philanthropic initiative in their mind. She is only doing it for a genuine want of money. So if you counsel them properly and tell them that, OK you know the disadvantages of being in a surrogate home is that you will not be with your kids and your husband and whomsoever. But the advantage is, look you will get great food, we will get your kids to visit you every week or every alternate day if you wish, you can teach our kids at the home, if the home is empty enough, you can keep your kids with you. (Dr Sid)

Such counselling was a way to ensure that surrogates knew what was expected of them in terms of behaviour as well as the potential penalties and rewards at stake.

Recognition without resistance

The surrogacy industry in India is geared towards and skilled at creating a steady supply of low-cost, docile, effective reproductive bio-labour - the key to its global success. But this machinery, although powerful, is not absolute in its effects. I learned that the production of the bio-worker subject does not go unchallenged because, despite anyone's best efforts, the lives and persons of surrogate wombs kept breaking into clinic procedures. Through the passing comments of doctors and others, or in more outright expressions of frustration, I came to sense the limits to surrogate objectification, despite never speaking to the surrogates themselves.

For example, in one clinic, the doctor told me she allowed surrogates to keep their children with them and made other occasional allowances so the women wouldn't 'start complaining of pain here and there and...'. I was curious about this situation where aches and pains are related to the presence of children, so I asked the doctor to elaborate. She did not. Instead, she brushed off my questions with a friendly resignation: 'It keeps them happy, so it makes my life easier.' The social and emotional suffering of surrogates seemed to be making its way to doctors in the form of physical complaints so that it would be recognised and acted upon.[16] In a system where the women's own needs were not given recognition, some surrogates had learned to express them in the only context they were listened to - the health of their reproductive bodies. Being able to keep their younger children with them seemed to be a commonly raised issue by surrogates. But there were others. Several doctors

[16] See the work of Mark Nichter (Nichter, 1981, 2010) for a thorough analysis of somatisation in India.

also spoke of surrogate women asking questions about the intended parents and requesting to meet them or asking for particular kinds of foods.

These were small gestures, but research indicates that they could be part of broader 'continuum of resistance that includes both narratives as well as individual and collective actions' (Pande, 2010, p. 970). Ethnographic research among surrogate women has shown that resistance to dominant rhetoric and practice extends to constitute a broader criticism of the overarching ideology of Indian surrogacy, as well as rejection of its narrative and of surrogate women's place in it. Alongside issues like payment and surveillance, surrogates reject the devaluing of their sacrifice and their motherhood being reduced to mere womb rental. In Amrita Pande's ethnography, Surrogate Chandra expressed her outrage as follows:

> I have satisfaction (atma trupti) in my own actions. I know that through my suffering I will have filled another home with a child. But what kind of people are these recipients [intended parents]? Can they ever have atma trupti? How do they face themselves and look that baby in the eye, knowing that they never allowed it to be even held in the arms of the mother (hettha thai) who gave birth to him? (Pande, 2010, p. 970)

Another quote from Pande's ethnography shows how the women often also feel a sense of unfairness over agents taking large amounts of the fee that their suffering has earned:

> This Nirmala [agent], she takes Rs 10,000 [$200] from us for getting us to the clinic. We take all the pain, and she earns so much money. See, we come here because we are desperate, but she has made a business out of this. This shouldn't be allowed to happen. (Pande, 2010, p. 970)

A lack of confidence in the moral nature of the people in charge of their welfare, coupled with a lack of transparency and information, could lead to surrogates becoming sceptical about the doctors. As a result, being told to undergo a caesarean rather than a less invasive and less risky natural birth could be received with scepticism, as in the case of this Delhi surrogate quoted in Sama's research:

> My chances of normal delivery were high, but nowadays doctors, in order to hike their fees, force people to go in for caesarean, and so I also had to go in for caesarean. Although the madam [doctor] said it was because of the baby's health, but there was still some time before the due date. (Sama, 2012, p. 68)

Recognition of the unfair and exploitative nature of the surrogacy industry and of its other issues did not, however, lead to the surrogates negotiating a better experience for themselves. For all its faults, surrogacy was still a relatively good form of employment for working-class women with very few options. Not only could they earn well, but the work was also more meaningful and often safer and less traumatising than the other options available to them. Sharmila Rudrappa has pointed out that the women:

> did not necessarily see selling eggs or surrogacy as benign processes. Nor did they misread their exploitation. However, given their life options, they believed that Bangalore's reproduction industry afforded them greater control over their emotional, financial and sexual lives. (Rudrappa, 2015, p. 96)

Any resistance on the surrogates' part needed to be carefully contained, or it would see the surrogate swiftly removed from the business and its promise of transformative income. As a result, surrogate women's attempts to have their lives and persons recognised, even if partially successful at times and an important

marker of the limits of power and rhetoric, fail to effectively challenge the order of things. Indian surrogates can negotiate to keep their children with them or recast objectification for themselves as a fulfilling relationship, but the system of the global surrogacy business remains firmly in place despite their efforts. It is an industry that, in its drive to generate spectacular profits as well as offer a no-fuss cheap service, carves its profit margins out of the systematic reduction of Indian women to streamlined bioeconomy production lines.

But this stark reality does not make resistance irrelevant. Despite the outcome, recognition by surrogates of their own wrongful treatment, coupled with the doctors or commissioning parents who, even within the established system, refuse to look at surrogates as mere bodies is not trivial. These small actions had big discursive backgrounds in a refusal to accept the reduction of the person to a womb for rent. I saw many examples of people with genuine care and compassion for surrogate women. Somehow, they were all too often drowned out or pushed out by other, louder voices of business, profit and foreign client volumes. But even if of little immediate effect, the existence of resistance to a profitable business with powerful rhetorical and practical tools at its command is a signal of the fact that global surrogacy does not need to function the way it does today and that, possibly, less objectifying bioeconomies can thrive if they are given the space to grow.

Conclusion

The process of turning a mother into a surrogate, when looked at as a function of clinic and agency practice, is a complex one. Terms like exploitation and

empowerment - often used to talk about surrogacy - fail to capture the many overlaid dynamics that come together to turn the gestation of babies into a streamlined business. In this chapter I have discussed only some of the ways in which language and clinic practice work together in the surrogacy process to become a powerful combination for the project of creating depersonalized yet nurturing bodies. The recruitment process of selecting submissive women in significant economic need and counselling them to accept their situations, coupled with a policy of blanket consent, and followed by clinic practice that excludes surrogate women from their own pregnancies, are all geared towards turning women into efficient bio-labour. Limiting the recognition of surrogate personhood to wombs for rent is an important aspect of maximising profit because it helps contain the complexity of human presence and the relationships that could otherwise threaten control and profits. Indeed, the surrogate's potential to form emotional connections and meaningful relationships can cause complications for the industry, but also anxieties for the intended parents, especially in the context of the contested kinship of third party-assisted reproduction. The management of this potential for kinship and the anxieties it provokes will be subject of the next chapter.

4. Mothers and workers: labour and kinship in commercial surrogacy

‘I think it salutary to think about the unsociable aspects of ARTs: to think more about processes of undoing and indifference and the ways in which kinship does not proliferate’. (Edwards, 2014, p. 53)

Introduction

Phil was rushing around his large hotel room trying to get ready, attempting to brush his hair, find matching socks and answer my questions all at the same time. I had managed to arrange this meeting in London because he was in town to give a talk on gay parenting, which he was now running late for. A gay dad through Indian surrogacy himself, Phil knows the business well. Since then, he has devoted his life to helping other become parents through surrogacy. Phil was telling me about the many challenges intended parents faced abroad, especially as the industry had spread beyond India, from visa problems to overcharging clinics, when suddenly his face grew tired and worried. He stopped, sat down on the bed, looked up at the ceiling and slowly spoke:

> There is a case in Thailand at the moment where a US citizen and a Spanish citizen, a gay couple, used a Thai surrogate. Just before they were going to get the papers signed she [the surrogate] decided she wanted to keep the child. Under Thai law that's within her rights. The problem is the child is in the possession of the intending parents right now, but they can't leave the country unless she signs the paperwork. It's an absolute nightmare. I've said to them, ethically, morally, their only choice is to leave the baby with the surrogate and start over again where the surrogate has been screened properly. They are

> still in Thailand looking for an exit route, an alternative route, to smuggle the kid out.

I tried to push Phil for more details of the case, but it was still a while before the story reached the media, so I did not get far. But the impact of the case on Phil was clearly evident. He had an enormous amount of concern for the two men whose quest for a family had gone so badly wrong. But he was also aware of the bad press this was for gay parenthood through surrogacy. Phil figured this crisis had come about not because of inherent issues with surrogacy, but because the couple had not made sure the surrogate had been properly screened. He further added that this is exactly what can happen when people simply hope for the best and commission surrogacy in countries that do not protect the intended parents. He was frustrated but, all too aware of the lack of options for gay men to become fathers, also compassionate. Being on the run from the authorities in a foreign country with a newborn and not knowing how it would all end is surely not how anyone expects their quest for a family to end? On the other hand, I could only imagine what the surrogate woman must have been feeling when the child she considers hers is out there somewhere in hiding with two foreign men. Indeed, given their decision to go into hiding with the baby, are the men persecuted parents or kidnappers?

Cases like these are rare but the stories abound, foregrounding important issues. If in the previous chapter I evaluated a case for commercial surrogacy as a kind of bioeconomy that focuses on the harnessing of the biological reproductive capacity of surrogate women, then this chapter further complicates that picture. The many difficulties faced by the industry in managing kinship, emotion and relationships in

the surrogacy arrangement show, with even greater clarity, how the reduction of reproduction to biology to be an aspiration for the industry that often does not hold in reality.

Indeed, kinship in surrogacy is a complicated matter. Instead of the big questions of what it means for humanity to be making babies in petri dishes and gestating them in women who are hired for the purpose, I am concerned here with something far more practical. How, once all the big questions have been asked, answered or at least pushed out of sight for the time being, do the ‘intended parents’ actually become simply ‘parents’ over the course of the surrogacy? While technology can produce a human child, it cannot produce and imbue with meaning the kinship relations that this child will grow up in. How do the relationships, contracts and technologies of surrogacy end up producing families? More importantly for the successful functioning of the industry, how are potential alternative kin relations rendered meaningless and irrelevant? To explore these questions, this chapter delves into the surrogacy industry’s world of biotechnology and business from a different angle to look for kinship, family and relationships, or to point out their notable absence.

Kinship matters

In fertility medicine, kinship is a world of seemingly infinite opportunity. Through a combination of biotechnology and the recognition of genetic, gestational, legal and social kinship, seemingly anyone can become a parent as long as they can afford to pay for the services needed. In public, policy and bioethics conversations around assisted reproduction, especially surrogacy, which are often provoked by some

ongoing legal dispute, questions of kinship tend to be raised in the context of determining who the ‘real’ or ‘rightful’ parent of the child is. This focus has meant that an important aspect of collaborative assisted reproduction is often overlooked: kinship does not just happen or fail to happen based on policy or a judge’s ruling. Both can establish parental rights, opening the door for kinship relations to develop, but they do not create such relationships, nor do they automatically dissolve other, alternative kinship ties.

The same can be said for reproductive medicine itself. For all its power to create and determine biological facts, it is, according to Charis Thompson (2005, 2009), not much use when determining what to do with them. In tracking the interventions of fertility medicine from a kinship studies perspective at fertility clinics in California, Thompson noted how categories of kin and parenthood, rather than having their underlying biology exposed as concrete through the application of science, are in fact further complicated in the process. Thompson argues that, in assisted reproduction, the connection between biological facts and socially meaningful kinship categories is highly indeterminate. Indeed, IVF with egg donation and gestational surrogacy are, from a procedural or biomedical point of view, identical procedures because in both cases an embryo is implanted into a woman’s womb for gestation with which she does not share any genetic connection. Who the intended parent is in these situations thus becomes determined by who commissioned the treatment, not by any biological or genetic connection. Such ambiguity necessitates constant work by all the parties involved to align accounts of biological kinship with those of the social so that they can become meaningful:

> Norms governing the family; laws regulating reproductive technologies, custody, and descent; the medical technologies themselves; and the financial dynamics of third-party, medically assisted reproduction are the feedstocks and products of this kinship work. Infertility patients, third parties, and practitioners routinely, and largely informally, do this kinship work; they are practical metaphysicians. (Thompson, 2009, p. 272)

Kinship in assisted reproduction, Thompson concludes, is about doing, rather than being. This 'doing' happens through what Thompson calls 'ontological choreography,' that is, 'the dynamic coordination of the technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics' (Thompson, 2005, p. 8). She argues that there is nothing accidental in the ways nature, nurture and intent are brought together in fertility treatments: 'What might appear to be an undifferentiated hybrid mess is actually a deftly balanced coming together of things that are generally considered parts of different ontological orders (part of nature, part of the self, part of society)' (Thompson, 2005, p. 8). These different orders are arranged in ways that produce recognised parents and children.

In her discussion, Thompson focuses on examples where the egg donor or surrogate is a close friend or family member because the threat of ambiguous relationships or association with incest (as in the case of a woman acting as a gestational surrogate for her brother's baby) make the disambiguation of kinship claims in such cases especially important. Indian surrogacy is in some ways at the opposite end of the spectrum. It is extremely commercialised and dominated by both social and geographical distance between the surrogate woman and the intended parents. Nonetheless, in researching the business I came across what could be described as strategies of disambiguation that sought to ensure there would only be one set of

parents at the end of a successful pregnancy. Indeed, it appears that the extreme social and geographical distance between the surrogate woman and the intended parents that low-cost surrogacy involves makes the disambiguation of kinship relations just as crucial here too. These strategies, however, take on a dramatically different form and rhetoric when the need to disambiguate kinship intersects with dramatic socio-economic inequalities. The ontological choreography of kinship in the Indian surrogacy clinic is thus very different from that of fertility centres in California.

‘That’s how they punish us’

A sense of normalcy can be in short supply for intended parents through donor conception or surrogacy, or even regular IVF (Becker, 2000), but especially so in transnational surrogacy. It can be hard for them to feel as if they are about to have a baby if there is no pregnancy around. Not much changes for them apart from their bank balance and the knowledge that somewhere in the world an embryo is slowly becoming their baby. ‘The whole time it felt surreal, until we were booking our flights’, said one parent of their experience with cross-border surrogacy in a clinic testimonial (“Testimonials, Fertility Solutions PGD”, n.d.).

During that surreal wait, there are things the intended parents do to begin to feel like expectant parents, to experience the excitement of pregnancy despite using a gestational surrogate and to ensure that the transition to becoming a family is a smooth one. Indeed, for the intended parents, their status as parents does not start when the child becomes theirs through post-birth bureaucracy, but as soon as a pregnancy is confirmed. Expectant parents engage in the consumer rituals of becoming parents by ‘nesting’: going on shopping trips for buggies, cribs and

countless nappies and setting up a nursery. The families, friends and co-workers of intended parents often organise baby showers and send presents. Such rituals are marked by the absence of a pregnant woman but are perhaps even more important precisely for that reason. Here is an example from the blog of two gay dads:

> One of the facts of having children through gestational surrogacy is that you don't get to see the day-to-day changes in a growing pregnancy belly. You don't get to see or feel babies moving, and unfortunately we aren't able to be a part of all the doctor visits, etc. But one way Matt and I are experiencing the growth and changes in the third trimester of our surrogate pregnancy is the growth and change in the number of gifts that have arrived for our twins in the past few weeks. It started with a trickle–a few boxes here and there–and culminated in a full-on deluge of colorful, thoughtful, adorable presents at the baby shower our friends and family recently threw for us. ("New Dads on The Block Blog", n.d.)

Focusing all energies on the baby's arrival can also provide a welcome distraction from any nagging concerns the intended parents may have. Will they feel like a family? What if the child grows attached to the surrogate, misses her and rejects her intended parents? Would it then be right for them to claim the infant? This is a topic that the genre of the surrogacy blog struggles to accommodate, but it is a common concern. Online surrogacy communities are full of practical advice on how to ease the process of transfer. Others address more emotional and psychological aspects, such as 'womb envy'. The goal of such advice is to make the intended parents feel like the baby is their family and they are its family, before birth.

Most of the advice, such as reading to the foetus or attending medical appointments, is not applicable to transnational surrogacy due to factors such as geographical distance, time difference and language barrier. The best that most parents can get is a quick meeting at the signing of the contract and a few Skype calls with a woman

whose language they do not speak. Very few can afford the time and expense of travelling to visit the surrogate, and communications with the clinic can be difficult. This lack of opportunities for bonding, coupled with a more broadly perceived lack of normalcy, can be a source of frustration for the intended parents. This clip from one parent's blog discussing the baby shower they threw for their Indian surrogate baby (but not the surrogate) touches on the kind of resentment the surrogacy process can foster:

> Speaking of normal… we finally had her baby shower last week… her first big outing… it went very well… finally, we got to experience one 'normal' pregnancy/new baby experience… it was nice for a change… got to experience it first hand… not by email or phone call… ("Mumbai Beginnings Blog", n.d.)

Adding further to intended parent concerns about involvement and attachment is the fear, even if implicit, of legal complications around the handover of the baby. What if the surrogate does not want to give the child up? Or what if the child will not be recognised as theirs by the immigration system? Making kinship in the context of Indian cross-border surrogacy is a twofold process that has both a legal and a personal aspect. In these issues, the moral and legal domains are deeply intertwined, and the parenthood claims created by each can work to reinforce the other. If a child is recognised as belonging to its parents in moral terms, then the legal side can often be worked out around that. But if this parental connection is contested, provoking fears of child trafficking, then the legal case for parenthood or custody can become difficult or impossible to win.

The legal position of the intended parents is protected in India by contract law, but they often lack the legal certainty of being recognised as parents in their home countries. The US, for example, requires a genetic match between the baby and one of the parents in order for the child to gain citizenship. This seemingly straightforward requirement can quickly become a personal and diplomatic nightmare when it turns out that a mix up of embryos in the clinic has left the intended parents with a genetically unrelated child through no fault of their own. Other countries have their own risky scenarios. Furthermore, in some other low-cost destinations surrogacy may not be regulated at all, meaning that the intended parents are left hoping for the best, with no real guarantees. The definition of who and what a mother or parent is remains the subject of uncertainty in the regulation of parenthood and citizenship. International variation in legal approaches and the court disputes that continue to challenge any such regulation are a continuous reminder of just how fragile any protections for new family forms can be.

Having their parenthood recognised is an especially prominent concern for gay parents. I asked Australian Phil, introduced above, a gay dad through surrogacy and an activist who also helps facilitate overseas surrogacy, how being a surrogacy parent worked out in the context of the country's attempts to curb the practice. He took a deep breath and explained:

> Good question… different government departments, some will accept surrogacy. The department of citizenship will award citizenship to these children because of the DNA link to the intended parent. So they can get Australian citizenship and based on that the passports. But that's separate from the Australian legal system recognising me as a legal parent. Our legal system hasn't caught up or isn't in tune with how our citizenship rules work as a nation.

The lack of certainty in his answer shows, that even within one jurisdiction, different government institutions might approach things differently. This lack of regulatory coherence means that in Australia many gay dads through surrogacy are not in fact their children's legal parents despite the children having no other carers:

> We all just live with the fact that we are not the legal parent, we just accept that. The legal parents are the surrogate mother and her husband. I've got to apply for a guardianship type thing, I think, if I went to court. Most of us don't do that because it's expensive.

The best such parents can do is to perform the role of parenthood so well that no one ever stops to ask questions. Such precarious parenthood, even if not a constant worry, can nonetheless permeate everyday life, such as going to the doctor:

> At the end of the day a doctor will assume we're the parents because we have the Medicaid cards which says our name on it. They don't ask for an Australian birth certificate; they don't ask for legal parentage. There's no legal parentage papers you have in Australia. It's a legal issue that's just not ever been satisfied. In the UK, you can apply for parental orders when you come home if you do that within the six months. But in Australia they are being bloody strong-minded about that, and they just haven't let any of us do that because that's how they punish us.

Phil has been through this argument countless times in his role as a surrogacy activist and facilitator. He seems all but resigned to the matter, yet even he gets emotional when describing the subtle state-enforced punishment for commissioning surrogacy abroad - you are not recognised as a parent. It is clear how, for someone having their first child through surrogacy, experiencing such precarity in their status

as parents can impact the entire process. I ask Phil if he or others ever worry that he and his partner will lose their children,

> The government wouldn't take the children away, but in theory the surrogate could turn up and say ‘I want the kid back, it's mine’, and in legal terms she'd perfectly be in her rights to do that. And that's spooked some people, but most of us know… or believe that wouldn't happen because we had surrogates who had families already and who didn't want other kids. But it does spook some people.

In having their children through surrogacy, gay dads like Phil are essentially signing up to a lifetime of precarious parenthood. It is unlikely that anyone would take their children away, but it is possible. Since the risks are greatest around the time of the handover of the baby, such concerns make the wait stressful for the intended parents. The building excitement about becoming parents and the desire to get to know and love their child as soon as possible is thus supplemented by the need for the intended parents to begin to feel as if the child is truly theirs from the very beginning of the surrogacy, that it belongs only to them.

Making kinship

Concerns over kinship can be especially pronounced in the case of surrogacy and particularly challenging to manage over long distances, as the child being born will have an embodied connection to the gestational carrier and often no biological connection at all to one of its future parents. In turn, the industry professionals who specialise in creating children through assisted reproduction have learned to make such disambiguation of kinship a part of their practice. This group effort involves not just the intended parents but also doctors, lawyers and facilitators, and it works to

establish the child as belonging to the family of the commissioning parents in both moral and legal terms.

Following Jeanette Edwards (2014), I have found it useful to look at how parenthood across national and cultural borders is managed in older institutions, such as transnational adoption, in order to understand better the dynamics of these complex biotech-mediated relationships. Indeed, while the new reproductive assemblages afforded by conception outside the body may have complicated assumptions about kinship, many of the issues that they raise have been around since well before the age of assisted reproduction. For the purposes of understanding the disambiguation of kinship in surrogacy, one of the most relevant concepts to come out of adoption research is that of 'kinning'. Developed by Signe Howell, kinning describes 'a process by which a foetus, new-born child, or any previously unconnected person, is brought into a significant and permanent relationship that is expressed in a kin idiom' (Howell, 2003b, p. 465). Howell's research looked at how Asian children brought into Norwegian families through transnational adoption were gradually turned into members of their new kin group and of the Norwegian nation:

> Each child is given a new name, new citizenship, new birth certificate, new kin and home, new social and cultural expectations, and new relationships beyond the family. This is a time characterized by an extreme effort to de-biologize origins and to transubstantiate the child's essence. The ultimate aim is to kin the adopted child into his or her parents' network. (Howell, 2003b, p. 471)

The purpose of kinning is to compensate for the lack of shared biology and history in adoptive families by transmitting to the children a sense of belonging to their new families and to bring their life trajectories in line with those of their adoptive parents

so that they can share a future as a family. In the context of assisted reproduction, kinning can thus be seen as part of the same broader effort to seek normalcy and establish oneself as a regular family that I discussed above. Its purpose, however, is more specifically about creating a strong and enduring bond that, once complete, reaches into the past as well as the future.

The surrogacy industry has found ways to help with that process. The arrangement of the entire surrogacy process, coupled with clinical practice, can be a powerful tool of kinning. Everything from decisions regarding the pregnancy and information-sharing to the language used to assign roles to the various parties works to establish who has the right to claim the resultant child as their kin and play a role in its life. From the intended parents' side, the need to begin bonding with their child despite the long distance often took the form of requests for updates, information, pictures and scans.

At times, the parents need to feel in some way involved in the creation and gestation of their child, even if all they can do is wait for the next update, can become all but obsessive. Managing intended parent emotions long-distance could be frustrating as well as time-consuming for doctors, so the job was often trusted to client managers and international facilitators. Gabriella, a major US-based international facilitator, described just how relentless intended parents can be:

> This one woman, she would call me every day, every day!' she laughed, 'and she would ask me 'Is my surrogate still pregnant? How is the pregnancy going? What is the news?' and for nine months every day I would have to run through the same answer that yes it was all exactly the same as it was yesterday. I was thinking to myself, 'Oh my god, I just wanna play you an automated message!'

Nonetheless, most Indian clinics, even with the help of facilitators, found ways to make their clients feel like they were a part of the pregnancy process. Some doctors would send their clients various scans and 'belly photos' and even videos of their surrogate undergoing ultrasounds. Others would go the extra mile and send images of fertilised embryos before they were even implanted because they knew what such small details meant for anxious and excited intended parents. When I was in Dr Sid's office, he called me over to show me an email he was about to send to a client. The message included images of the embryos, explanations about how they were graded, how grading related to success rates and what all that meant for the couple's future options. In that same update Dr Sid also had a scanned image of the surrogate's uterine lining with another blurb of text to explain its significance. He then showed me an email he had sent to a couple whose surrogate had just had a transfer. Included was a scan of the surrogate's uterus post-transfer, with the embryo visible as nothing but a white speck and accompanied by numerous blessings, both a 'good luck' and a 'god bless.' Dr Sid does not mind sending this information because he considers it natural: 'This [the need to be involved] is the beginnings of the parenting instinct, so of course they worry and this calms them.' In Dr Sid's view, it was beneficial for everyone to let that parenting instinct flourish as much as possible.[17]

Many others shared this understanding of the importance of such contact and the different forms it takes for domestic and international clients. An experienced Indian

[17] Foetal imagery is increasingly important in developing kinship and parenthood in regular pregnancy as well. Barbara Duden (Duden, 1993) and Sallie Han (Han, 2009) are examples of the growing field of literature on this topic.

client manager explained to me the background to overseas intended parents' seemingly endless requests for updates:

> When they call up, the first thing they say is that they want to meet the surrogate, to see the surrogate, choose it because… One is a selfish issue of theirs: it is their baby growing in another mother's womb, and she should be psychologically sane and stable, because otherwise it affects the child. Even after ET [embryo transfer] they would like to visit, see that the mother does OK. We are very transparent, so they can visit the surrogate any time, and all the tests and scans are sent. Domestic clients come visit and bring cashew nuts and treats for her just to keep her happy and all that. But clients from abroad might not be able to come. So they will request photographs and videos to be sent to them. Usually these things are done. (Kritarth, client manager)

While part of the function of such a flow of images is to prove to clients that there is indeed a surrogacy underway, these same images are also welcomed by the clients as an opportunity to feel present in their as yet unborn child's life. 'We send everything, scans, reports, everything. They probably can't tell what it is sometimes, but they like it, they like just because it is about their baby. So we just send it', shrugged an international client manager from Delhi. Online blogs and forums, as well as my conversations with international surrogacy facilitators showed that not only do intended parent look forward to such updates from the clinics, they then spend hours on Google researching the implications of the various numbers and terms, and post scans on social media to announce to their friends and family any progress or challenges in their pregnancy. The clinic's work in supplying information and images, coupled with pregnancy activities back home, together help co-create the pregnancy as the client's rather than the surrogate's.

Keeping in touch

Most doctors also advertise and aim to provide opportunities for the intended parents to speak to the surrogate - and thus their baby- over Skype. Dr Chopra, who strongly supported such bonding activities, described her system to me:

> Parents get updates monthly. Some want to Skype with the surrogate. It's difficult because of the language, but we try to get someone to translate. We allow them to communicate as much as they want and as much as is possible. We do what the patient wants, and people are different. Some want to bring lots of presents and meet the surrogate many times, but some are more distant.

Dr Chopra's comment about doing what the intended parent wants illustrates the extent to which the client's wishes take priority in a consumer-focused private medical-care industry. But it is also revealing of more significant hierarchies of power and their relationship to kinship claims. The way information is shared and communication organised reflects how the needs of the various parties to surrogacy are perceived and their roles defined. In stark contrast to the intended parents, surrogates often have very little information about the intended parents and the baby they are carrying. Dr Chopra's ideal of bonding over the course of the surrogacy that involved the gestational carrier was rarely found amongst fertility doctors. However, she expressed to me her sadness over the fact that many of her clients did not wish to build even a basic relationship with the surrogate:

> The surrogates are curious too, they come in to ask, madam, whose baby am I carrying, what are they like? Knowing the parents and meeting them makes it easier for her too. Even just a letter goes a long way. I really encourage the intended parents to communicate with their surrogate. Often surrogates say they never even saw the baby. And I feel like it could be such a beautiful bond, why would you not want it? So I encourage it. So some of the IPs come

> and show the surrogate the baby and click pictures, and it means so much and it's just beautiful.

There is not much Dr Chopra can do apart from encouraging the intended parents to reach out to the surrogate. The fact that showing the surrogate the baby she carried and taking a few pictures is seen to constitute a relationship goes to show the extent to which the role of surrogates is limited.

Language of kinship

The language of and around transnational surrogacy is an effective part of the constant reconfirmation of various actors' roles in the creation of a child. Clients are always referred to as either intended parents or simply parents, while the gestational carrier is only ever called the surrogate and very rarely surrogate mother. In fact, on one occasion an international facilitator referred to the surrogate as the surrogate mother in conversation, only to quickly correct himself. Language can be a useful tool for disambiguating relationships.

In one surrogacy blog, the intended parent describes how he got a call from his husband to tell him about the pregnancy 'Guess what? We're pregnaaaant!!!' ("New Dads on The Block Blog", n.d.). The text message from the clinic, a screenshot of which was posted on the blog, merely read that 'Your surrogate has tested positive' and then went on to give readings of pregnancy markers and promising a report soon. The power of the language used to talk about pregnancy to frame and disambiguate parenthood becomes apparent in such key points in the surrogacy. The intended parents, both men, declare themselves to be pregnant, while the

surrogate has merely ‘tested positive’. Such daily details, while not always immediately significant in themselves, add up to powerful statements.

Accounts of the surrogacy often focus on the challenges the couple faced in undergoing surrogacy, the miracle of medical technology and the hard work of doctors, with the surrogate again almost absent. Such systematic practices of the inclusion of the intended parent and the simultaneous exclusion of the surrogate, coupled with the rhetoric that surrounds them, work to develop the intended parents’ sense of their identity as expecting parents, while at the same time ensuring that the as-yet-unborn child is already being incorporated into the family as kin.

The socially naked child

From the way surrogates are excluded from these kinning practices, we can begin to see the other crucial aspect of the disambiguation of kinship - that of de-kinning. Indeed, in surrogacy, practices which confirm the status of the intended parents as the only legitimate parents are in surrogacy coupled with practices which seek to delegitimise or make impossible the potential claims to parenthood from others. De-kinning practices, or what Thompson (2005) has described as the establishment of parenthood by rendering other participants prosthetic, work to create the ‘socially naked child, a child denuded of all kinship; denuded, that is, of meaningful relatedness’ (Howell, 2006, 2007, p. 26). In her writing on adoption, Howell describes the abandoned child (the ideal candidate for adoption) as already socially naked by nature of its abandonment: ‘By abandoning the child anonymously, the biological parents are in effect de-kinning it’ (Howell, 2007, p. 26). A child in this position is ‘the

example par excellence' of the autonomous individual and ready for adoption by a new set of kin. Social nakedness, Howell suggests, is what makes transnational adoption possible and morally acceptable for both donors and receivers. As a result, many adoptive parents prefer children whose parents are unknown, as it is thought to ease the kinning process, to which the existence of other potential kin is seen as a potential threat.

The surrogate baby, however, lacks such desired social nakedness by reason of being in a woman's womb, rather than anonymously abandoned. Amrita Pande's (2016) research on surrogacy in Gujarat, India, has indeed shown that the rhetoric and practice of surrogacy arrangements has limited effects on surrogate women's understandings of their role. Pande explored kinship in Indian surrogacy and noted that surrogate women made alternative moral claims on the baby based on a construction of kinship that disrupted established biological and genetic approaches. Instead, surrogates focused on kinship as an everyday practice of labour and shared bodily substance. While the intended mothers' moral claims, based on their genetic connection or, in the absence of it, their hardship and the devotion they had shown in the course of fertility treatment, were considered paramount in the public narratives of surrogate pregnancies at the clinic, surrogates emphasized their own labour and sweat in bringing the infant into the world in order to make alternative claims. 'It may be her eggs, but it's my blood' - the title quote from Pande's article - forcefully captures the challenge to conventional approaches that surrogacy entails.

Intended parents, however, do not wish to share their position as parents and can feel 'such a need to encompass in a singular occupancy the role, status, and identity

of mother to their child that they engage in rites of integration that end up downplaying or entirely eliminating the surrogate's role', as Elly Teman (2010, p. 198) has observed in the context of surrogacy amongst Jewish Israelis.

The potential for alternative kin ties also constitutes a potential threat to the legal recognition of intended parent kinship in cases where the intended parents are not automatically considered the child's only legal parents. The lack of alternative parental candidates and the absence of any competing legal claims are often a big part of court rulings that establish parenthood in surrogacy, meaning that the avoidance of any such potential claims serves to secure the position of the intended parents. Local specialised surrogacy lawyers described to me the extent of some intended parents' worries and the lengths they would go to in order to feel secure:

> I came up with my own document that confirmed that the surrogate had been paid, that she consented et cetera, so everything is covered. But some clients are very apprehensive and they want consent clearance for everything: school, university et cetera. They had this apprehension that it might be needed in the future maybe because they were gay couple, so there was no mother - the surrogate was the mother. (Sindhu)

In the anxious minds of intended parents, the surrogate could even claim the child, and depending on the circumstances, have the moral and legal basis to do so.

Whether or not that is actually a realistic scenario is almost irrelevant once the very possibility of such a development is introduced into the minds of the intended parents. The result of these anxieties is the perceived need to de-kin the child from the surrogate mother continuously and proactively and thus create a socially naked child.

This is where Howell's work on kinning and de-kinning intersects with the issues of global and national inequalities that it overlooks. Orphans and abandoned babies are too rare to be able to fill the global demand for socially naked children. Quite the contrary, such children need to be created by actively de-kinning them from their birth parents. Claudia Fonseca (2011) has used the concept of de-kinning in her work on adoption in Brazil to highlight the institutionalised violence against birth mothers that produces children for the adoption business. She describes de-kinning not as abandonment, but as 'the institutionalized effort that goes into undoing the naturalized category of biological motherhood.' De-kinning usually happens after birth, when the adoption is confirmed, and it takes the form of cutting off the birth mother from all contact with the child and withholding information about the birth mother from that child. Fonseca points out that in such adoption arrangements, babies move from lower-class birth mothers to upper-class adoptive parents, a dynamic that closely resembles that of surrogacy. She argues that this process of creating what Howell (2003b, p. 472) would refer to as a socially naked child is imbued with a power dynamic that puts the birth mother's interests last.

Deconstructing motherhood

In surrogacy, de-kinning is incorporated into the very fabric of industry practice. One of its pillars is the industry-wide insistence in commercial surrogacy in India, and almost without exception elsewhere too, on only offering gestational surrogacy. The surrogate in gestational surrogacy lacks a genetic connection to the child because ova are sourced from a separate egg donor. This is true even of pregnancies that use donor eggs, such as gay surrogacies, or where the client woman's eggs are not

viable and an Indian egg donor is used. In fact, a woman could at different times act as an egg donor for one pregnancy and a surrogate for another but never both for the same pregnancy. This might seem irrational because traditional surrogacy using IUI (intrauterine insemination) is both safer and cheaper than gestational surrogacy through IVF, but it makes sense in the context of the kinds of anxieties I have been outlining in this chapter. It is as if having the genetics as well as the gestation from the same woman - as is sometime done in the West, especially in altruistic surrogacy - would create too many connections between the surrogate and a child for it to be contained in a non-kin relationship. 'It would… be too close, then it is just like her own child, so we do not do that', said one Indian doctor of the separation. This sentiment was widely expressed by professionals on all levels of the business and even enshrined in legality in the (by now effectively obsolete) Assisted Reproductive Technology Bill, which states in Section 34:13 that 'A surrogate mother shall not act as an oocyte donor for the couple or individual, as the case may be, seeking surrogacy' (Ministry of Health and Family Welfare, 2008).

The focus on containing the surrogate's contribution in gestation, while present throughout the conception and gestation process, is especially apparent in arrangements for the birth and aftercare of the child. Surrogate babies are routinely delivered by caesarean section. This is partly a practical matter, as the procedure is much more amenable to advanced planning for clinic schedules and flight bookings than natural birth, guaranteeing that the intended parents can make sure they are present to receive the baby immediately. But some industry professionals argue that

caesarean births are important in preventing bonding between the surrogate and the baby.

Once out of the womb, it is common practice to separate immediately and permanently the newborn from the surrogate, who in some cases never even sees the child. Intended parents sometimes hire carers for the baby to help with childcare, especially in the case of multiple pregnancies. Most clinics and international facilitators can offer such services through established partners. Premature babies, which are relatively common in surrogacy due to the prevalence of multiples, move into what is known as NICU, a neonatal intensive care unit, where they are looked after by hospital staff. In either case, this woman is not the surrogate, a role that is considered finished. Instead of moving from mother to nurse, the newborn is seen merely to move from one hired carer to another.

Cutting off ties with the surrogate can create strange arrangements around breastfeeding. Most doctors and intended parents recognise breast milk as an important resource due its nutritional and immunological benefits. They want the child to benefit from it, but not through breastfeeding. The surrogate is therefore sometimes required to use a pump to express breast milk into a bottle so it can be fed to the infant by the intended parents. Rudrappa (2015, p. 154) covered the issue of breastfeeding in her book on surrogate lives. She used a post from an intended parent blog (the same Twindimama blog I have used elsewhere in the thesis) to show the extent to which a surrogate's body can be used to nourish the baby while carefully restricting her access to it:

> Everyone knows…[...] Breast is better. Well, my breasts don't have any milk in them. [...] Kailash does have milk in her breasts, and I want it. [...] Part of the

> surrogacy contract requires Kailash to provide breast milk for fifteen days. After that, we can have more, but we need to negotiate the details.
>
> The first days in NICU, before we got here, I'm not sure what was happening on the breast milk front. I think nothing. Then I asked for it, and Kailash started pumping. [...]
>
> I realized I needed to be managing Kailash and telling her what I wanted. I erroneously assumed someone else directed her to pump every two hours and to deliver that milk to the babies. When we brought the babies back to the Rama [hotel], things got even worse. Now the milk needed to be delivered down the street. [...] Back and forth and forth and back. [...] I feel like a drug runner, or a gerbil on a treadmill. I'm almost ready to quit, but working on finding a runner to pay to do the back and forth. Everything can be outsourced in India.

Rudrappa's argument about the denial of the surrogate's needs and emotions is powerfully illustrated in this post. But the milk-running exercise is also a powerful display of the relative roles of the two women in their interaction as mother and mere worker.

I asked Joseph, a European man in his mid-fifties who was a father of two through surrogacy and an activist for gay parenting, about the insistence on bottle feeding and the 'yuck' response of some people from the thought of the surrogate breastfeeding. His response, passionate and animated, began unpacking some of the complexity and emotionally charged nature of the topic: 'Nobody actually thinks the surrogate is dirty, it's not about that. It is just that breastfeeding is so powerful! It's so symbolic! So powerful!' Joseph became animated when explaining this, his tone growing louder and gestures bigger. This visceral reaction to the thought of the surrogate breastfeeding is especially intriguing given that Joseph himself had been able to forge a genuine and lasting relationship with the US surrogate who bore both his children. Such situations highlight the extent to which, even with the best

intentions, the intended parents' attempts to manage their situation as best they know how can impact the surrogate woman in unintended negative ways. Joseph clearly really valued the surrogate's contribution, but found breastfeeding to be a step too far. For Joseph and many others involved in surrogacy, breastfeeding was seen to create and represent an almost mythical bond between mother and child, one even more dangerous to the successful emotional, moral and legal transfer of the baby than the gestation itself.

Indeed, this idea of breastfeeding as potentially creating an unbreakable link between surrogate and infant was also commonly expressed by the doctors, who argued that rather than simply settling the anxieties of insecure intended parents, bottle-feeding was as much for the surrogate's benefit. Breastfeeding, many professionals argued, would risk creating too strong a bond between the surrogate and the baby, making eventual separation even harder. Excluding and controlling the surrogate again became represented as a benevolent and necessary step for protecting her, this time from her own mothering instincts.

This benevolent guardianship argument was presented to me as an explanation of the need to protect the surrogate Indeed, Sharmila Rudrappa (2015) has similarly argued that many parents' anxiety over breastfeeding is a manifestation of insecurities in their role as parents in relation to the surrogate. This insecurity in turn was often rooted in a recognition that the surrogate might have some moral claims over the baby. The replacement of breast-feeding by the surrogate by bottle-feeding by clinic staff or, even better, the intended parents themselves was in this interpretation part of a broader process of what Rudrappa describes as 'claiming the

surrogate's pregnancy as their own, declaring themselves to be pregnant, imaginatively reassigning the surrogate' labour to their own bodies' (Rudrappa, 2015, p. 130). Such strategies work together with the nesting and kinning practices, and when coupled with the intense control of the surrogate's behaviour and role that I described in the previous chapter, make the erasure of the surrogate relatively easy. The clinic's willingness and vested interest in being a part of the management and containment of the relationship between surrogate and infant meant that the intended parents could enjoy their exclusive relationship with their future child in confidence, even over a long distance.

No strings attached

Most clinics discourage the development of any kind of relationship between intended parents and surrogates beyond rare and highly orchestrated clinic encounters, such as during the signing of the relevant paperwork. I was given numerous reasons by surrogacy professionals for the necessity of this separation. Most drew on those same representations of surrogate women as greedy, jealous and potentially dangerous that I discussed in the previous chapter to make a genuine relationship seem impossible and reckless. Ishaan, a client manager from a metropolitan Delhi clinic, told me of the threat of either party (ostensibly the surrogate) making additional demands: 'We don't allow the IP and the surrogate to communicate in case someone wants something from the other or any such matter. It all goes through us, and the patient only deals with us, and we deal with everything else.'

Surrogacy activist and facilitator Phil also told me that separation and the anonymity it allowed was a protective mechanism:

> That's why perhaps the Indian clinics don't encourage ongoing contact with the surrogate during the pregnancy and don't allow any direct contact with the surrogate after the birth. It's all got to be done through the clinic. Probably for that reason. So the surrogate and family won't know which child to claim and our address. Yeah, so contact's not really possible.

After a quick pause, he continued:

> That made me think of something else… There were cases in the early days when parents did ask for direct contact with the surrogate and they got it, where the surrogate and/or her husband, when they were carrying twins, would write to the IPs and say we want more money for twins, otherwise we will go and abort them. And because that started to happen a bit, the agencies started saying, 'OK we're not going to allow any direct contact' because of that issue that was coming up for some cases. (Phil)

Whether or not a woman carrying twins should indeed be entitled to additional compensation for the inconvenience and health risk was not a matter that Phil focused on in this case. His concern was with the fact that a relationship between the surrogate and the intended parents would place the surrogate in a position where she could make demands for a better arrangement. For someone like Phil, the sense of vulnerability felt by overseas intended parents dominated interpretations of the surrogate's actions and intentions.

From the professionals' point of view, any relationship the intended parents develop with the surrogate represents a risk, as it can be a distraction from the surrogate's prescribed role as a gestational carrier only and complicate their work. Indeed, while not always openly talked about, clinics nonetheless had their own interests firmly in

mind when setting out rules for the conduct of various parties: ‘After that [the first visit], we don’t encourage too much contact. It makes our work difficult for us. The surrogate starts… to feel too important… and… it makes things more difficult for us’ (Phil).

Surrogacy professionals were skilled in combining different factors in their rationalisations so as to blend the interests of the intended parents and the surrogate woman creatively in ways that made the industry’s preferred modus operandi emerge as the only feasible one. Take for example this quote from the head of a surrogacy agency, describing to me how, through counselling, both surrogates and intended parents are brought to accept the industry’s preferred setup:

> We counsel both the surrogate and the intended parents about the surrogacy relationship, and we don’t want them to mingle. Surrogate has some greedy nature. Surrogate want to get more familiar and get more money and presents. We say to intended parent not to share their contact details. [EL: Why?] Motherhood… she knows it’s not her child, and we counsel that this is just for money and it won’t be a child for her and all, but it’s still motherhood, she had that baby for nine months. So if they mingle, then she might get pain from that and attached more and feel it’s her child. She can’t forget then. (Amit)

Amit starts off by painting the surrogate in greedy and dangerous colours, hinting at the chances of blackmail, moves on to imply that the surrogate could become attached to the baby and demand to keep it, but with an impressive turn then manages to conclude on a point about the surrogate’s best interests. These different arguments manage to draw on intended parent fear, sense of vulnerability and compassion all in one comment.

As was the case with the medicalisation and control of the surrogate during her pregnancy, arguments regarding the best interests of the surrogate woman again become a tool for the justification of how they were treated. Those who enforce the separation of the surrogate from the baby and the intended parents often argue that such practices exist for the surrogate's own best interests, to keep her from becoming overly attached to the baby and the family before it is all taken away from her. As such, Dr Swetesh explained to me that they aim to make sure the surrogate never even sees the baby as a way of sheltering her from the emotional effect it might have. This notion of benevolent if firm guardianship, of protecting the surrogate against her own wishes, is one that anthropology has taught us to be suspicious of. This relationship relies on the power imbalance between the surrogate woman and those making the decisions on her behalf, highlighting the difference between those with a voice and those without. Similar dynamics have been analysed in adoption research, where scholars have noted the use of the concept of protection as a tool of power. In such relationships, '"protection" implies a loss of autonomy to "pastoral powers" that claim to understand, better than the subjects themselves, what is best for them' Vianna 2005 in Fonseca 2011, p.320).

Awkward assemblages

Intended parents' responses to this separation vary. Some just accept it as it is, while others try to develop some kind of relationship, even if this is limited to sending presents. Others, however, can in fact welcome the separation as an opportunity to distance themselves from the surrogate and thus shelter themselves from any

potential emotional distress from a failed cycle, pregnancy complications or simply the surrogate's own life realities (Rudrappa, 2015).

Indeed, the position of the intended parents in these situations can be challenging. Getting the relationships around surrogacy right is difficult even in the presence of the very best of intentions. The largely uncharted social and emotional territory of cross-border surrogacy is the site of an ongoing struggle over the meanings of the bodies and relationships involved. It is a complex web of relationships, and those involved figure things out for themselves as they go along, creating sometimes confusing roles and relationships along the way. Some of global surrogacy's strangest arrangements have been created with the best of intentions.

This tension between being grateful to the surrogate and at the same time wanting to keep a clear separation between kin and non-kin is illustrated in the surrogacy guidebook by prominent surrogacy blogger and activist Richard Westoby (2013). Recounting his own experience of surrogacy in the US, Westoby goes to great lengths to express his love and gratitude for the surrogate throughout the book, as well as in his other writing and public appearances. Westoby and his husband also went beyond what their contract prescribed in taking care of the surrogate and supporting her through the experience. But when discussing relatedness, Westoby says in his book that he wants to make it clear that the woman is 'literally just the oven' (Westoby, 2013) and that she is carrying the baby as part of a commercial arrangement, thus safely bracketing her off as labour, rather than someone with whom the family has any form of kin connection.

The fact that Westoby is a gay man is significant here. Of all the groups who need surrogacy to access biological parenthood, gay men have perhaps faced the strongest opposition and the position of gay men as legitimate parents remains subject to often heated public and legislative debate around the world. In her ethnography of Israeli gay men seeking surrogacy in India, Sybille Lustenberger has located some of the challenges gay fathers through surrogacy can experience when trying to negotiate the place of the surrogate women in their need to justify a gay partnership as a suitable and legitimate form of family:

> The same-sex spouses remain legally invisible and outside the family core. [...] They wanted to be recognized as families in their own right and criticized the heteronormative presumption that a child needs a father and a mother. They encountered this presumption in their everyday lives: in their exclusion from surrogacy in Israel; when special offers for baby clothes addressed only mothers; or when a passerby innocently asked, “Where is the mother?” For my research participants, such incidents were disconcerting, as they forced them constantly to explain and defend their family structures. The thought that the surrogates could be regarded as an additional party in their family was therefore not just a threat to the positions of both men as fathers, it would also question the very concept of same-sex parenthood. (Lustenberger, 2016, p. 211)

The separation of the various parties in a transaction as a way of sanitising the arrangement is not unique to surrogacy and can be found in other bioeconomies. Monica Konrad (2005) has described a similar phenomenon in relation to egg donors, where many parents prefer anonymous donation, where the parties only interact with the agency and never with each other, to ensure that the donor could never become a part of the child’s life. An insistence on an anonymous and mediated relationship is also common in cadaveric organ donation, where doctors and donor agencies similarly work as gatekeepers for relationships between donors and recipients (Sharp, 2006). As in surrogacy, most donor families and recipients accept

the impossibility of these strange and complex relationships, while others refuse to do so and spend years looking for each other through newspapers and dedicated organisations. Sharp (2006, p. 14) argues that professionals in cadaveric organ donation are driven to enforce such separation aggressively in order to sustain a situation of 'ideological disjunction' between competing and mutually exclusive interpretations of the symbolic nature of organ transfer. In the case of surrogacy, the separation of the various parties helps to create or preserve an image of low-cost surrogacy as a morally unproblematic practice for the intended parents. Separation allows for the human cost that sustains surrogacy's production line, with low costs, flexible services and no strings attached, to be kept out of sight.

In this respect, such separation, variously carried out by the clinic, the intended parents or both, again bears a striking resemblance to adoption, where similar separation and anonymity became the norm over the course of the twentieth century:

> As the professionals of specialized agencies and court bureaucracies moved to mediate the transfer, direct relations between giving and receiving families were minimized, 'sanitizing' the transaction (Ouellette 1996, see also Zelizer 1985). Information that birth and adoptive parents might glean from one another as a result of direct contact and oral exchange gave way to written records controlled by the mediators. (Fonseca, 2011, p. 313)

Adoption, organ donation and surrogacy, while different in significant ways, nonetheless have in common the key working principle of anonymity and separation as a response to the potential complexity of the intense and potentially disruptive human relationships they could foster. These tactics aim to ensure that the potentially messy and often heartbreaking supply side never meets the cheerful and life-affirming demand-side experience. Adoption's 'socially naked child' (Howell,

2003b), organ donation's representations of organs as mechanical spare parts (Sharp, 2006) and low-cost surrogacy's 'wombs for rent' thus represent different incarnations of the same narrative. Potential interactions between the providers and the receivers of children or of organs can threaten the overarching narratives of these various businesses - that a morally and emotionally straightforward handover is conceivable and desirable. Relationships are thus made to be, or at least seem, impossible.

The importance of love and money

In part, the issues that often arise in the management of relationships in commercial surrogacy arrangements, and possibly also in adoption and organ donation, can be down to the overlapping and often conflicting interpretations of, and expectations for, the exchange. Margaret Jane Radin (1996) has argued that rather than neatly fitting into distinct categories of market and non-market, most things in life fall somewhere along the continuum between the two. Moreover, Radin argues, when it comes to contested concepts, such as the sale of children or prostitution, where there is a lack of crystallised understanding about the nature of an interaction, individuals can consider some things and interactions to simultaneously both belong to the market domain and the nonmarket domain. Radin (1996, p. 102) refers to this as 'incomplete commodification' and argues that complex as it might be to negotiate on a practical level, such competing yet co-existing understandings allow for certain things to be commodified and made market-alienable only to the degree to which it is necessary,

without doing injury to personhood and human flourishing - be it on the level of individual harm or harmful social rhetoric.

Indeed, Marcin Smietana (2017) found in his study of gay men commissioning commercial surrogacy in the United States that economic and affective dimensions of the surrogacy relationship were not at odds, as is often argued, but mutually constitutive of each other. Smietana identified:

> an affective narrative of gift-giving and relatedness, and an economic narrative of agency and equality. These narratives co-existed and mutually reinforced one another, and were shared by both the surrogates and the gay fathers. (Smietana, 2017, p. 5)

In the context of Indian surrogacy, an emphasis on the surrogate's financial motivations can help the intended parents manage their relationship with her and create distance. As one intended father put it, 'They do it because they want to earn money. This is their only reason. We make a contract and pay the money. It is a transaction. They are employed for nine months to carry the child' (Lustenberger, 2016, p. 212). The image of surrogate women and their motivations put forward by the industry reinforces such opinions in the intended parents, working to reduce the relationship to a financial transaction. Money can, indeed, be a powerful tool in managing relationships. Viviana Zelizer (2005, 2012) has argued that money, and distinctions between different kinds of monies, can be an important aspect of relational work in the effort to establish, manage and terminate interpersonal relations, including intimate relationships. 'People work hard to maintain such distinctions: they care greatly about differentiating monies because payment systems

are a powerful way to mark apart different social ties' (Zelizer, 2012, p. 151). Such practices of boundary-drawing are especially important when there is the threat of confusion, because 'relations resemble others that have significantly different consequences for the parties' (Zelizer, 2005, p. 34). The focus, both by industry professionals and the intended parents, on the surrogate's financial interests can therefore be seen as part of a broader set of strategies that seek to distance her from the family unit of the intended parents and their children that she is central to creating.

Approaching surrogacy as a contract between two parties who each have what the other needs provides the starting point for the fulfilment of this contract, and thus closure for the intended parents, allowing them to move on with their lives. If the relationship is only a contractual one, then paying all dues to the surrogate means that the debt is paid and the parents can move on. This can help the intended parents avoid relationships they would not know how to deal with. The following quote from the blog of American intended parent Jennifer, expressing why she found the forced distance in overseas Indian surrogacy a welcome relief, captures the sentiment of many others like her:

> In comparing Indian surrogacy with surrogacy in the US, I was attracted to the forced distance in our relationship. In the US, I could imagine hanging out with my surrogate on a Friday night, watching movies and eating root beer floats. We'd be besties...but then she'd deliver my baby (or babies), and what? Would we stay friends? Would we vacation together? Would my kids know her as surri [short for surrogate]? Would she feel a 'special connection' with my kid? Did I want that? It could get awkward, fast. Kailash and I don't speak the same language. She wanted to hold the babies, and we let her. We took a bunch of photos together, and will give her some prints before we leave. We smile and try to communicate, taking advantage of a translator whenever we find one. We really have tried to treat her well and with respect, but we aren't best friends. I don't have her cell phone number, and if I try to send pictures of Camilla and Oliver as they get older, I've heard they won't realistically get to

> her. I think she's happy she helped us. I think she is happy to be going home soon to her family. (“Twindimama Blog”, n.d.)

For Jennifer, the commercial and distanced nature of Indian surrogacy provided certainty that, when the time came, the surrogate would go back to her family, thus allowing Jennifer to move on with hers.

In the context of domestic surrogacy in the US or the UK, where the parties have more freedom to decide on the nature of their relationship, it is indeed not uncommon for surrogacy relationships to turn awkward after the birth of the child. Charis Thompson (2009) described the case of commercial surrogate Vanessa in the US, who was hired as a commercial surrogate and treated like family by the intended parents during the pregnancy. They had taken an interest in her life, bought her presents, spent time with her and temporarily conferred on her their higher social status. Vanessa was shocked when, immediately after the birth and handover of the child, those ties were severed. The intended parent couple stopped contacting her and avoided any attempts she made at contacting them. Through painful disappointment, Vanessa found out that what she had considered as being accepted into the family had in fact been the intended parents’ love for the child she was prosthetically embodying.

At the various surrogacy events I visited in the UK, panels of former US or UK surrogates and intended parents would indeed always reiterate the importance of being clear about the kind of relationship both sides were looking for right from the outset, and to be prepared to continuously renegotiate that relationship, ideally with a mediator. This was not always a case of surrogates wishing to be included in the

family. In fact, some surrogates at such panels argued that they felt like an ongoing relationship was forced onto them when really they just wanted to move on with their own lives and be with their own children. In light of such cases, a well-communicated contractual yet respectful relationship with an end date at the child's birth might seem the least disruptive one for all involved.

This reduction of the surrogacy relationship to the contractual and the monetary might seem at odds with the simultaneous emphasis on surrogacy as a generous gift that I discussed earlier in the thesis, but it makes sense in the context of the practical reality of surrogacy relationships. As the intended mother Jennifer's blog quote showed, intended parents are faced with complex moral questions and conflicting feelings, torn between what they want for their child and what they feel is an acceptable way for them to act as moral persons. Focusing on the contractual and commercial nature of surrogacy is not necessarily the result of the intended parents not recognising the impact of surrogacy on the surrogate woman. It can be the result of the opposite, of a sense of gratitude and guilt that they simply do not know how to deal with. Take, for example, this reflective blog post from a mother of young children through Indian surrogacy:

> It is very emotional and sometimes overwhelming to come to terms with the gifts that our beautiful surrogate bestowed upon us. There really is not a day that passes that I do not think about Ms S. and all the love she gave to our girls as they grew. I am forever grateful and feel so very blessed. ("Dreams Come True in India Blog", n.d.)

Despite the commercial nature of Indian surrogacy and the separation of surrogates from the intended parents, the extent of sincere gratitude the intended parents feel

towards their surrogate can be intense and enduring. Those involved in surrogacy show a significant ability to simultaneously think and act within the context of seemingly irreconcilable approaches towards, and opinions of, surrogate women. Intended parents can combine their own competing views of surrogate women as greedy and poor and potentially not with their child's best interests in mind with those of the surrogates as caring mothers, disadvantaged women and simply nice people in ways that can be difficult to add up.

Moreover, as Kalindi Vora (2014, p. 75) has noted, cultural differences in the ways economic relationships are approached can lead to misunderstandings about the motivations of surrogate women. Vora argues that the surrogate women's expectations of a lasting relationship were not expectations of kinship with the child but rather ones of enduring support and payment for themselves. Rather than greed, as it was often represented by surrogacy professionals and perceived by intended parents, such expectations are better understood in the context of the South Asian model of the enduring duty of a patron towards a client:

> The insistence upon the open-ended nature of the surrogate's relationship with the commissioning family can be seen in this context as a relationship of continued life and connection as opposed to its end or death represented by the exchange of money and associated cutting off of social ties. What is read by commissioning parents as solicitation and manipulation for more money and resources by a surrogate can alternately be understood as a way for her to insist on the transcendental nature of what is bestowed through surrogacy, which necessarily exceeds the surrogacy fee and creates an opening that logically insists on continuing relationality and exchange, even if it can simultaneously be the pragmatic pursuit of an opportunity for accumulating resources. (Vora, 2014, p. 75)

In line with Radin's (1996) argument on incomplete commodification, expectations for the surrogate can be equally complex. Lustenberger (2016, p. 216) has similarly found that gay fathers through surrogacy showed, either simultaneously with or at different stages of the pregnancy, conflicting expectations of the surrogate's behaviour. This 'double expectation' (Lustenberger, 2016, p. 217) saw intended fathers present the surrogate's role as purely economic, even expressing anxiety over the surrogate's potential shows of emotion. Underlying that, however, was an expectation of some kind of emotional connection with the surrogate that led to disappointment and the need to come up with various rationalisations when the surrogate did not act accordingly. Amrita Pande (2010, p. 976) picked up on a similar dilemma in the way surrogate women were counselled:

> The surrogate is expected to be a disciplined contract worker who will give the baby away immediately after delivery without creating a fuss. But she is simultaneously expected to be a nurturing mother attached to the baby and a selfless mother who will not treat surrogacy like a business. This mother-worker combination is produced through a disciplinary project that deploys the power of language along with a meticulous control over the body of the surrogate.

Surrogacy is not unique in combining commercial and non-commercial frameworks. Other sections of the bioeconomy with a similar potential for complex relationships walk the same tightrope between the realms of the personal, emotional and altruistic and those of the commercial, contractual and distanced as a way to navigate the uncharted emotional and relationship territory of bioeconomy. Research on organ donation relations has shown how organs can become vessels of complex quasi-kinship relationships between the deceased donor's kin and the donor recipient and their family. As is the case in surrogacy, such relations mix gratitude

and guilt in ways that people often struggled to make sense of or live with. These tensions were especially apparent in cases of live kidney donation between friends and relatives. Such donations happened in the context of a shared understanding of a kidney as too precious a gift to put a price on (Sharp, 2006).

While this understanding could eventually lead to mutual love, it also had the potential for insurmountable conflict. The magnitude of the gift that cannot be repaid, what Fox and Swasey (2013, p. 40; see also Sharp, 2006) have called ‘the tyranny of the gift’, can make even previously close relationships collapse and wreak havoc on the mental and emotional health of the party who feels indebted. It is thus not enough to assume that conceptualising these relationships through metaphors of kinship and altruism is inherently superior to commercial relations. Commodification, despite all its negative connotations, can in fact become a desirable format for surrogacy relations because of the way it simplifies, disambiguates and contains potentially overwhelming relationships while simultaneously providing closure.

Contested kinship, stratified reproduction

The market, however, can work on kinship and reproduction in multifaceted ways. Moreover, its structures and dynamics do not protect all parties to the surrogacy equally well. Most of the time, the intended parents come out of such arrangements with the child they wanted and with no sense of obligation towards the surrogate. The sanitation of their embodied and emotional work in gestating a baby down to a contract for a rented womb only serves to disadvantage the surrogates’ position further. They are left with imagining fantasy relationships with intended parents, in

which they are cared for and supported long after the birth of the child, without ever having any power to actually make such desired relationships a reality (Pande, 2009b; Vora, 2014, p. 75).

The research Claudia Fonseca (2011) carried out on the birth mothers of adopted children in Brazil mapped out similar dynamics. Fonseca argues that the promotion of 'clean break' adoptions, where the child will have no further contact or knowledge of her birth mother, is geared towards streamlining the adoption business and constitutes in it a violence towards the birthmothers, who are made to live as if they had never been mothers at all. Plenary adoption as the hegemonic global form of adoptive family formation makes use of the disadvantaged socioeconomic positions of birth mothers vis-à-vis the families who receive these children to break kinship ties that the birth mothers would often like to maintain. Even as the complete exclusion of birth mothers serves to simplify the process for the future parents and maybe even the child, it does so at the expense of the interests of those who are excluded.

The surrogate women's efforts to fulfil the industry's expectations and produce in themselves a relationship of commodification towards their bodies goes unnoticed (Rudrappa, 2015). The women worked hard, Rudrappa notes, on positioning the babies in their wombs as aliens with whom they had no emotional ties, but this effort went unrecognised. Surrogate women resented the way both the extent of the physical harm and also the shame and emotional burden they had to bear in their role as a reproductive resource for surrogacy's global bioeconomy was being ignored and denied.

The women in Rudrappa's (2015) research also often expressed the unrecognised and unremunerated impact surrogacy had on their own kin. Their extended families had been forced to look after their children, and their husbands were left without a family to come home to after a day's work. The weight they had gained in surrogacy hostels bearing a child for someone else, that measure of the benevolence of the surrogacy industry and the fairness of the arrangement (See Chapter 3), stood in contrast to the weight their own children had lost due to not having their mother at home. The privilege of the professionals and clients of the surrogacy industry in denying surrogates their personhood and thus shielding themselves from the complexities and sufferings of their lives thus ended up adding to the alienation of surrogacy work the additional degradation of being reduced to a prosthetic gestational carrier.

Phil never needed to worry about the two men, Gordon and Manuel, who were on the run from the authorities in Thailand. Eventually, they handed themselves in and started a legal battle for custody. The case went on to make global headlines, as the men appealed for public and diplomatic support, successfully mobilising the gay community and social media in their favour. There were hashtags, crowdfunding campaigns and interviews. Meanwhile, all we heard of the surrogate, Patidta Kusolsang, was that she wished to keep the child after finding out the intended parents were two men. The contrast between the parties' respective abilities and opportunities to tell their stories to the world and to command attention was striking. So it was no surprise when, despite commissioning surrogacy in a country where there was no legislation for it, hiring a surrogate who had not been counselled to make sure she understood what she was doing and then going on the run from the

authorities, the men walked away not only free but with the child in question now legally theirs.

The case is a telling example of how kinship is played out in the intensely commercialised context of transnational surrogacy. Even if on the surface, the case can be interpreted as showing that the market at times fails intended parents, as Phil suggested, and that the reduction of women to wombs and kinship to contracts does not work, the development and conclusion of this case confirm the opposite. The image of the two men emerging from the courtroom as fathers after the ruling, wearing custom-made T-shirts with the words 'Finally Love Won' written on them was widely used in reporting the outcome. The image was as powerful as it was divisive. To some it was a symbol of gay rights, but to others it raised questions. Had love won, or had money and power triumphed once more in a deeply unfair battle?

Such cases, although rare, are a powerful illustration of the contradictions of kinship and reproduction on the market.[18] They highlight the fact that the processes of the disambiguation of kinship described above are not isolated from the broader structures and practices that surrogacy entails and the power dynamics they operate within. The patterns of whose claims to family and kinship are heard and valued and whose are ignored can have implications beyond assisted reproduction. Even within the more regulated US context, Charis Thompson warned of the possible implications of commercial surrogacy for personal freedoms and reproductive integrity:

[18] See the photo at (BBC News, 2016).

> Given the history of US kinship, where under slavery the ownership of another's reproduction was a means of denying kinship, the significance of money in establishing procreational intent and thus claiming biological kin is especially important. Its unintended as well as foreseen effects - especially in overturning or superseding laws that are enacted to prevent a return to possession of rights in the body or reproduction of another - should be carefully watched. (Thompson, 2005, p. 145)

Thompson's argument is based on observations of donor egg IVF and surrogacy in the US, a country with a very specific history in relation to slavery. But its implications for the Indian surrogacy industry and other low-cost destinations are important. Just how relevant Thompson's words are is highlighted in the comments made by Justice Thackray in his ruling on another notorious case over surrogacy in Thailand. The judge argued that the case

> should also draw attention to the fact that surrogate mothers are not baby-growing machines, or 'gestational carriers'. [...] They are flesh and blood women who can develop bonds with their unborn children.[...] This case serves to highlight the dilemmas that arise when the reproductive capacities of women are turned into saleable commodities, with all the usual fallout when contracts go wrong. (Cook, 2016)

For a judge to feel the need to make such a point shows just how lost that recognition of basic humanity and emotion can become in the whirlwind of a booming global industry.

Indeed, low-cost surrogacy has been one of those phenomena that really capture the transnational context within which the concept of stratified reproduction (Colen, 2009; Hochschild, 2000; Parreñas, 2002) first developed. In surrogacy, just as in migrant care labour and international adoption, the reproduction of some classes of women is systematically valued, supported and rewarded while the reproduction of other

classes of women is simultaneously disadvantaged or even despised. This blog post highlights the trade-off between the surrogate's need for kin relationships and the blog author's desire for a baby:

> The surrogates who become pregnant here leave their families for their entire pregnancy and are put up in one of two houses managed by Dr Patel and her staff. From my perspective, hopeful mama, it sounded great. I had every assurance that my babies would get all the nutrients, vitamins and pre-natal care they needed. I knew my surrogate was passing her days munching on snacks (probably spicier than the root beer floats I consumed every day of my pregnancy), watching Bollywood movies, and gossiping with another 30 or 40 pregnant women in her same situation. India gave me relief from wanting to call my surrogate every day, from wondering if it was her car in the pileup on the 880. I knew a world away she was insulated. Insulated from her daily chores, hunger, and stress, but also (here's where it starts to get complicated.....) isolated from her community, family and home. ("Twindimama Blog", n.d.)

The trouble with getting close

The rhetoric of separation as the best policy for all concerned is not without its limits. Many in the surrogacy industry, be they professionals or intended parents, recognise the problematic nature of such isolation and denial of personhood. Nir, an intended father from Lustenberger's (2016, p. 216) research, expressed the sudden sense of wrong he felt when he finally met the surrogate:

> This felt so wrong to me that I left the room and started to cry. I understand that she has to disconnect in order to be able to give up the child. But somehow it did not feel right to me, this situation. In this moment I felt that it is not right that we see her only once, and it is as if she had not been there for the last nine months. All the arguments against surrogacy, about exploitation, that you use her as an instrument, suddenly I felt it. And I felt a little bit guilty. I do not think that we did anything wrong. We did not force her, and with the money we bought her children education. But at that very moment I felt the critique.

The path towards establishing a different dynamic is not straightforward, partly because, as I discussed above, individual interpretations of surrogacy's potential relationships vary. The line between what is and what is not an appropriate or desired level of distance and convenience in the making of a baby can create confusion between the parties.

If some struggle to understand why they cannot have regular contact with the surrogate and make real efforts to get through the gatekeepers of agencies and clinics, then others feel like they might as well just cut out the ceremony and simply have the baby delivered to them. Kritarth, an international client manager for a large South Indian clinic described to me the wide range of expectations he has worked with:

> Most people don't care much about the surrogate but then at the same time there are some who really do. You wouldn't believe some clients – when they come they bring treats for the surrogates, and once the baby is born they shower the surrogate with gifts. But then there are clients, once they get the baby they don't care about the surrogate. They just take the baby and walk off. It's not a cultural trait as such that has developed, I think, but just personalities.
>
> You will find all categories of people here, not all will be the same. Some clients, they will just say, 'Do we need to come at all? Shall I just come to pick up the baby?' They don't care what happens, they want to just post the embryo by mail or send their sperm along if it's a donor egg. 'I'll send my sperm! Just make the baby and send it to me!' If we could send the baby, they would be very happy. (Kritarth)

Certainly not everyone wants to exclude the surrogate from the pregnancy altogether. I described some doctors, rare though they might be, who wanted to create more of a relationship between surrogates and intended parents. Equally, many intended parents, as revealed in comments by industry professionals, as well

as blog posts and forum discussions by intended parents, genuinely want to connect with the surrogate and value her contribution, making real efforts to locate her even years later. In personal accounts and blogs, any mention of the surrogate is often preceded by the word ‘awesome’ or ‘beautiful’. Intended parents also express their gratitude to the woman who carried their baby and may describe how much they liked their surrogate and how pretty or sweet she was. It was common for intended parents to wish to give their surrogate additional gifts, or to offer to pay for important things such as better housing or and education for her children.

In fact, some try very hard to circumvent the clinic’s barriers to client–surrogate relationships developing and give presents and additional payments. Darsh, a client manager from a large Delhi clinic, described the efforts some intended parents make:

> From the Middle East they often come back and give gold and presents. From elsewhere too sometimes. They come to thank the surrogate. You know, this is highly emotive stuff, people do funny things, like being in love. But you get many nice stories. We try to discourage giving presents because it is wrong if one gets and the other not. But then this one couple from the UK, they came and gave presents to every surrogate to get around the rules in a nice way.

Others have made repeated attempts to find out their surrogate’s address, to send money directly to her or to find out more about her.

But we should be careful not to interpret these relationships as kinship, family or even friendship. As one intended mother explains in her blog:

> There is an impossible divide between the Indian surrogate and the intended parents. In our time here, we have seen both ends of the spectrum. One American mother tries to bond with her surrogate, spending the last months of pregnancy here in India, treating her like family long after the children are born. We see the husband [of the surrogate] continue to ask for money from

> this woman. To us, it appears that the woman is willing a relationship to exist that doesn't. She is naive. On the other hand, we have seen most families make a small (sometimes meagre) gift to the surrogate or their children. They aren't so careful to make sure that the surrogate feels appreciated, and they don't consider her feelings. Their focus is on moving forward, past the surrogate days and onto their lives as new parents. We carefully walk the line in the middle, ultimately knowing that Kailash feels positive about her experience and us. In a few years, when we explain our actions to our children, they will be the ultimate judge. (“Twindimama Blog”, n.d.)

Lustenberger (2016) argues that the affection and appreciation the gay men in her research felt towards their surrogates and the need they had to bring the relationship to a good end conflicts with a view of surrogacy as work and implied the existence of some form of intimate relationship. Placing surrogacy in the context of other care work such as childcare and live-in maids reveals the opposite: in the context of certain kinds of work, relationships can develop emotional and affectionate dimensions that can coexist with what are considered more strictly employment relationships, but that fundamentally do not shift the nature of those relationships from work to anything else. Visits and presents are not the same as accepting someone as kin. Such seemingly enhanced relationships are more about the intended parents than they are about the surrogate women. In the excerpt above, generous acts towards the surrogate help the intended mother feel like she is doing the right thing. Interestingly, they also become a way of managing future relationships between the intended parents and the babies, whom the mother thinks will be the ones to judge.

In fact, going beyond minimal requirements in terms of contact and compensation does not even amount to accepting someone as an equal party to a commercial relationship. When the intended parents build a relationship with the surrogate

beyond the initial meeting, this relationship only ever works on their terms. The power dynamic embedded in the arrangement and in the vast socio-economic distance between low-cost surrogacy's providers and consumers ensures that the intended parents can build a relationship as they please and cut if off when they decide to. The sweet colours in which visits and gestures by intended parents are painted stand in illuminating contrast to the way any attempts at contact on the part of the surrogate are feared and made impossible.

Moreover, even as clients refer to their surrogates as beautiful angels, they nonetheless ask that they be housed in hostels, away from their own families, and be subjected to procedures such as embryo reduction or caesarean section. The fact that the intended parents can manage this double image of the surrogate as simultaneously an angel and in need of strict control for themselves is in itself fascinating. There are parallels here to similar dynamics between wealthy Western families and their childcare workers. It is not uncommon for those families to claim that the domestic worker is part of the family, but at the same time feel jealousy over her closeness with the children or force her to work late nights and thus keep her from spending time with her own family (Bakan and Stasiulis, 1997; Colen, 2009). The contradiction inherent in denying family life to someone while claiming them to be part of your own family seems lost on the employers of these women.

Indeed, for the surrogates, a maternal relationship is only ever evoked to get them to go beyond what contracts prescribe in their care for the foetus. The use of family ideology is indeed an important and well-choreographed part of the 'counselling' of surrogate women, who are encouraged to care for the growing foetus as if it were

their own but then to give it up without hesitation. Amrita Pande (2010) has identified such counselling as a crucial part of the success of surrogacy arrangements. Without a simultaneous focus on the maternal, the process of convincing women that the baby they are carrying is truly not theirs might lead to them not taking sufficient maternal care of it. It places the surrogate in a double bind where she is caring for an unborn baby she is not allowed to develop attachment to. Activists from the women's charity Sama explained to me that this kind of manoeuvring can lock the surrogate into a grey area where she cannot have a relationships with the baby she is carrying but cannot shut it out altogether either.

In her work on immigrant domesticas in the US, Mary Romero (2016) found that the women tended to resent being told that they were considered family by their employers. In their experience, being considered family did not bring any of the benefits one would expect, as the employers still cared very little for their needs and wishes. Instead, they used the more casual relationship to get the women to perform unpaid work or stay late at short notice. Those domestic care workers who did not resent the description of their personal relationship with their employers as family were those who felt that the rewards of the relationships, both economic and emotional, made it worthwhile. In these cases, working additional hours was only one part of a broader relationship that benefited the domestica by offering her greater freedom, better working conditions and good relationships, rather than using her framing as 'family' to overlook her rights as a worker.

It is therefore not enough to assume that kinship relations, or indeed close interaction in general, is necessarily beneficial or desirable for surrogate women. In addition to

the potential burden of the ‘tyranny of the gift’ for the intended parents that I discussed above, the power imbalances involved can make such relationships potentially harmful for the surrogate. Indeed, a doctor once told me that some of her Indian clients had even asked for the surrogate to live with them during the pregnancy, as a sort of maid: ‘Indian couples sometimes host the surrogate in their house to make sure all is well, that she eats well and… takes her medication.’ She told me this to show me the extent of local Indian intended parents’ commitment to the surrogacy and the child being born. I asked her whether this did not constitute an unusual amount of control by one person over another person. ‘It’s care!’ she responded; ‘they want to have complete involvement.’ This boundary between care and control is easily blurred in kinship relations even outside the novel quagmires of assisted reproduction, but it becomes all but invisible to the eye when wealth, power and biomedicine meet a surrogate woman separated from her own social and kinship support networks.

I came across various demands on surrogates by local intended parents. One couple even had the surrogate travel across the country from her Mumbai home to go to a specific temple in another part of India for blessings. I heard of this when the doctor was arranging the surrogate’s medication during travel. He laughed and told me he found it a bit odd and kind of a hassle to arrange. He read the surrogate’s itinerary out to me:

> Indians are very ritualistic, so there are some rituals they want to do and take her to a temple, so that everything works out well for them. Surrogate will return after six days, spend four days at clinic until urine pregnancy test is done. I pray to god that she is positive [for the result]. Then she will be staying back with her family in Mumbai for three months. Then, if she agrees, we can

> shift her to a surrogate home, because the home has a caretaker and food facilities and everything. (Dr Sid)

He never made any mention of how the surrogate might feel about this. Not everyone in the industry was this uncritically accepting of such expectations. One client manager told me he felt that some especially involved intended parents were taking over the surrogate's life:

> Indians think… they think she is their…. I don't want to say servant but a bit like that. Like they now own her for nine months. They come in and give her things like some coloured strings to tie around her arm and ask her why are you eating this and don't do that and so. International patients, they have a lot of respect for the surrogate, like she is an important person to them. The international surrogates are much happier, the foreigners care for them, the Indian ones suffer a lot. I wouldn't say the Indians care more, they just interrupt and disrupt and make these really ridiculous demands. (Darsh)

Sustaining a relationship during and after the pregnancy can thus be a source of problems and further responsibilities for the surrogate woman, ones her subordinate position makes it difficult for her to challenge. A closer relationship is therefore not necessarily always desirable. Moreover, as some intended parents and doctors pointed out, many surrogates keep their surrogacy a secret from their community or extended family. For a wealthy Western family to turn up to visit her at her house unannounced would raise questions the surrogate may prefer not to have to answer, and parents should respect their privacy in that. For women employed as reproductive labour, be it before birth in the case of surrogates or after birth in the case of domesticas, being recognised as kin may provide psychological benefits and a sense of meaning. But such recognition remains deeply embedded in power

relations that have the potential to exploit this relationship in the employer's favour. Losing track of those dynamics favours those with power in their context.

More than anything, surrogates need to be recognised as persons in themselves with their own emotional worlds, lives and families. On a fundamental level, relationships between surrogates, intended parents and professionals need to be about welfare, justice and employment rights and to be guaranteed irrespective of kin relations.

Conclusion

The complexity of surrogacy relationships cannot be overlooked in any context. But when this complexity is overlaid on to enduring and permeating global economic, racial and gender inequality, on to a free market economy, postcolonialism, emerging economies' glossy dreams and the lure of the dream of a good life, then it can become an impossible task to figure them out. I opened this chapter with a quote about the way kinship often does not endure in these new assemblages of technology, money and people that together make babies. I will close it with one that describes the lived emotion of such breakdowns in human connection in the words of a gay father through surrogacy, as expressed on his blog:

> When she entered the room with her translator, I could feel my knees get weak and had to sit. I'm not even really sure what I said to her. She has children, and I think I asked her if they would be properly cared for during this ordeal. More important than what was said was what wasn't said. As I stared at this woman, so obviously nervous and shy by my presence, I realized this meeting was not for her. She didn't need to meet me like I needed to meet her. The cultural divide between this poor illiterate woman from Northeastern India and us, two middle-class white gay Western men, was thicker than a concrete wall. As hard as I tried not to, I began to cry and thank her for giving us this opportunity. I hope she was able to comprehend how much I truly appreciate her act of generosity but truthfully, I'll never know. ("India Calling", n.d.)

As I hope this chapter has shown, the surrogacy industry continues to face difficulties in managing the relationships that develop, or have the potential to develop in the surrogacy process. This is partly because much as the individuals involved in surrogacy like to think of reproduction as reducible to biology, and surrogacy to the bioeconomy, the reality is more complicated. While surrogacy harnesses the reproductive potential of surrogate women, it also relies on care and emotional engagement. The industry therefore does not only need to manage reproduction, but also kinship. The ongoing work of creating kin connections between the baby and the intended parents is matched by the work involved in breaking them between those who are becoming a family and the surrogate who is deemed not to have a place in it. This process, interlaced with relationships of power, is far from straightforward and uncontested even for those with the power to change it. Those who become involved in surrogacy are confronted with the absence of a single agreed way to approach the relationships it entails. Instead they are left to figure it out in the context of their own anxieties over parenthood, conflicting representations of surrogate women, cultural as well as geographical distance and severe socio-economic inequalities.

Some emphasise kinship, some the priceless gift of parenthood, some commerce. Some want to nurture the relationship, while others appreciate its absence. But these relationships all have one crucial thing in common: while the intended parents have the option to work towards and even demand the kind of relationship they desire, kinship or otherwise, and doctors and facilitators can use their position to shape these relationships so as to streamline their work, the surrogate woman has no such options. Thus, at their most basic level, the everyday practices of kinning and

de-kinning at the Indian fertility clinic that I have described are about power relations, about the distinction between parents and workers, an expression of who is allowed to parent and who is not and about who gets to make those decisions. This dynamic puts various intermediaries, such as agents and doctors, in a position of complete control as the supposed guardians of both parties. As a result of the separation of surrogates and intended parents, coupled with carefully managed representations of surrogates as only interested in money, these intermediaries come to benefit from the power to control flows of payment and information, often to the detriment of other parties to the surrogacy arrangement. It is to the role and impact of these various surrogacy professionals on the industry that I will turn to in Part II.

Part II. Surrogacy markets

5. Connecting the dots: building a global surrogacy industry in India and beyond

‘It [surrogacy] is probably more comparable to how the British got settled over here - it just slowly happened, and nobody realised it. So similarly it slowly happened and suddenly one day, when you are looking around, too much excess is happening. And they were not able to control it because it is a private transaction between two individuals.’ (Arun, specialist ART lawyer, India)

‘We are all in the same sea, just fish swimming. There are some sharks and sometimes they maybe eat the smaller fish.’ (Sindhu, specialist ART lawyer, India)

Introduction

Transnational surrogacy in India was for some time a great business to be in, with no regulation or international competition to cap the sudden and drastic influx of overseas clients and the profit they generated for Indian clinics. ‘This is big money!’, exclaimed Sindhu, a surrogacy lawyer from Mumbai, when she described the sudden boom transnational surrogacy had generated; ‘You do IVF and soon you’ll be driving a big foreign car!’ Indeed, once the cross border surrogacy business had taken off, all the big established clinics had waiting lists, sometimes for years in advance, and new clinics were constantly cropping up. Amidst this frenzy, it soon became apparent that providing surrogacy services to foreigners could be challenging in unexpected ways, with non-clinical matters such as legal issues, the daily practicalities of transport and accommodation as well as dealing with the culture shock experienced

by many intended parents proving surprisingly difficult to handle. Attempts to manage the surrogacy process better changed the business from a simple clinic-intended parent relationships to an ecosystem of services, products and actors. Meanwhile, India's attempts to curb the low-cost surrogacy industry's boom within its borders brought on a gradual move out of it to new destinations in Asia, Central America and Eastern Europe. As the first chapter of Part II of the thesis, this chapter begins to tell the story of this transformation.

Learning on the go

The first challenge was helping overseas clients navigate their stay in India and come out of it with their determination to start their family in India intact. Indeed, commercial surrogacy in India, often described as the extreme frontier of global outsourcing, nonetheless required its overseas clients to be present in India and involved in the process on at least two occasions. The first was a trip to India to provide their own genetic material for the creation of embryos via IVF and sign any necessary contracts and paperwork. This trip was generally short, lasting no more than a week. Once the surrogate pregnancy was approaching its full term, the intended parents needed to book their flights to be there for the birth of their child. This second trip was much longer and more involved. The intended parents needed to stay in India long enough to secure paperwork and ensure that any medical complications for the baby were cared for. If the need to keep pre-term babies in intensive care added a few weeks to the stay, then bureaucratic hurdles could take significantly longer. Depending on the intended parents' home country, the local authorities and nearest embassy in India and the extent to which all parties had

made necessary arrangements ahead of time, obtaining birth certificates and passports could take anything from a few weeks to a year. During their stay, the intended parents needed to negotiate local bureaucratic establishments and any medical arrangements while caring for their newborn baby, or, as was often the case, their twins. This second trip could be very challenging for intended parents struggling with the differences in climate, language and culture. The fact that many intended parents had never left their home country before made matters worse, leaving them struggling to cope with the unfamiliar surroundings and sensory overload they were experiencing. Several larger clinics even hired client managers especially for dealing with the non-medical needs of their overseas clients who were perceived by the Indian surrogacy industry as largely helpless.

Over time, much like the broader Indian medical tourism industry (Connell, 2006), surrogacy adapted to provide its overseas clients with a fully managed Western experience of hospitality, transport and escorts, capitalising on the additional revenue it brought. ‘It’s employment for the driver, hotel, hospital, restaurants, everyone is benefiting, right?’, said Dev, an international surrogacy facilitator, of the benefits for the broader tourism infrastructure from surrogacy and other assisted reproductive treatments in India. While such services had a clear function in making the clients’ stay as efficient and comfortable as possible, they also served a broader purpose of making India ‘OK for Western needs’ (Ishaan), less like India and more like the West. Five-star hotel complexes, shiny clinics and restaurants with Western foods meant that the air-conditioned drive from the hotel complex to the clinic could be the only glimpse of India outside its medical tourism industry that clients ever got. Dev, an

Australian-indian man who had built a business out of making Westerners feel comfortable in India, described his full five-star hospitality set-up to me:

> I use the same model all the time, meaning I've got the same drivers, doctors, same procedures. I've got a friend who is the general manager of a large five star hotel. He's my best friend, in fact I am staying at his house when I'm in Bombay. He offers me a very good package, bundles up things like airport pickups, breakfast, lunch and dinner buffets, so you don't have to worry about going out, you've got your hands full with babies etc. They also offer you drop-off to the hospital as well, they give you things like a certain number of laundry pieces done in a day. Those kinds of things. Plus general attention. The manager is accessible any time of the day. It's a full service.

How much use a client can make of such services depends on their preferences and budget. Some clients prefer to do some of the legwork themselves, finding hotels and exploring the surroundings. Many feel that they should get to know India because it is the birthplace of their child. Clinics and facilitators often have small flats or houses in quiet neighbourhoods, so many opt to stay in those as a way to get to be more embedded in a community while saving on the cost of hotels. Some even venture out for day trips to see the Taj Mahal. Others opt for a full Western service, even going as far as having the facilitator travel with them in person or send a chaperone. The extreme of this sees some clients staying in special accommodation located inside the clinic itself, thus never having to leave the safety and comfort of the complex during their entire stay.

Facilitators

Some of the issues of the transnational surrogacy industry in India were more difficult to address directly. For example, it quickly became apparent that local doctors and

Western intended parents had very different understandings of how the process should be handled. It did not help that most clinics were taking on very high volumes of cases, meaning they were always too busy to take time to deal with the concerns of their clients, but also that sometimes things were dropped, forgotten or mixed up. Intended parents, worried and frustrated, would bombard clinics with enquiries, threaten to withhold payments and write scathing online reviews or even complain in the media.

Those who were hoping to travel to India for surrogacy turned to the former intended parents for advice on the experience. Indeed, some clinics began referring their new clients to their previous successful clients for advice and support. It was not long until some of those helpful former intended parents decided they could make a business out of facilitating the relationships between Indian clinics and their overseas clients and the role of the international surrogacy facilitator, a kind of broker who works between surrogacy provider clinics and the intended parents, was born. Such independent facilitators were largely based outside of India in countries with large numbers of intended parents, such as the US, UK and Australia. They worked mostly as small agencies made up of the facilitator and their team, but they usually had wide networks of contacts that they could rely on for help and information.[19] While facilitators would often visit the clinics they worked with in India or do other local research, such as trying out hotels in the area, much of their daily work happened largely online through email and video calling. International facilitators managed relationships and provided information to help make the experience more

[19] Some larger corporate clinic chains, with branches in different countries, offered the facilitation service in-house. My interest in this thesis is on independent facilitators who partner with several clinics.

comfortable and less stressful for the intended parents. These individuals were specialised in managing the surrogacy process as a whole, rather than just a clinical procedure across the vast geographical and cultural difference between Indian clinics and overseas intended parents. They quickly became an important part of the surrogacy industry.

The relationship between Indian clinics and international facilitators was a complicated one. While international facilitators could be demanding and required a cut of the clinic's profits, they were also very helpful and, over time, became the source of significant client numbers. Working with the right facilitator could transform a clinic's fortunes. I discuss the challenges of the doctor-intended parent relationship in cross-border surrogacy and the brokerage role of international facilitators in the next chapter. For now, it is important to note the kind of position of power international facilitators found themselves in, as the trusted point of communication between Indian clinics and their Western clients.

Legal matters

Meanwhile, the successful completion of India's first cross-border surrogacies had raised another challenge - the complete lack of international, or even local agreement on the regulation of cross-border surrogacy and the legal recognition of the children born of it. Moreover, no one had any experience dealing with the issue. The medical professionals of Indian clinics had no issues creating babies for their foreign clients but no one was prepared for the fact that the kind of diffusion of parenthood that made surrogacy possible (discussed in Chapter 4), would also make ambiguous the baby's nationality and claims to citizenship. Industry professionals

would recount to me stories from the early days, when the absence of any legal guidance or even precedent left everyone in the dark and simply hoping for the best. Sindhu, one of Mumbai's top surrogacy lawyers, argued that it took Indian fertility clinics a while to realise that their clients needed legal assistance, so she first became specialised in the industry due to the demand from clients who were already stuck in India with their babies:

> There were no rules and I found this very interesting, so it became a focus. Plus the demand was huge, so there was work in this. Clinics were getting clients from several countries, but nobody was aware of how to do it. But back at that time even the doctors said to the patients, you don't need a lawyer. (Sindhu)

Indeed, while the Indian surrogacy industry had been keen to welcome the lucrative business that foreign clients offered, it was utterly unprepared for the enormous challenge of getting the babies home with their parents. If anything, Sindhu argued, clinics were keen not to involve legal professionals in their arrangements because doing so would mean losing their total control over the industry and having to share their windfall profits. But it was not long before the consequences of this attitude became apparent. The discrepancies between surrogacy regulation in India and in the many countries intended parents hailed from meant that babies were becoming stuck in legal limbo between India and their parents' home countries. In the eyes of the Indian government these were foreign children, but their intended home countries sometimes refused to recognise them as such and denied them citizenship and entry visas.

One of the most difficult of such cases ws that of Baby Manji (Points, 2009). In November 2007, a Japanese couple hired an Indian surrogate to carry a baby for them using the husband's sperm and anonymous Indian ova. The couple divorced during the surrogate pregnancy and the wife wanted nothing more to do with the surrogacy or the baby. Indian laws, however, would not allow the husband to exit the country with the child as a single father. Japanese laws further complicated the issue because they recognised the birth mother (in this case the Indian surrogate) as the legal mother. The baby was left in an Indian hospital without papers, parents or citizenship for a year.

Such cases dragged on for many months, causing financial and emotional hardship for the parents and diplomatic embarrassment for the embassies involved. Those countries that did allow babies back into the country would often demand the kind of paperwork and guarantees that were simply not available in the Indian context or caused long delays to assemble. A doctor from one of Mumbai's most renowned clinics admitted that they learned about surrogacy's international legal pitfalls the hard way:

> An international patient approached us about surrogacy. The inquiry was that 'I cannot carry a baby, can you find some lady who is willing to carry?' So we thought 'Oh, what is this,' but we started researching it and about surrogacy and then started asking our social workers and aides and looking for a woman to carry. It was very difficult to find someone, but we finally found a lady. So we drew up this contract with the help of a lawyer. It was all so simple then! We were just trying to figure it out!
>
> But getting the baby out took time and it was difficult. For some time I thought, now this baby and the parents are all going to have to live in India, they cannot leave! Because nobody knew what this was and what to do. Even the consulate didn't know what to do. But finally the baby got to go back...
>
> But we were only just learning about this, so we didn't advertise it or anything. But we started getting more requests, I think it was spreading through word of

> mouth. So with these inquiries we would ask the patients and countries if the babies would be allowed to enter, and we also got lawyers to help us with this and confirm things. We started doing our own research that way. But it took a long time before we felt confident to start advertising such services.
> (Dr Chopra)

I have quoted Dr Chopra's account here in full because it shows the extent to which this was truly uncharted legal territory. Making babies was easy, but supplying these new persons with birth certificates and passports embroiled the Indian surrogacy industry in broader international legal and social debates about parenthood and citizenship.

Doing what you are good at

Much of the internal industry gossip at the time of my Indian fieldwork was made up of stories of greedy doctors who thought they could do it all. They took on too many cases in order to maximise profits at the cost of dramatically lower success rates and even severe errors such as mixed-up babies. These stories were indeed often mirrored in intended parent experiences, as expressed in online forums and blogs. It seemed as if very popular clinics often began receiving bad reviews after allowing a drastic rise in client volumes to drive down standards.

Clinics had more than just legal matters to contend with: they also needed to find women willing to become surrogates, recruit egg donors, manage surrogates in dedicated hostels, market their services to potential intended parents and deal with the constant need for communication and updates with existing ones. All this additional work for the clinic encouraged the industry to try to find a more streamlined way of arranging its work. International facilitators and lawyers might have been the

most powerful and important professionals who found a business in surrogacy, but there were many others, from local recruitment agents for surrogates and egg donors to surrogate hostel managers and drivers.

The increasing involvement of various auxiliary partners did not do away with the challenges of transnational surrogacy, but it did mean that doctors could focus on creating and managing surrogate pregnancies, while dedicated, experienced and well-connected professionals took care of the rest. According to Sindhu, specialised experience counted for a lot because cross-border surrogacy in India was still a very volatile field:

> By now I have so much practical experience. That's the only way we can work without a full system [of surrogacy regulation in India]. We just have parts of a system, and we have to fill in the rest and the experience tells us how.

Dr Sid, a young and ambitious doctor who ran his own clinic, explained to me that, while trying to do everything yourself might be tempting, it is better to keep focused and excel at your own field. Despite opportunities to do so, Dr Sid was resisting the temptation to expand his field:

> You have to be so focused on what you don't want to do. [...] It's a saying in Hindu mythology that, if you're honest, you don't have to go get work, work will come get you. You cannot put your hands in every basket and hope you snatch everything from every basket and then feed yourself. No, concentrate on the basket that you like, and then see to it that you attack the basket!

Dr Sid followed up his comment by exclaiming: 'I guess that's a philosophy that very few doctors follow out here in India. They will even go and coach Chelsea!' implying that many doctors take on too much at the expense of the quality of their work.

Equally as important as specialisation was the need to keep work volumes manageable.

Finding the right people

There was clearly much to be gained from expanding one's business and influence through networks, but it could be risky. The wrong kinds of partners, both clinics and international facilitators, could hide profits or errors, be difficult to communicate with, or lose clients with their low professional standards. Doctors will seek out facilitators who they have seen bring in a lot of business to other clinics, while facilitators will be on the lookout for doctors with good reputations for the quality and transparency of their work. 'People talk!' is what I kept hearing over and over in my research. 'There is a list of names we all know that we will not do business with,' said Gabriella; 'their name comes up in a conversation, and it all goes quiet. We all know.' Despite being international, the surrogacy industry is still a relatively small community, and people know about each other, have met at conferences or have at least heard about each other. Individuals would also use their existing networks to find out information and recommendations about potential partners, and to arrange introductions. Dev told me that since he was good at his job, the internet and professional gossip helped him find new partners:

> Once you are in this business, doctors are also keeping an eye on you, even they want more business. When you tell them you're coming to meet them, they know exactly who you are – you don't have to give them any background, they've done their research on you before you go and meet them.

Building the right networks is especially important for facilitators, as the quality of the packages they sell to their clients, and thus their reputations, is only as good as the clinics they work with. Choosing clinics to partner with is thus a thorough procedure. Initial background research and introductions are followed by often repeated clinic visits, dinners and meetings to assess a doctor's work, but also their work ethic and style of communication. Facilitators focus on matters such as surrogate and egg donor screening, IVF success rates, procedures for managing surrogate pregnancies. They also want to visit surrogate accommodation personally and look at lab equipment and clinical storage facilities.

I asked Adam, from the large Israeli surrogacy agency GlobalBaby, about his tactics for finding partner clinics he could fully trust and rely on. He responded that the best partnership is working alone, by hiring your own people either directly or through satellite companies, because that is the only way to be sure of the standards of your work. He then laughed and said he was joking, but that what he said was nonetheless true. But since working alone was not scalable for a facilitator, he instead took great care when choosing who to work with:

> If we go into a new place, we will do very thorough research on who are the main players, how good they are... We sit with them, we discuss with them. And of course we will be there not once, more than once, to see things. We talk to past clients. We will do every part of the research we can, and then we choose a partner. It's the same with donor agencies, clinics, shipping companies [for frozen embryos]. You just need to do your research. Being in the market for so many years, almost everybody knows us and we know most of the main players.

I was indeed often told that in the surrogacy business there was no substitute for turning up and meeting people, having a good look around and asking difficult

questions. Phil, an experienced transnational surrogacy activist and facilitator, argued that in his experience even major, crucial aspects of a clinic's or surrogate agency's work can be entirely made up. He brought up surrogate housing as an example, because having surrogates housed and monitored is something that Western clients usually insist on and pay significant money for. Since the intended parents are not there to oversee things, and the surrogate herself has no communication with them, housing is an easy thing for clinics and agencies to cut corners on and save money:

> The majority of doctors do not house their surrogates or do not house them properly. Very few do. They [facilitators who do not check up on their partner clinics] don't know the underbelly because they never get off their… They're never in India or anywhere else [in surrogacy destinations] in the world.

For Phil, partnerships were what made a facilitator, and it was thus a facilitator's duty to be present on the ground, or to have their own staff present. With so much of the global surrogacy business taking place online (Berend, 2016), businesses in the industry have become well-rehearsed at creating an impressive online presence, often with the help of dedicated digital and social media professionals. Gabriella found out the hard way when she first began expanding her operations in India: 'What I find is that all of these Indian doctors, they all have fabulous websites, and then you go to their clinic and you're just like 'What. The Hell. Is This?!?' She explained that while sometimes clinics do intentionally mislead clients and facilitators, it can also be a simple matter of mismatched expectations:

> This doctor, they were begging: 'Oh we have a great clinic, we have whatever you need, so when you come to India please visit.' And I went there and I was like, 'Oh shit!' And they were like, 'What do you think?' I'm like, 'This is a dump!' And her husband started to cry... Someone told me that the locals,

> because they are in nowhere, they treat these people like their God. No one's ever gonna say to them what you'll say to them. I'm like, 'I could never send my clients to this trash'. And their website is …. [makes impressed face].

Yet even if many of the clinics that wanted a share of transnational surrogacy's profits did not meet the basic standards for international medical tourism, there was no shortage of clinics that did. The large urban centres of Delhi, Mumbai, Bangalore and later Bangkok were full of clinics and hospitals that had been catering to rising local middle classes and overseas medical tourists for many years. In some areas there were so many that during my fieldwork in those cities, I could often walk from one clinic to the next. So finding a clinic with the right equipment and standards was not the challenge; it was finding the right people. What the facilitators were looking for in potential partner clinics was not necessarily what the doctors thought they had to promote. Indeed, when trying to impress visiting facilitators, clinics would emphasise their modern Western building, Swiss or German IVF equipment and foreign-educated embryologist, or claim incredibly high IVF success rates. Most would also have their own version of the story of a couple who had tried IVF everywhere else without success, only finally to get triplets on their first attempt at their clinic.

But when it came to IVF success rates, or really any facts, numbers and standards, it was widely known in the industry that anyone could make up just about anything they wanted in India. Facilitators knew that all too well. As a business, low-cost surrogacy ran on verbal assurances and thus relied heavily on the strength of personal relationships that were based on trust. They took a long time to build and were thus highly valued. In the absence of concrete evidence or reliable surveillance,

facilitators focused on trying to find out as much as they could about the ‘heart of a clinic’, rather than trusting its decor or the credentials hanging on its wall. In a meeting, I heard Dr Sid explaining to potential partner facilitators that although his clinic looked simple he was planning to make things more luxurious by introducing televisions and added amenities into the clinic wards. The facilitators would not even let him finish and told him his clinic already had everything they needed - an ambitious and trustworthy doctor. ‘We are looking for the heart of the doctor, not the interior design’, they laughed.

Later on, at the same clinic when I asked a different facilitator, Dev, about his decision to work with Dr Sid, he also pointed out the importance of non-material qualities. He said had been going over his clinical procedures and mentioned various small details such as specific tests for hormone levels that showed an attention to detail that not all clinics share. Facilitators come to know the IVF procedure in quite some detail over the years, so they can pick up on small details like this even when doctors think they cannot. These can help them identify the people whose work they will trust in as partners. Moreover, in a field as full of emotional peaks and valleys as surrogacy, communication and interpersonal skills are particularly important. Facilitators emphasised the importance of finding someone who is a team player and prepared to invest their energy and time into making clients and thus facilitators happy, as well as having a good track record of IVF success. All of this made it important to get to know one’s potential partners as well as possible before agreeing to work with them.

The many calculations involved in looking for a doctor with the right kind of heart was, however, more complex than merely having good people skills and commitment. Most facilitators were also looking for a certain kind of flexibility and creativity of approach on the part of the doctor. I found out more about this when I pressed Dev further about Sid. I asked him why, at a time when most surrogacy clinics were struggling to attract business from abroad, Dr Sid had managed to break into the surrogacy market and attract the attention of several foreign facilitators. Dev replied ‘he has made the effort….’ and then continued with a slow smile ‘...aaand he is willing to bend the rules slightly.’

This last, almost passing comment was nonetheless a significant one. It reflects the way that working in the surrogacy industry requires professionals to be ready to get around the law or, when it comes to it, bend it. I am not referring to major crime. Rather, doctors are expected to play their part in the small quotidian manoeuvrings that make the surrogacy business run smoothly and that I described earlier, such as not checking certain paperwork or looking the other way when it came to intended parent details. There are varying levels of law-bending and law-breaking going on. Some doctors and facilitators are very cautious and will only go around the law but never break it, while others do whatever they can get away with, and sometimes even end up in trouble with the police as a result. Most are somewhere in the middle, operating according to what their own moral compass allows and what will keep them in business but out of trouble.

Very often this kind of flexibility was incorporated into daily work so seamlessly as to become almost imperceptible. For example, I had seen Dr Sid make arrangements

to ensure that a local Indian client was able to use her sister as the egg donor. This is against Indian ART guidelines, which state that Indian egg donors must be supplied anonymously by independent agencies. Dr Sid compromised between the two demands by telling the client to send her sister to sign up as a donor at a specific agency, one Dr Sid knew he could count on to bend the rules for him. The agency would then send the sister to Dr Sid's clinic as an anonymous donor when requested for her eggs to be used in the client's treatment. What on the surface will look like a regular anonymous commercial egg donation will thus in fact be an intra-family arrangement. Such small details were crucial for providing fertility clients with the options they were seeking. Interlocking networks of people all willing to look the other way or bend the rules here and there were therefore crucial to making the business run well.

Challenging partnerships

Despite such efforts, partnerships for international facilitators, as well as for doctors others in the industry, were often fraught with difficulty, dominated by mutual distrust and the tensions and fallouts that come with competing over income and market dominance. Indeed, it was not uncommon for facilitators or doctors to express deep frustration towards their partners. Some facilitators would even dedicated staff in surrogacy countries who were locals to help them monitor and control the clinics they were sending intended parents to. Facilitators, doctors, agents and even lawyers alike would tell me how they wished they could work alone, only involving their own full-time and trusted staff.

Indeed, bypassing the growing crowd of surrogacy's associated service providers was attractive for many reasons. Most obviously, it was a way to cut out other contenders to the business's profits. I came across clinics having their own in-house facilitators rather than working with externals for this reason. A law practice was looking into opening a branch in London so their clients would not be fleeced by what the lawyers thought were exorbitant British prices. They could do the same work for much less cost and more effectively by doing away with complex communications, thus benefitting their clients and growing their business.

But perhaps even more importantly, going solo held out the promise of being able to work according to one's own understanding of what was right and wrong in a morally contested business - an important, if often overlooked aspect of surrogacy professionals' decisions. Arun, a lawyer who spent hours explaining to me his concerns about the way surrogates were treated by the industry, later told me he had moved from merely drawing up surrogacy contracts to running a small surrogate and egg donor agency. This way, Arun argued, he had more impact on the industry because the women he recruited were literate and received genuine counselling. In his view this made them more capable of giving informed consent and, if necessary, standing up for their rights, thus making exploitation and fraud less likely.

For the most part, however, such aspirations of a one-stop-shop service remained just that - aspirations. For all the reasons set out at the beginning of this chapter, working alone in a business so complex and convoluted in its demands for time, investment and expertise was rarely a realistic option while the promise of large volumes of highly lucrative work was attractive and ever present. When they needed

to, both doctors and facilitators found themselves working with partners that they consider untrustworthy and would, under more favourable circumstances, avoid being associated with. The need to work together was a strong motivator for the industry to find a way to get along, with some sensing an increased camaraderie between doctors, lawyers and facilitators as the business came under increasing pressure from regulation.

The end of an era

When India's surrogacy clinics, enthusiastically or not, began working with international facilitators to help them find and manage clients, they could hardly have imagined how the global surrogacy industry would change in the following years and how that would change the dynamic of their relationships. By 2012, low-cost surrogacy in India had evolved into a steady state of operation that seemed to be working for the clinics and the clients. Intended parents could choose from large corporate clinics in urban areas or head somewhere smaller and quieter, opting for one of the many single-doctor clinics. There were numerous options for donors, with affordable local agencies offering Indian donors and specialist international providers ready to send donors from mainly South Africa and Eastern Europe, but depending on demand also the United States, Latin America or Asia. Even legal complications were fewer, as local lawyers became more experienced and the embassies of the nations where most foreign clients came from developed procedures for dealing with surrogacy-born children. The by now very large body of information on Indian surrogacy that had developed online through various blogs, forums and websites, coupled with the help of facilitator services, made for a smoother experience, as

there was less surprise and guesswork for the intended parents. Demand was growing, the business was expanding, and daily operations were becoming more straightforward. This was a time that many industry professionals would refer back to with nostalgia as a kind of golden era of Indian surrogacy.

There was even hope in the industry that commercial surrogacy would become fully regulated in India in a format that would favour the industry. Not long after the start of transnational surrogacy in the country, the Indian government began putting together a bill, the Assisted Reproductive Technologies Regulation Bill (Ministry of Health and Family Welfare, 2008), to regulate surrogacy and other assisted reproductive services and to establish the rights and obligations of everyone involved. The first draft was circulated for consultation in 2008. However, it received criticism from women's rights groups and academics for prioritising the streamlining of the industry at the expense of surrogate women's rights and health (Qadeer, 2009; Sarojini and Sharma, 2009; Unnithan, 2013). In her analysis of the draft Bill, Maya Unnithan (2013) argues that while the proposed law, with its recognition of the rights of the infertile to have access to treatment, is in some sense notably progressive, it fundamentally ignores or even entrenches the deep healthcare and reproductive inequalities amongst Indian women because it makes these services available only to those who can pay for them. Moreover, Unnithan criticises the draft Bill's reliance on informed consent procedures for safeguarding the welfare of surrogate women because the extreme poverty that drives surrogacy, coupled with the lack of full individual control most Indian women have over their reproduction and sexuality severely limit their ability to negotiate the terms of their involvement. In India, years of drafts, consultations and debate on the Bill followed, to the point where most

industry insiders had stopped worrying about it, with some jokingly likening the wait to the second coming of Jesus Christ.

In 2012, seemingly from out of nowhere, the Indian Ministry of Home Affairs introduced a special surrogacy visa, for which all intended parents looking to have a baby in India needed to apply. The move was ostensibly aimed at streamlining the legal process of surrogacy and ensuring that no babies were left in India for months after birth. One of the conditions for receiving a visa was a letter from the intended parents' home government confirming that any children born through surrogacy would be granted citizenship and the necessary documentation to be able to leave India. Many welcomed this step as a crucial move that would bring low-cost surrogacy from the socio-legal margins into the sphere of regulated medical practice.

The new visa, however, had a second, more problematic condition: the applicants needed to be a heterosexual couple who had been legally married for a minimum of two years. The move provoked outrage from gay and alternative family activists from within India and across the world. It also effectively halved the client base of the Indian surrogacy industry, creating the intense competition and sense of loss I experienced when I arrived in India for my research in 2015. The business was still up and running, but it was clear to everyone that the golden age of transnational surrogacy in India had passed.

By the time the visa restrictions were introduced, almost a decade after the first cross-border surrogacy arrangements took place in India, low-cost transnational surrogacy had grown too large simply to go away. Intended parents from around the world wanted access to affordable unregulated surrogacy. Parts of the industry rose

to meet that demand by moving low-cost surrogacy to new destinations. As I elaborate in Chapters 6 and 7, international facilitators began looking for unregulated low-income countries to set up new partnerships with local clinics there and some Indian fertility doctors began exploring options for moving at least some of their work abroad, while also trying to find ways to get around Indian restrictions.

India began losing its place as the global centre of surrogacy. A new era of constantly changing destinations had begun for low-cost surrogacy, the causes, impacts and dynamics of which I will analyse in the following chapters. The immediate result, however, was that Indian doctors gradually lost their influence in the business, and international facilitators became central. Through the introduction of visa regulations in India and the beginnings of surrogacy in other destinations, facilitators rose from a position of relative marginality to one of increasing importance in transnational surrogacy, building resilient and successful businesses through elaborate global networks.

Chains that connect and separate

If the benefits of an interconnected global network of businesses and people for the delivery of surrogacy services are clear for doctors and brokers, they can be far less obvious for surrogacy's less powerful parties, namely the surrogate women but also the intended parents, for whom the addition of all these links has not been without consequences. The industry has become increasingly commercialised. Surrogates and intended parents, the two ends of surrogacy's global commodity chain, are now connected by individuals with their own agendas and fees. Indeed, surrogacy in India

saw a drastic rise in prices for overseas intended parents from less than USD 20,000 in 2012 to around USD 40,000 in 2016. Overall, as Daisy Deomampo has argued, the introduction of third-party brokerage has intensified the commodification of surrogacy as an industry, since brokers set up their operational relationships in ways that will generate the greatest profits for them (Deomampo, 2016).

It is not just money that becomes diffused in these transnational chains, the links of which not only connect the various parties but also separate them. Responsibility, care and accountability are easily lost in the many layers of links and connections that all communications and payments must traverse. As facilitator Adam had told me in relation to clinic partnerships, the best way to guarantee standards of service and surrogate care is to do everything yourself. He kept coming back to that point over and over again, identifying many of the ills of the surrogacy industry and the challenges in his work in the convoluted modus operandi of the business.

The rights, remuneration and welfare of surrogate women are especially vulnerable to the impacts of these changes to the industry due to the power relations involved in the arrangement. The introduction of additional actors, often from overseas, makes it harder for the surrogate to negotiate or solve problems, as she may not even know whom to raise issues with, let alone have the means to access them. It is not trivial that Adam's comment above on how involving too many people made it harder for them to remain in full control as an agency was made in the context of surrogate care. While many in the industry expressed similar opinions, it was never quite clear what section of surrogacy’s production chain was superfluous or even exploitative. ART banks and surrogate agencies were often openly despised by doctors and

International facilitators for what they argued was a greed unchecked by professional standards or a concern for a reputation. As a result, agents were blamed for attempting to send clinics women who were underage, were suffering severe illnesses or reproductive disorders, not paying surrogate women, not housing them in appropriate conditions and not providing adequate information about the procedures involved, let alone counselling. Darsh, a representative from a large Delhi fertility centre, blamed these issues on the fact that anyone could open an agency, and even open a new one if the old agency's reputation had been ruined by scandal.

> The problem in Indian surrogacy isn't the foreign patients but the ART banks [the agencies that recruit and manage surrogate women and egg donors]. They take money that belongs to the surrogate. Most of them are businessmen like that. No reputation to worry about because they can just set up another brand if things go wrong. So even if the fee is 8-10 lakh [USD 12,000-15,000], you pay 13 [USD 19,500], the surrogate doesn't get it, all goes to the bank.

Transnational facilitators argued that a key part of their role was to keep all these problematic parties in check, and as such they functioned as a positive force of standardisation and oversight. Such representations often included less than favourable accounts of Indian clinics. Yet many doctors I spoke to disagreed with this statement, arguing instead that it was the facilitators who charged exorbitant fees for answering a few emails and were living off the hard work of Indian women and doctors. Indeed, the relatively dominant position facilitators had come to occupy was resented by many clinics, who saw them as a negative influence that had taken control of the industry away from the clinics. 'Right now the people controlling this business and making the real money are actually just a bunch of mercenaries going

around the world!' exclaimed the representative of a major fertility centre, as he threw his hands in the air.

The pattern in such observations and often outright accusations often revealed the lines of old rivalries or grievances, but on the whole it was distinctly circular. Doctors, facilitators and agents alike conceded that the surrogacy industry in India had its issues. But rather than accepting their place at the centre of this problematic economy, they instead pointed the finger at anyone and everyone else (including, as discussed in Chapter 3 and 4, the surrogate women and intended parents) and presented their own work as a remedy for the corruption and exploitation in the industry. Professionals would often tell me about the unethical practice of partners with whom they were still actively working, overlooking the fact that it was their ongoing partnership that promoted these practices.

Such accounts were often followed by expressions of hope for future regulation to get the industry under control. Darsh explained to me that only regulation followed by strict enforcement can weed out unlicensed clinics and what he perceived to be rampant malpractice because it can often be impossible for clients to know respectable industry experts from unqualified quacks:

> Wild Wild West, that's actually the perfect word to describe IVF in India! You do what you want there, and nobody stops you. Once the rules come into force and the 120 clinics in Delhi become the twenty that actually are doing things, right then we will no longer be the Wild Wild West. But right now we struggle because the patients don't know the difference and the state won't regulate. (Darsh)

At the end of the day there was no one to take responsibility, and all but very few efforts to enforce it eventually run out of steam somewhere along the many links of

the surrogacy chain. The kind of interconnectedness, dynamism and digital prowess of the surrogacy industry that I described earlier as the key to its success also makes for an impenetrable web. Even those who ostensibly would have had the power to demand answers and compensation when things went wrong rarely got to do so in reality. Indeed, while surrogate women are no doubt the most vulnerable group in surrogacy, these issues do also affect the intended parents and the children born of these arrangements. Cases of undelivered services, split gamete samples and mixed up babies have far reaching emotional, financial, legal and personal consequences for which there is rarely any redress.

Indeed, when well-known surrogacy broker Rudy Rupak was convicted of fraud charges in the US in August 2017, it came as a surprise to many. The people he had wronged had given up ever bringing him to justice. Rudy was the founder of Planet Hospital, a medical tourism company that ended up specialising in surrogacy after reportedly taking the first US couple to India for surrogacy and later operating in Mexico. While Rudy advertised his business and global surrogacy in numerous high-profile TV programmes and interviews, he also defrauded his clients out of huge amounts of money by charging for services that were never going to be delivered, giving false cost predictions, and even posing as various doctors under fake email aliases to mislead his clients into thinking that everything was going to plan. There was also evidence that only a fraction of the payments were reaching the surrogates and underage or ill women that were being recruited. Whenever any of the parties raised complaints, Rudy, a masterful manipulator, blamed any issues on the other

links in the chain. After Rupak's arrest, Catherine Moscarello, a former employee of, described the pattern of fraud:

> The object was to get money… [Rupak] would keep changing [fertility] clinics, and whenever his relationship with a clinic in India or Thailand or Cancun broke off, he would disparage the clinic and the doctors there. But what was really happening was that he wasn't paying his bills. (Lewin, 2014)

In one of his email replies to an intended parent, published in the New York Times around the time of the indictment, Rupak skilfully turns a refund request around to present himself as the guardian of intended parents' interests against the fraudulent practices of clinics: 'Here is a little secret for all of you. There is a lot of treachery and deception in IVF/fertility/surrogacy because there is gobs of money to be made' (Lewin, 2014).

As Rupak's victims pursued justice, the circle of implicated individuals and businesses continued to expand, involving egg donor agencies, Planet Hospital staff, clinics and investors. Many companies turned out to be Rupak himself, operating under various online domains. Not all of them had necessarily been involved in the fraud, but it was hard to tell which had and which had not, nor which had merely aided the crimes by continuing to partner with him and which had simply been committing fraud of their own. Indeed, when it came to some fertility clinics, the line between victim and partner in crime ran blurred. Rupak often never paid the clinics, who in turn would not pay the surrogates and refused services to the intended parents. This behaviour went unpunished for years until Deepak wronged a lawyer in Washington, who pushed for a criminal case to be opened. After his operations were shut down, Rupak's clients found that they could not retrieve their embryos or their

babies' papers from Mexican clinics because the latter were holding them as bargaining chips to demand payment for unpaid bills. Even if Rupak's conviction brings some sense of justice to the many people he cheated out of money and children, it does little to undo the damage that was done or to guard future participants in global surrogacy against other similar actors.

Indeed, while Rupak's case is an extreme one, it is by no means isolated. The prevalence of fraud and unethical practice in transnational surrogacy is directly linked to the modus operandi of the industry and the way responsibility and accountability are dispersed in a global supply chain that largely operates online. The fact that many if not most doctors and facilitators run perfectly legal businesses and are committed to helping their clients build families is of little help to those who make their entry into this complex market, whether as suppliers of consumers, because the legal and the illegal, or the ethical and the unethical, are hard to separate. Indeed, several very highly regarded clinics have ended up at the centre of scandals. Sometimes clinics start off doing things by the book and begin cutting legal and ethical corners once client volume puts them under pressure. Darsh's earlier point regarding the quality of IVF in India, that 'the patients don't know the difference and the state won't regulate', seems to hold true for much of the business as a whole.

Surrogacy as a global commodity

While commercial surrogacy is a relatively new phenomenon, the kind of global cooperation that its transnational forms operate through is certainly not. Anything from food to clothes and more recently cars and telephones has been travelling through and been created in various forms of global networks for centuries. The

women who used to make jeans and T-shirts for the West can now produce babies for the West too. In fact, in Bangalore's garment factory districts women sometimes do both in their lifetime, as surrogacy recruiters draw upon the population of young female factory workers in the city (Rudrappa, 2015). Could surrogacy be understood by using the same tools that are used to study other commodities? Economists and development studies scholars have long been interested in picking apart global economic integration, using concepts such as value chains, commodity chains, outsourcing, conglomeration and production networks, among others to analyse how the needs and capabilities of different businesses and locations come together to form complex global arrangements that result in the production of products or services.

These concepts have much to offer to an understanding of how global surrogacy works and the challenges it entails. Yet their dehumanising focus on processes, value, assembly and products sits uncomfortably with the fact that surrogacy uses the reproductive capacities of women's bodies and results in the birth of human persons. The fact that these concepts are as fitting as they are uncomfortable says much about the internal contradictions that commercial surrogacy continues to grapple with. If we accept that commodity chain research is a helpful framework for analysing surrogacy arrangements, then are we implicitly accepting that human babies are commodities? This discomfort can be powerful and ethnographically illuminating.

From an analytical perspective, different theoretical concepts for understanding global businesses and industrial relations, when applied to surrogacy, also

foreground different aspects of the phenomenon and downplay others. A commodity or value chain analysis (Gereffi et al., 2005) would highlight the increasing distance between the intended parents and the pregnant surrogate, while a production network approach (Dicken et al., 2001) would place emphasis on the relationships between the various businesses and individuals that make up the global business and thus make valuable the surplus fertility of low-income women. What we can learn from all these different approaches is that, uncomfortable though it might seem, the development of commercial surrogacy as a global industry is in fact not particularly different from the industries that make our consumer goods. These similarities mean that we can use production network and value chain research into longstanding global industries to try to predict where the surrogacy business might be headed in the future, what forms its governance structures and dynamics might take, and the issues that might arise. From a certain point of product complexity or geographical reach, relying on the complementary competencies of other firms becomes necessary for a business's success (Gereffi et al., 2005). Such linkages, whether conceptualised as networks or chains, allow individual actors to focus on their core competencies, as well as to outsource certain cost heavy processes to more affordable locations. Reliance on exclusive partnerships, personal relationships and industry reputation to facilitate complex interdependence has also been widely described, as has the power of brokers and wholesalers without the need for commitment and investment in what Gereffi calls 'buyer-driven global commodity chains' (Gereffi, 1994).

It is equally important to bear in mind that, much as global surrogacy might seem on some level to fit the description of general global production networks and value

chains, it nonetheless has important distinctions that are related to its unique position as both a bioeconomy and an intimate care economy. The complicated regulatory, often quasi-legal position of surrogacy adds uncertainty and complexity to it. This can make surrogacy more akin to trades in antiques and exotic animals than in computer parts and jeans. More than anything, however, surrogacy brings its own special challenges in the way the industry organises itself due to the fact that its end products are human babies that have to be gestated in surrogate women's bodies for a long nine months. The level of emotional involvement, the fragility of the product together with its unyieldingness to standardisation and the high stakes of creating a new human to order across many continents present special challenges for the actors and risks for those involved. If the result of failures in the production chain for apparel is a badly fitting shirt, then in surrogacy the consequences can be far more lasting and extensive for its many vulnerable parties.

Perhaps the most significant insight for this thesis from research on global production networks and commodity chains is the issue of labour rights violations in these long chains. One aspect here is the inability of ethical trade and corporate social responsibility initiatives to enact meaningful improvements to the way people are treated in the out of sight sections of the various chains that produce the things we consume in the West (Mezzadri, 2014; Ruwanpura, 2016). As I noted in Chapter 2, some anthropologists have started thinking of surrogacy in these terms to highlight the parallels between surrogacy and other productive industries, especially when it comes to the treatment of its unskilled and socio-economically vulnerable labour force.

Sharmila Rudrappa explicitly called the phenomenon of her study the production line of surrogacy, as she traced the threads connecting Bangalore's garment production industry and its surrogacy business to find that outsourced surrogacy has found a home amongst other, often far more exploitative means of value extraction from India's socio-economically vulnerable populations (Rudrappa, 2015). Kalindi Vora (Vora, 2015) has drawn comparisons between surrogacy and the outsourced customer service industry in India, using call-centre workers and information technology professionals as examples. Her verdict on the possibility of consumer knowledge of and power over the welfare of workers far across the long global value chain is bleak:

> Recent controversies surrounding the globalised neoliberal economy, from iPhone related suicides to smuggled human rights pleas, highlight the growing gulf between racialised, gendered, and ostensibly endlessly exploitable populations who labour in places like China, Bangladesh and India and consumer subjects who worry about their own ethical position within the globalised economy they enjoy. (Vora, 2015, p. 141)

Both scholars use concepts of global production and value chains to tie surrogacy to a broader approach to global business where labour rights give way to high profit margins and on-demand supply. The adoption of the language of economics, and especially of labour violations research, to describe something many believe should remain outside the realm of the market, let alone operate in the intensely commercialised and largely unregulated form it takes today, helps make powerful statements about the state of the current low-cost surrogacy industry. Indeed, the description of the growing gulf between populations working in low-income producer

nations and consumer subjects in the West speaks to the issues of depersonalisation and separation that I described in Chapters 3 and 4.

Complicating the global divide

The nature of the networks that together make up the global surrogacy industry is still a matter for debate, but much can be concluded from their shapes and dynamics. The space that connects surrogates, doctors and intended parents across state borders, language barriers and continents also brings together global histories, socio-economic relations and the multiple aspirations of various actors. The commodity chain of transnational surrogacy has its consumers mainly in the West, its producers in the South and its brokers somewhere in the middle, often from migrant communities. Yet there is more to these networks than an outsourcing commodity chain framework can capture. On which side of the global-local divide do Western-educated English-speaking doctors fall? Or the many facilitators, such as Dylan, Dev or the convicted Rupak, who have grown up in India or other surrogacy destination countries, but emigrated and now use their connections and local knowledge to do business?

In analysing corporate social responsibility in global commodity chains, Alessandra Mezzadri (2014) argues that a distinction between ‘the global’ and ‘the local’ is not necessarily useful and that the concepts are becoming increasingly problematic as a result of the changing scenarios of global competition. Moreover, poor labour outcomes are not imposed by ‘the global’ onto ‘the local’, but rather by capital on labour, a reality evidenced by the fact that issues of exploitation are also present in local labour markets, not just transnational production (Mezzadri, 2014, p. 328).

Indeed, while the alliances and connections of the networks I have described in this chapter follow important migration, urbanisation and outsourcing trajectories, they largely escape any definition beyond a common commercial interest in providing wealthy consumers with babies from surrogate women in low-income countries across borders.

The growing set of professionals involved in transnational surrogacy is the result of the multitude of challenges beyond those of biotechnology that bringing new humans into the world in a foreign country entails. The lack of involvement and support by the governments of intended parents, or in some cases the presence of state opposition, has not curbed the business but instead pushed it fully into the realm of a largely unregulated commercial service economy. Kirsten Peterson (2014) has urged us to resist interpreting such economies as destructive or necessarily opposed to the state. Rather, she argues that, when the state fails to facilitate its citizens' consumption needs, such alternative, popular economies develop to fill the gaps left by the formal economy.

Conclusion

The case of Indian transnational surrogacy is an example of the thriving businesses that can grow out of the combination of inconsistent state involvement, powerful consumer demand, globalisation, entrepreneurial initiative and a willingness to bend the rules. While each actor taken separately fills a role in the industry that some of its other actors have deemed necessary, put together they create an ever-broadening divide between surrogate women and the intended parents, making exploitation

more likely. The restriction and eventual banning of the surrogacy industry in India has changed the face of it by making the ability to adapt and move quickly paramount to success and even survival. Chapters 6, 7 and 8 will explore the enabling factors of the increasingly complex and transnational surrogacy industry in more detail.

6. Facilitators: Brokering global markets

‘These individuals themselves are as much an invention of the times as the medical and technological innovations that have decoupled reproduction from sex’. (Rudrappa, 2015, p. 9)

Introduction

Of the impressive economy that developed around making babies for Westerners in India, it was the international facilitators who rose to prominence and who not only survived the industry’s move to new destinations, but thrived in this new reality. These individuals have had a dramatic impact on the industry, and it is important to understand their histories and approaches to make sense of their significance. This chapter explores the reasons behind their special success as a combination of the specifics of their role and the changing demands of the industry. In order to understand the place and significance of surrogacy facilitation in transnational surrogacy, as well as the many different ways in which facilitators have come to position themselves in the business, it is important to go back to the beginning and ask how these individuals became involved in the first place.

Helping out

Back in the early days of Indian surrogacy, the role of the international surrogacy facilitator seems to have grown out of the industry itself. The first intended parents went to India with very little knowledge or assistance. The clinics helped them as much as they could, but, as discussed in the previous chapter, Indian surrogacy in its

early days was very much about figuring things out as one went along. The lack of knowledge and experience often led to delays, additional costs and a lot of stress and worry. But as a result of exploring something entirely new and unheard of, many of those first intended parents found themselves speaking to the media about their experiences and writing long detailed blogs (some of which I have used in my research) about anything from how many nappies to bring to how to interpret clinic emails to how to find the right counter at the Foreigner Regional Registration Offices in the city. Those who were interested in following in their footsteps began contacting intended parents, sometimes even before their own children were born. Meanwhile, Indian clinics that lacked the skills to deal with intended parents' non-clinical concerns or the interest in doing so began directing their clients to previous successful intended parents for advice and support.

As Gabriella, a highly successful US-based facilitator who had started out as a client and then moved to helping others explained to me, she felt the demand for her services from both the clients and the doctors. Her account is worth quoting in full, as it reflects the extent to which there existed a genuine market that, in a sense, created facilitation as a practice and facilitators as a phenomenon:

> Once our children were born there was a lot of interest in what we were doing, a lot of parents were contacting me for help. A few doctors were contacting me to help them, just to sort of bridge the cultural divide. It wasn't a paid job – I was doing it for free until it just sort of became something I could no longer do for free. When people started asking me to travel with them to India, that they were afraid to go on their own, that they weren't getting the necessary information that they needed from doctors and wanted an intermediary. So probably for a good three years I did it pro bono, and then eventually I decided, you know what, I sort of enjoy what I'm doing, so let me just incorporate, figure out how to manage this.
>
> Dr Singh kind of took me under her wing really and started telling me about the surrogacy world in India and what you have to look out for. I wasn't even

> doing this, I was just curious. I was asking her “What is this really like, what other doctors do it?” And then she was like “Maybe you can help me with a few of my clients because there’s this huge cultural divide, and I can’t really deal with handling all these clients, I’ve got hundreds”. And I didn’t even have sense at that point to say “Well, maybe you should pay me.” I was just like “Alright, since this woman’s helping me to have kids, I’ll help her out”. I didn’t even know what I was walking into really…

While Gabriella’s success is rather extraordinary, the pattern of a former surrogacy client turning into a facilitator is in fact quite common. Several accounts from such intended parent-turned-facilitators converged on the fact that, rather than consciously choosing to broker low-cost surrogacy as a trade, they had at one point found themselves already doing it and decided they needed to start charging a fee. Ray, another facilitator, had started by putting up a website with information for intended parents so that they would not have to learn things on the go, often the hard way, the way he had to. Dr Chopra, his Indian partner doctor, still remembered Ray's quest:

> Ray came in with his research and asked me soooo many questions. I answered them all, and then only he told me that he was going to put it all up on his website! I thought he was just asking for his own baby. Then he got his first baby and started helping others. He put it all up online. Started with parties [for those who want to learn about Indian surrogacy] and invited me.

Having one’s own children through surrogacy was a great entry point into facilitation. It provided these individuals with the knowledge and contacts they needed to obtain quality service and expedite the process wherever possible. They also had the practical knowledge of planning and costs, anything from passport applications to hotel recommendations. Former intended parents emphasised their understanding of and personal compassion for the emotional rollercoaster and bitter realities of seeking low-cost fertility services. They could relate to the seemingly irrational

decisions, desperate hope and often very difficult behaviour of intended parents because they could still see themselves in all of it. Moreover, it is hard to overestimate the importance of the broker's own children in building confidence in their business. The sight of a happy healthy child is possibly the most powerful tool for convincing aspiring parents that the risks are worth taking and the price worth paying for international surrogacy. As such, pictures of facilitators' own children would often feature heavily on their websites and social media presence to boost confidence in their work and in low-cost surrogacy overall.

While common, turning one's own experience of surrogacy into a facilitation business was not the only route into the industry. As a growing business, surrogacy was soon attracting businessmen from all walks of life, sharing only the common goal of making money from this new and exciting opportunity. Dylan and Dev may not have had personal experience of surrogacy, but they were both of Indian heritage, allowing them the kind of local knowledge that can prove crucial in a process as long, complex and difficult as surrogacy. They knew how to work the system in India, they knew what to watch out for and how to get their way. Such dual positioning as simultaneously Indian and American/Australian made facilitation work just that much easier for Dylan and Dev. Moreover, the men both had backgrounds in doing business in the medical industries. In fact, Dev told me how becoming involved in the low-cost reproductive industries had for him been a calculated choice from the many potential options he had considered:

> In 2007 I decided to do something different, and I wanted to do something in business. I was looking at all the options and wanted to do something that was outsourced back to India because this is where I can connect obviously, and I also realised that medicine is one of those things that will never die

> down. Invariably, even if there's any kind of recession, people will still be getting sick, people will still be wanting to have babies.

Dev's account highlights the extent to which low-cost surrogacy, for all its self-representations, is for many of its central figures just one of many lucrative ways to make a living in emerging global bio-economies. It is placed here on par with the tissue economies of stem-cell research and even the trade in kidneys:

> I was looking at all the industry, I looked at transplant, stem cell research, kidney transplant, heart transplant, everything you could ask for under the sun. There are people who travel overseas for these things. Fertility was an area that offered not only hope but better returns, and I was very very impressed. I had a bit of knowledge, I had done a bit of research, and I knew that was there and I just had to exploit that.

It did not take Dev long to set up full commercial operations, and he has not looked back since. Dev enjoys the work, the travel and the opportunity to spend more time in his native India. Dylan, too, loved being in India and welcomed the opportunity to travel around the country and spend long periods of time in his home state. The lack of a personal connection to surrogacy specifically did not seem to hold anyone back, however, as some of the top international facilitators did not have any personal experience with surrogacy. They capitalised on their specific experience in moving goods and bodies across borders, often in medical contexts, their people skills, business acumen and overall entrepreneurialism.

Managing relationships

As more clinics and intended parents began utilising the help of professional facilitators and the Indian surrogacy business entered a relative steady state of

operation, the role of the transnational surrogacy facilitator began to take shape. The work of a surrogacy facilitator is that of a middleman, involving work with clients and their home governments, as well as partnerships with the providers and governments of surrogacy's destination countries. Facilitation agencies earn their incomes from helping clients manage the legal, practical, bureaucratic and emotional aspects of surrogacy abroad. This can involve anything from managing communications with the clinic to actually travelling to the destination country with the clients. Dylan, a successful US-based facilitator, described his business model as follows:

> I offer a one-stop agency for parents looking to have babies through surrogacy but who cannot spend the money needed for the US. We take our clients through the process step by step, we have organised everything, the legal, the clinics, the practicalities because it's an emotional thing. We have a personal approach: I meet all my clients in person in the US and really look after them through the whole process.

By offering such full services, and even the option of a travel chaperone, facilitation work has been crucial to opening up the market of surrogacy to those clients who would not have dared venture out to India by themselves, thus helping create the booming international market that existed in the industry's heyday.

Facilitators, while proud of the elaborate service packages they could offer, nonetheless identified the source of their success somewhere else, in relationships or what Dylan described as a personal approach. Time and again, the same argument would emerge: the difficulties of Indian transnational surrogacy were largely a matter of a culture clash between two very different approaches to medical care meeting in a highly stressful, dragged-out and complicated situation. More than anything, the key to the success of international surrogacy facilitators and their

growing importance within the Indian industry came down to the fact that they were situated within the social and cultural worlds of the intended parents and found it easier to communicate with them and create trust with them. Dylan, who had Indian roots but had moved to the US in his youth, relied heavily on his knowledge of India and his understanding of Indian culture in his work. But he was very aware of the benefits of being American: ‘My trump card is that I am based in the US. It’s easier for them to work with me and trust me.’

Indeed, comments by industry professionals often revealed a sense that, behind the intended parents’ seemingly practical issues like hotels and restaurants, or choices regarding medical treatment, there may have been a generally negative attitude towards India. Ishaan, a client coordinator from a Delhi-based clinic, began his comments by outlining issues such as language skills to explain why foreign clients needed extra help and said he could relate to their need for additional support:

> Domestic patient has the privilege of understanding the language. So foreigners need a bit more support. We assist with accommodation, getting the medicines, even salt, if they need salt we help them find some. We take them through and assist them at every step. It’s our moral responsibility to help them – they are foreigners and here for treatment with us.

But he then went on to identify some of the challenge in the confrontation between Indian realities and the expectations of Western clients: ‘They [foreign clients] often arrive with an itch in their mind. People aren’t used to India and the way things are here and the streets... ‘. Others more openly expressed what they perceived in the helplessness of foreign clients as a kind of ignorance and the unwillingness to embrace difference:

> They [foreign intended parents] think India is the land of tigers because they saw some nature show and they think we all sleep on a bed of nails because they have heard of some sages doing that. To convince them that is not it…. well, that's what I'm paid for! (laughs).

In conversations with Indian surrogacy professionals, I could sometimes sense a quiet resentment for what they perceived as the unfair and unnecessarily negative mind-set with which many foreign clients approached India, how they criticised it without taking the time to find its charm or choosing not to look for it at all, instead assuming the superiority of their way of life and expecting India to aspire to imitate it. Another experienced facilitator, Ray, told me that some clients would go to great lengths to try to avoid confronting India altogether, even on longer stays:

> A lot of foreigners, especially Americans, are afraid to sample or to venture out or do anything in India – they stay in the hotel room with the babies. There's a guy who comes out once a week to get a stack load of hamburgers from McDonalds, eight, ten, twelve at a time, that's all he thrives on. He's been in India for half a year already, and that's all he eats. The woman's no better – she just buys chicken and rice and cooks it at home. When I was in India, every day I came home with food for them to sample, and they left all of it.

Ray, of Indian heritage himself, felt baffled and even offended by this guarded approach towards India. 'Why not give it a chance?' he wondered, but then added that in his experience, people who have not travelled can often have very strong preconceived ideas about the places they have never been to. Facilitators tried hard to be understanding of their clients, but they could also relate to the frustrations of Indian surrogacy professionals. Gabriella described the intended parents' complete unawareness of, or interest in, just how disrespectful their statements and actions could come across as:

> Half the time they [Indian doctors] are already disrespected because a lot of the foreigners, they call and then they make statements like ‘We don’t want an Indian egg donor’, as if everybody is beneath them, you know, like ‘We just want a Caucasian egg donor.’ And they don’t even hear themselves! I get that you may want that, but there is probably a certain way you should say it. Because people say that stuff to me, and as a woman of colour and mother of children from an Indian egg donor I find it quite offensive. Funny sometimes what people can say when they’re paying.

The attitudes of foreign clients when confronted with Indian doctors’ similarly strong preconceived ideas of how the surrogacy process should work could make surrogacy challenging. The position of the intended parents here was certainly not an easy one. Being an intended parent through transnational surrogacy is mostly about waiting. They wait for cycles, results, updates, paperwork confirmed dates, and feel rather anxious, powerless and vulnerable in that situation. Their attempts to access further information, photographs or video calls were not welcomed by most Indian doctors. Gabriella explained that Indian doctors simply did not see that as part of their job:

> A lot of doctors, they don’t have the time to help clients really. Their job is to create the embryos, place them in the surrogate, do their job! They didn’t really have time for hand-holding at all, and in India culturally that’s just not what they do. It’s a very different relationship there.

Gabriella’s reference to a different relationship is concerned with the difference in approaches to doctor-patient relationships between India and the US, where most of her clients were from. Despite having travelled to India, her clients seemed to expect the same kind of treatment as they would get back home:

> Westerners try to project wherever it is they live on to these doctors. I try to be so tactful with them [and explain] that that sort of stuff isn’t really gonna fly, but they don’t get it. [...] There are times when I have to keep...the clients have to be put at bay because they have the tendency to...they can sour a relationship with a doctor very quickly.

Indian doctors were often deeply resentful of Western patients' attempts to ask questions or take control of their treatment, something they perceived as unfair distrust and lack of respect. Swetesh, a fertility doctor and owner of a very successful clinic, found that of all his overseas clients (he also treated patients from the Middle East and Africa for IVF), Westerners stood out from the rest for what he perceived as suspicion:

> Westerners are always really suspicious. Do not trust the doctor, always ask questions, double check everything, want to see everything. I had this Australian couple, and they were being so difficult, and then I spoke to my friend who is a GP in Australia, and he told me it is not just your couple like that, they are all like that here!

Several doctors I spoke to lamented that it felt like some intended parents had decided in advance that Indian doctors were either incompetent or dishonest and that this could really complicate their work as the relationship quickly became strained.

According to Gabriella, many Western clients' attitudes of entitlement and superiority towards India made matters worse:

> What I find a little disconcerting is that a lot of Westerners, they feel that, because they paid forty grand, that these doctors are at their beck and call when truthfully these doctors are very wealthy people, and they don't really need your forty grand. There's a hundred more, I'm being real honest, there's a hundred more of you who want their service, and they don't really feel the need to be disrespected.

During a meeting with Dr Sid, one of their partner doctors, Gabriella and Dylan described their role to me as that of a cushion or 'bullshit barrier' between Sid and

the never-ending demands and complaints of the intended parents. Facilitators had the emotional and people skills that doctors sometimes lacked or simply did not have time for, but it could be hard work. Gabriella always remained understanding of exactly why some of her clients were as demanding, controlling and emotionally challenging as they were, but, having enjoyed a very successful career elsewhere before becoming a surrogacy facilitator, said she sometimes wondered if the money was worth having to deal with it all:

> It's not an easy way to make money. There are a lot of emails and emotion management, a lot of legwork, and the money isn't that great. Some of the clients can also be…I mean some are a delight but some…they are also not in the best place in their life when they come to me.

Quality and care

Mediating the relationship between doctors and the intended parents could be especially tricky because, much though the industry complained about intended parents' constant need for control and involvement, there was real cause for them to be cautious. Experiences of bad practice, low standards or even deeply unethical practices were all too common, and stories of such incidents became a powerful driver of suspicion. To keep the relationship from breaking down, facilitators needed to find ways of checking things up on behalf of their clients without appearing territorial. Respecting boundaries and trusting each other's work was crucial for a successful partnership between fertility doctors and international facilitators, so quality control was a constant challenge:

> In a weird sort of way I am representing both [the doctor and the intended parents]. Although there is a separation. The doctors that I work with, I need to make sure that [they deliver] what we signed up for, making sure that the

> surrogates are being well maintained and I'm getting all the reports and there's a proper protocol going on. But you don't wanna go in being territorial or thinking you know more than the doctor. Because I'm not a medical doctor and I certainly would never presume to know more than them. (Gabriella)

However, facilitators must balance out sustaining a good relationship with the need to ensure that agreements are followed and promises delivered on. They would describe to me the elaborate arrangements that allowed them to keep an eye on their partner clinics. This usually involved establishing local networks of contacts and affiliates who spoke the local language, knew the industry and would check on the clinic's work while the facilitator was not present, which was most of the time.

Often this role was filled by individuals whose primary role was to assist foreign intended parents in the surrogacy country and who would then also subtly check up on the clinic. Gabriella, however, went so far as to send her people to sit in on crucial medical procedures to ensure everything was done properly and reported upon truthfully:

> When we have clients come in town, if I want someone to go when a surrogate is being sonogrammed, if I need someone to go get paperwork, I have people who can just go do it. So I can have my people sit in on sonographies, and I know no other agency has that. People just don't. I was just lucky enough to meet the right people and some who've already done surrogacy who are very passionate about the subject. They, especially the Indians on the ground, they know everything that happens in that surrogacy world. So I think it's really smart having people like that embedded.

Indian-born but American Vedang, Gabriella's main partner who handled many of the local Indian issues, argued that constantly checking up on people was the only way to guarantee a fair service for their clients:

> There is rampant unethical practice, it is so difficult to find someone decent. The things they do here, splitting your sperm samples and selling off the rest or keeping some embryos and telling you there were only a few and selling the rest of them to someone else. The IPs, how are they to know? They have no choice but to trust because even we don't know.

Someone like Vedang is invaluable to Gabriella's business. He was born in India but now also has American citizenship, a pattern that was common in the industry, and thus he understands both worlds. He also enjoys spending time in India, providing Gabriella with a more permanent physical presence in the country.

Both of these factors are crucial in maintaining trust, accountability and oversight in a turbulent environment of operation. Indeed, facilitators would often recount to me stories of catching clinics either misreporting success rates or attempting to overcharge. This placed facilitators in a difficult position, as they often needed to work with the clinic despite these issues, but they also had to make sure their clients had successful surrogacies. I asked Vedang how he found out about such issues:

> We go and stand at the door. We find the lowest common denominator. The agents, not the ones that get clients, but the ones on the ground who go into the villages and find the surrogates and offer them to the clinic. They know everything. Because they might offer some fifty surrogates and after screening the clinic chooses eight. But the agent offers the surrogates to all the clinics so the ones that one rules out the other might take. Also they are just involved in it all so much that they know.

Individuals in the surrogacy industry thus often end up with further networks of people to keep an eye on their main clinic partners. Gossip is common and often highly charged, with allegations of various forms of misconduct circulating amongst what is really a relatively small group of actors where everyone knows everyone else. This could make conferences tense and professional associations cliquey sites

of power struggles. The system of partnerships, however, carried on nonetheless, as all parties needed the others to successfully work in the industry. Even those doctors who had fallen out with certain facilitators in the past could thus be seen working with them again in the future.

Having personal connections with trusted key individuals was important to facilitators because it was only through overlapping and interlocking relationships that they could hope to cover all angles, becoming all but local, despite often being on another continent most of the time. Being able to operate like a local is important. Depending on the individual, partnerships could give facilitators a local advantage in language skills, local knowledge and political connections, or simply by keeping an eye on things and reporting back anything potentially useful:

> Even from the drivers. Siddesh, who we've known for almost eight years, who is a driver, knows everything about surrogacy in Gujarat. He is best friends with Dr Singh's husband, who is also a doctor, because they grew up together. He drives clients to airports and everything; that's his job. So he gets to hear it from the clients and the inside out. He knows what's happening with the clinics, the employees, with your egg donors, surrogates. To get that kind of first-hand experience from them is amazing. (Gabriella)

For a facilitator, there was no such thing as too much information about what was going on in their absence, and they were skilled at developing such deep and overlapping networks to make sure nothing was missed.

Brokering success

Due to the various challenges involved in facilitating transnational surrogacy, it took a very particular kind of person to be truly successful at it. Gabriella argued that at the

core of her skill set was simple common sense. When I told her that much of her work sounded like cultural brokerage, Gabriella vehemently agreed:

> It is exactly cultural brokerage. Especially with surrogacy, even more so than other treatments, you don't want that relationship to go sour. I think while my professional background helped me here a little bit, a lot of it is just common sense and really knowing your surroundings and listening to what's said and watching what is not said. And you learn everything.

Indeed, almost immediately after meeting Gabriella, I most certainly would have trusted her with the life and well-being of my unborn baby. I first met her in a small doctor's office at a fertility clinic on a bustling commercial street in Mumbai. She had come to visit Dr Sid and international facilitator Dylan in order to discuss the three of them partnering up together in India and new upcoming destinations. From the moment she entered, Gabriella's confident and calm presence dominated the room. She had the kind of firm no-nonsense approach that would make you want her fighting your corner, while managing to be caring, patient and approachable with her clients. I could immediately see why Gabriella was as successful as she was, why Dr Singh had asked her to help manage clients all those years ago, and why Dr Sid and Dylan were on their toes to make the meeting a success.

All the surrogacy facilitators that I met were most obviously, and without exception, very good with people. As I observed them while they spoke to doctors, took calls from clients or asked questions from the nurses, they seemed to have an uncanny capacity to shift gear seamlessly in their style of interaction and thus get the best out of everyone. This was your counsellor, your administrator, your travel operator and

your lawyer all in one, sometimes all at the same time. Facilitators were also notably strong characters: knowledgeable, confident and persuasive.

Long stays in India had allowed them to get to know the doctors they partnered with and really establish strong relationships. Dylan considered such personal relationships crucial: ‘I find the clinics I work with by being very involved in the business, but also locally. I go there, I visit for months at a time. I inspect the clinic, but I also break bread with the owners and doctors to really get to know what people they are.’ Personal relationships with clients were of equal importance to Dylan:

> We are successful because we have our own personal approach for them. First time they visit the hospital for IVF, they don’t get any medication, they get dinner! We all sit down together with the doctors, and everyone gets to know each other. So then in the treatment room everyone knows each other personally, and that just changes the whole dynamic.

Even if it is somewhat aspirational, this comment highlights just how much importance Dylan places on his role in bringing people together. Whether this is just an ideal or something that always plays out is to some extent irrelevant. Dev also felt that a personal approach was important in this line of work, a fact I witnessed for myself one day at a surrogacy clinic in Mumbai. Dev came up to me and pointed towards the recovery ward where his client was recovering from surgical sperm retrieval, a very painful procedure:

> I was there with them this morning. I’m taking them to lunch this afternoon, or tomorrow at least. These memories will remain with them, and I’m sure even if the treatment doesn’t succeed with them, they will refer us [to their friends] or they will come back to us for their second baby. If you start getting repeat clients, that’s a good sign for your business.

Dev really seemed to work according to this principle of personal attention. He admitted that it was impossible always to be around for every customer, but he made the effort when he could. Indeed, later that afternoon I noticed him negotiating with the doctor over something serious. I went closer to see what it was about, only to find out that Dev's client wanted a milkshake. But Dr Sid said it was still too early for him to eat anything. Dev would not back down. He kept pleading with Dr Sid, arguing that his client was not feeling very well and was in pain, and a milkshake could really make a difference. Dr Sid relented 'OK, in a few hours.' Dev pushed further and suggested going to get the milkshake then and there, as it would take time to get back to the clinic with it. Dr Sid let out a frustrated but friendly sigh, Dev smiled and got up to head out. Whether or not a milkshake was at that point medically advised for the client, there is no way of denying Dev's commitment to easing his suffering.

With Dylan, it was also clear that he really enjoyed the personal connections his work allowed. For him, surrogacy facilitation was rewarding work. He told me about the excitement and pride he feels when new parents hold their baby for the first time: 'That's my Oscar moment!' The gratitude he received from people who, thanks to him, finally had a family was something that both motivated and animated Dylan's work. Relationships thus not only established and sustained Dylan's business operations, they also made him feel special, a part of something bigger than himself.

Over time, facilitators became the established norm in transnational surrogacy. Potential clients would contact them directly rather than getting in touch with an Indian clinic, and it was up to the facilitator to recommend a clinic to work with. This development had serious consequences for the clinics, which, despite also selling

their packages directly, now increasingly depended on facilitators for business. International facilitators became truly central to surrogacy when the industry moved beyond India.

A whole new world

The introduction of visa restrictions in India for their gay and single intended parents in 2012 (as discussed in Chapter 5) and the resulting need for the surrogacy industry to find new markets in other countries for those clients led to significant changes to surrogacy facilitation and a marked rise in their importance. I noticed this shift during my fieldwork in 2015, a period of rapid change and profound uncertainty for the Indian surrogacy Industry. The initial visa restrictions on foreign gay and single intended parents had taken hold, and their impact on local clinics was showing. Reduced client numbers and lower profits had increased competition, and worries over what tomorrow might bring were dominating industry talk. More than anything, however, as I suggested in the vignette with which I opened this thesis, my observations and interactions revealed a sense of the end of an era (see Chapter 1). Many of the professionals I spoke to expressed fears of more restrictions or an outright ban (which was indeed imposed soon after), pointing out the conservative policies of the BJP and the government of Narendra Modi, the increasing criminalisation of homosexuality,[20] the impact of feminist and human rights organisations and the role media coverage had played in turning public opinion

[20] The Indian government effectively criminalised homosexuality in 2013 (Gowen et al., 2013).

against surrogacy. Consecutive bans in other countries were further adding to the sense of a global determination to root out surrogacy. These were pessimistic times.

However, while opponents of the industry celebrated the end of the practice of low-income women carrying babies for money, and as Indian most surrogacy clinics prepared to refocus their business on the provision of IVF to locals, it soon became clear that the shutting down of the Indian surrogacy market, rather than heralding the end of low-cost commercial surrogacy, had catalysed the market to move out of its birthplace and into new destinations all over the world. One after the other, new destinations would open their doors to intended parents from all over the world. First, there was Thailand, where commercial surrogacy began growing as an industry even before the Indian visa regulations (Whittaker, 2016) but that took on much of the gay and singles surrogacy demand between 2012 and 2015. It took longer to set up transnational surrogacy in Nepal due to a lack of medical infrastructure but the first surrogate pregnancies there were nonetheless achieved only a year after the business moved out of India.

Several other destinations have experienced a short boom since then, including Mexico, Cambodia and, most recently, Kenya. Different facilitators had invested in different destinations, depending on their own needs and capabilities. The details of who and why low-cost surrogacy destinations moved to certain areas are discussed in the next chapter, but none would come to have the same expertise and infrastructure that India had developed. Most of those destinations would eventually also introduce bans on surrogacy, yet the industry managed to stay one step ahead through elaborate multi-country arrangements. This new reality would stretch the

courage, budgets and often also the ethics of intended parents to new lengths. Equally, it would see surrogacy professionals invent seemingly incredible strategies to keep capitalising on their lucrative business.

The constant regulatory change that has come to characterise low-cost surrogacy, with the uncertainty and potential legal complications it brings with it for intended parents, as well as the need to establish and manage new destinations, made intended parents increasingly reliant on facilitators because the constant change in the clinics that were offering services meant that the latter's reputations could no longer be relied on. International facilitators were increasingly the only constant presence in a business of unpredictable change. Over the course of only a few years, international facilitators' brokerage role evolved from managing cases between specific Indian clinics and their Western clients to travelling the world connecting medical expertise, technology, investment, surrogate women and intended parents across multiple destination countries.

Presence without commitment

All of the facilitators I spoke to operated in various countries, with most claiming to work in all destinations that were available at the time. Being in charge of a constantly changing catalogue of destinations for a variety of service packages was crucial in order to meet their clients' needs. A well-connected facilitator can consider factors such as the client's age, gender, sexual orientation and marital status, as well as their spending capacity, location, timeline and exact services needed, and offer them options accordingly. Indeed, these days, clients often turn to facilitators for help in going to a specific country they have in mind, but in reality they often cannot

access surrogacy there due to legal or financial restrictions. It is crucial for facilitators to be able to offer feasible alternatives so as not to lose the client to a competitor:

> The first question they ask you is, how do I exit the country [with the newborn]. And the discussion will go like, sorry, you won't qualify to get into the country in the first place! So in that case, let's talk about Cambodia, that's how we work. So you tell them India is not an option for you, but you can go to Cambodia or Mexico, there's the package on Cambodia, there's the package on Mexico, you get back to me and tell me where do you fit yourself, what sort of budget do you have in mind (Dev).

Having a confident representation of global presence was important in these common scenarios, as it gave clients the confidence to trust the facilitator to ensure them access to the best destination for them to commission a baby. This also provided additional security in case of legal changes in the surrogacy destination during the pregnancy. Clients liked to know that, even if things were to change and they had to move to a different country during the long surrogacy process, their facilitator could make sure the end result for their clients was a guaranteed baby.

Achieving this kind of global omnipresence was not simple given the small size of most facilitation agencies, most of which were either family businesses or otherwise made up of a few key employees. Operating in many geographically, culturally, linguistically and legally distant destinations required local knowledge in all these different areas, as well as eyes and feet on the ground. Well set-up relationships were thus crucial for thriving, or even simply surviving, in the surrogacy facilitation business. 'I have connections, partners, ventures all over the world,' explained Dylan, exuding confidence and pride. Moving to new destinations makes facilitators

especially reliant on local partners, while they themselves have become accustomed to the working culture and local peculiarities of the country:

> I work with local lawyers, you have to work with local lawyers, but I have a local partner in Thailand who is a lawyer himself, and he acts as my liaison because I need someone who speaks Khmer and Thai, someone who is there, who speaks English as well, but is on the ground all the time. Because it's an alien country at the end of the day, it's not like Thailand where you can get round. Just getting to Cambodia is a task in itself. (Dev)

These connections were not just a part of the facilitators' business; in some ways, they constituted it. Indeed, rather than take clients to one particular clinic in one particular country, facilitators began partnering with several clinics in different countries as a way to respond to the changing global market landscape of surrogacy. Moreover, as the market filled up and the regulatory environment grew ever more complicated, many facilitators turned to setting up partnerships amongst themselves in order to work more efficiently. A facilitator could broker surrogacy packages to a destination where they did not have a direct presence by going through a facilitator who did, and giving them a share of the profits in exchange for the connection. They would in turn sell packages to destinations where they had good or even exclusive partnerships to other facilitators on a similar wholesale basis.

Some facilitators, such as Dylan, made significant business out of these wholesale partnerships. He invested significant energy into exploring and developing new destinations in order to secure exclusive partnerships. Dylan's skills, experience and connections put him in a good position. At some point Dylan recognised the potential for earnings that his connections entailed if he were to expand his operations beyond what his own client base afforded. Dylan became a surrogacy wholesaler in addition

to being a direct facilitator for clients: he began setting up exclusive partnerships with fertility doctors and then acting as a wholesaler for their surrogacy packages. He would buy the packages from the doctors for a set price. Some he would sell directly to his own clients, while in other cases he would add his own fee and then send them on to other facilitators who had clients but lacked Dylan's connections and partnerships. He did not care how these packages were sold on: ‘I charge Gabriella 40,000 dollars, and she charges whatever she wants. Simple deal.’ This way Dylan could earn a profit from his own clients and those of other facilitators. The exclusivity Dylan held his partners to whenever he could placed other facilitators in a position where they had to work with him. The deal was equally simple for the doctors: partner with me exclusively and I will bring you international business to make your clinic a success. It was a lucrative offer. As I explained earlier, getting international business directly was becoming increasingly difficult. Moreover, for doctors, partnering with a facilitator meant not just an increase in business but also the opportunity to benefit from their extensive knowledge and experience.

No one could be present everywhere, so facilitators often relied on other facilitators to help them out in destinations they were less established in. Indeed, the first time I met Dev was through Dylan. Dev was meeting Dylan at an Indian clinic to discuss new destinations Dylan was looking to open up to surrogacy in the near future. We sat in a vacant recovery ward, talking as we waited for the day’s clinical business to finish and everyone to arrive for the meeting. When I asked him about his relationship with Dylan, Dev was keen to make it clear that the two of them ran separate independent agencies:

> I'd say I'm the wholesaler. Dylan's not my partner at all, he is his own agency himself. He outsources stuff to me which he can't do in other countries. See, I have partners of my own and they don't go anywhere else, they just refer cases to me directly.

Not all facilitators aspired to be wholesalers. Others were more focused on their large client base and industry presence, establishing themselves in a few key destinations and using the help of other facilitators where needed, but not acting as wholesalers themselves. Overall, this arrangement of layered networks allowed facilitators to do the work they were best at and specialise in the destinations they were well established in while still being able to advertise their services to all destination countries, thus attracting more business. Indeed, between them, a handful of well-connected individuals, working in partnership or side by side, divided up the world.

The global surrogacy facilitator personifies the figure of what Karen Ho (2009, p. 314) has described in the context of global investment banking as the single unit of global business, a globe-trotting flexible worker with a laptop, cell phone and Internet connection. This character was, in Ho's argument, the product of investment banks' dream of global omnipresence without local rootedness, influence without commitment. There was no need for a permanent fully staffed office in each country of operation as long as there was the appearance of presence, coupled with a boastful representation. According to Ho, we should take a more critical look at globalisation, not simply as fact, 'but [as] a hope, a strategy, a triumphalist ideology.' Global surrogacy facilitators personify such boastful global aspirations. Unlike large corporate hospital chains, which operate full hospitals in carefully selected

destinations, facilitators do not have such facilities. Instead, they work in between various destinations and facilities and thus manage to claim a global rather than just a multinational presence. Looking behind surrogacy agencies' bold self-representations of their global presence reveals a more complex picture made up of dynamic collections of locations and locals constantly being woven together through ever-evolving partnerships and networks even while simultaneously being disentangled from places that no longer serve the needs of the industry, as facilitators hustle their way around the constantly changing global marketplace for surrogacy.

In fact, while one can develop a rough understanding of the size of various facilitation agencies from their online and social media presence, media coverage, industry presence and the opinions of their competitors and other related professionals, it can be very difficult to estimate accurately the size of the businesses operating in the surrogacy industry. I learned that with facilitators just as with fertility clinics, a well put together website of flashy stock images can make the smallest of operations look equal to corporate powerhouses.

The size of the business has implications for the dynamics of global operation, and it sets the work of most facilitators apart from that of the investment bankers that Ho describes. If consistent corporate backing allows such bankers to be airlifted in and out of countries when markets shift, facilitators' movements are more complex. Apart from the back-up of their small companies, there is no big Wall Street bank, no corporate strategy. Instead, their global presence works through the personal relationships facilitators go out into the world to establish and welcome when such

connections come to them. These relationships give facilitators the capabilities and resources they need without tying them down in any one place, thus allowing them to respond to changes in global surrogacy while also pursuing their own strategies and long-term goals. This is why Dylan was so proud of the network of partners and connections he had built up.

Resilience in uncertainty

The notion of presence without commitment takes on special importance in the context of the chronic uncertainty that has come to characterise surrogacy markets. As I will discuss in more detail in Chapter 7, successive restrictions and bans by various state governments mean that no one in the business can fully count on anything. In a situation where whole markets can be shut down overnight, networking becomes a crucial survival strategy that affords resilience in the face of uncertainty. Extensive connections could be helpful both in potentially providing advance warning of regulatory restriction or a ban, and in allowing facilitators to set up new destinations rapidly or even in parallel to making the most of existing ones. Indeed, well-connected facilitators would have already started moving their business to the next destination before a ban happens because they would have seen it coming.

I spoke to Dev around the time that the surrogacy was suddenly banned in Nepal, which had been the biggest gay and single parent destination. To my surprise, he did not seem particularly concerned. Dev explained to me that he had received warning signs through his networks and was already operating in Cambodia. All that was left to do was to make it formal on his website and social media presence:

> In fact if you see my website tomorrow, Cambodia IVF Clinic, it is the exact same as Nepal, I have transferred the entire content there. Tonight and tomorrow I will go over the content, replace Nepal with Cambodia, replace the profiles of doctors.

Such extreme fluidity and dynamism, afforded by minimal investment and broad global networks, allows well-connected facilitators to follow any changes and transitions immediately, if not pre-empt them. My earlier comparison between this way of working and Ho's (2009) description of investment bankers thus extends to the business model they follow: global omnipresence within the constraints of limited resources is achieved by running a lean and fluid operation that lives and moves at one with the market. Had Dev owned and managed a full business of clinics and surrogate hostels in Nepal, he would have lost huge amounts of invested money, and it would have been hard as well as time-consuming to get the same kind of set-up running in a new destination country. Time here is just as important as money because, in the often quick and volatile cycles of booms and bans, that I described earlier, time is money. Getting to a destination late can mean missing out on its profits altogether. But Dev never invested any significant effort or funds in Nepal and could thus easily sever any ties to clinics there and start running his business though new ones in Cambodia overnight. Indeed, the websites of international facilitators would often still refer to old destinations in the main text, even as headings and titles had been changed for new ones. Working mainly online and over the phone, with only occasional visits and very low investment, allows facilitators to be highly mobile and suffer minimal disruption in the event of a market ban.

Moving with the business

Dev's comment about needing to replace the profiles of doctors is telling of the fact that the latter cannot move to new destination countries with the facilitators. There are several reasons for this, but they all come down to the fact that, while facilitators do most of their work online and over the phone, doctors need to be physically present in the clinic and legally certified to practise in order to carry out clinical procedures. Most Indian clinics were owned, at least in part, by the doctors who ran them. These individuals had invested personal funds, time and effort in acquiring the necessary equipment and paperwork while also building up a customer base and a reputation. Leaving all that behind was not a great prospect and could be very complicated. Moreover, there are additional restrictions associated with practising medicine. Doctors would likely not be able to operate legally in the new destination country without long paperwork and potentially even retraining to be able to secure a medical licence to practise. Operating without one would constitute a criminal offence in most countries, something facilitators need not worry about.

Understanding these restrictions helps put the importance of Nepal as a surrogacy destination and the heartbreak felt by industry professionals over its ban in 2015 into perspective. Due to its proximity and other factors discussed above, Nepal had been an exception to the limited movement options of Indian fertility doctors because it allowed them to escape Indian regulations without having to leave India. Doctors would often discuss with me their hopes for other such satellite destinations, but admitted that the very particular circumstances that had made Nepal so perfect were hard to find elsewhere.

Even if they could move their clinic to a new destination, most fertility doctors would probably choose not to do so. Doctors cannot work from a distance with the same ease that the facilitators can, and a new destination would involve moving their lives and families to a new country for an unknown length of time. That said, I did hear of the odd Indian doctor having started up a clinic in Thailand or Cambodia, so it was possible, if rare, to do so. Others would sometimes keep working on creating embryos and then ship them out to be implanted into surrogate wombs in new surrogacy destinations, thus avoiding the regulations. Most doctors, however, were left behind to find new ways of making their clinics economically viable in a drastically changed market. The networks and interconnections that made up global surrogacy thus served some of its actors far better than others.

Indeed, the ability to follow, or even lead the surrogacy business to new destinations further served to secure the place of facilitators at the centre of the global surrogacy industry. Markets could come and go, but they would remain constant. Facilitators could build up reputations in one destination country, such as India in its heyday, and use that to gain consumer trust in new and more risky markets. Dylan found this crucial:

> Of course these new places are scary, very scary. But we have built up our credibility one baby at a time, so we can explore new places. It's easier now to create and maintain trust than it was four years ago. Now my work speaks for itself.

Facilitators could also put hesitant intended parents in touch with previous clients who had already successfully brought home their baby through them as a way of giving them confidence. The sight of a happy healthy child is possibly the most

powerful tool in convincing aspiring parents that the risks of international surrogacy are worth taking and the price worth paying. The surrogacy industry is well rehearsed in leveraging this power.

Having a track record of hundreds of babies successfully delivered to their new parents provided top facilitators with an advantage over any new facilitators entering the market. The existence of established facilitators who often had exclusive partnerships with doctors had turned surrogacy facilitation into an increasingly exclusive club:

> It's becoming a closed market now. It's hard to break into. The people who are established are established, and the circle is closed. It's so risky and complicated now that you can't come in and say, 'Hey, I have had two deliveries I'm an agent'. (Gabriella)

The same was true of doctors, for whom it was increasingly difficult to work completely independently. Indeed, aspiring doctors would actively seek out international facilitators as a way to gain access to the lucrative field of transnational surrogacy. Doctors would work hard to get the attention of facilitators, which was not always easy to do. As a researcher I was often asked by doctors about my relationships with these facilitators, with some trying to use me to gain information or pressuring me to arrange meetings or even just put in a good word for them. 'So how can you help me? Put me in touch with foreign agencies, only big ones, with volume!' insisted one particularly determined doctor as I sat in his office. Such attempts complicated my fieldwork, but they do shed light on the impression many doctors had of facilitators as the gatekeepers to a world of lucrative high-volume transnational surrogacy work.

In order to be able to work effectively and attract clients, facilitators worked hard to create some form of uniform process in their work, despite different local contexts. This allowed them to advertise the same services, results and quality to intended parents, no matter what the destination. Dev argued that having a well-oiled system in place had helped him become as successful as he was:

> We've got the process that we follow in either Mexico, India, Nepal, Cambodia, Thailand - anywhere, it's exactly the same. I just have a different set-up and the actual team members that work there. Costs are different, clinics are different. But the way we prepare surrogates, the way we interact with clients, is similar. So it's just the repetition of a model from one country to another country.

Dev's words place him in charge and his system at the centre of the process. In this view it is as if the destinations the clinics there were themselves mere disposable containers for the industry that can be easily substituted for one another.

Balancing risk and opportunity

International facilitators position themselves quite differently in this new world of opportunity. Some love the adventure and the quick earnings potential of untested destinations or quasi-legal arrangements, while others look for security and stability. The difference was not a matter of initiative. Most international facilitators were actively engaged in looking for potential new destinations and negotiating with governments and clinics. Their approaches differed in the extent to which they were willing to complicate the arrangements and take legal, medical and financial risks on behalf of their clients. Understanding how and why different international facilitators came to inhabit different parts of the global surrogacy business can help illuminate

some of the moral, geographical and historical contours of low-cost transnational surrogacy.

Parents and businessmen

For some, generally more risk-averse sections of the industry, the facilitator's varying approaches to risk came down to their motivations for being in the business, with some being more focused on profits, while others place relatively more emphasis on the reproductive justice aspect of their work. Dave, the head of a small agency, lamented the profit-driven large agencies as the root of the industry's ills, juxtaposing them to what he considered to be the more sensible approach that he was taking and advocating:

> There are two types of people in this business. I personally believe in this process. And then there are businesses that recognise enormous profit potential. Work in the grey area of the law and are always the ones in the centre of issues. These big businesses are the reason it shut down in Bangkok, and there is fear of it in Nepal.

Statements such as these are highly biased and therefore need to be unpacked in the context of a competitive and contested business. As with many other topics in my research, allegations of 'bad practice' seem to go round in circles, with each individual locating the ills of the industry in the practices of others. Indeed, while Dave might run a small agency, he partners with Dev, a specialist in the grey area of the law that Dave is criticising here. Even if things are not quite as black and white as Dave is making them out to be, his words highlight the importance of taking a closer look at how facilitators became involved in the business in order to fully appreciate and understand their different approaches and styles of operation.

Indeed, while profits may have been most lucrative in the new destinations, not everyone was willing to place their business at the frontier of global surrogacy. Some international facilitators were significantly more cautious about their moves. Most facilitators choose the safer and easier route of only working in established destinations or ones they at least have some legal certainty about. Gabriella's agency was a good example of this approach. At the time of our interview, when the booming and unchecked market in Cambodia was attracting business from all over the world, Gabriella had decided to stay out of it. She did not consider it established enough as a destination and was worried about various rumours:

> Yes, they have been getting babies out of there. There are a lot of pregnant surrogates there too, but I hear it's very problematic, and for my company, we take a stand where we are not the first in and the last out. We won't send clients anywhere unless we see that it's a well-oiled machine. (Gabriella)

It was over a year after the first babies started coming out of Cambodia before Gabriella decided to get involved, and even then she did so cautiously. A good reputation was important for Gabriella; she wanted her clients to have confidence in her service and trust her only to take them to places where they could bring the baby back from without issues.

Gabriella's own children has been born without problems, so her diligent approach to safety was a matter of running her clients' surrogacies to the same principles she would have wanted for her own. Not everyone had been so lucky. For Phil, who was in any case an activist first and a facilitator only a recent and distant second, his emphasis on good practice was instilled in him from the heartbreaking loss of his first two children. Over the years, Phil's organisation has grown to be one of the best

recognised surrogacy advocacy groups in the world. Phil campaigns tirelessly for the reproductive rights of those suffering from infertility, with a special interest in the recognition of gay families and reproductive rights. For now, the organisation also functions as an agency to help intended parents commission surrogacy abroad. It is a hard line to walk, and sometimes Phil find himself giving a platform to businesses he believes are unethical because he needs the funds to do advocacy work and hold events. In a strange irony, Phil hopes that his educational work will help people steer clear of some of his own sponsors. Phil's hope is that, with his campaigning and policy work, someday there may be legal surrogacy options in Australia so intended parents would no longer need his services to travel abroad.

At times, being careful meant missing out on lucrative opportunities and the large inflows of income that short booms could bring. This was a cost these individuals were willing to bear for the sake of the reputation of their business or their personal sense of right and wrong. For Adam, the decision not to deal with cases and destinations that pushed legal and moral limits beyond what his company considered acceptable had been a conscious one that it stood by, despite the pressures to find new destinations quickly:

> At the end of the day, you are responsible for the whole process. If you are selling them stories that you're not a hundred percent sure that you'll be able to fulfil what you promised. So we are really trying not to go into these places. It's difficult. I can't see myself sitting in front of a client explaining to him that we will break the law in such and such way. I really can't do that, you know, with a clean conscience. So we are just not doing it, we are just not doing it. I know there are some that, that do it, but that's not GlobalBaby's way.

Such more cautious international facilitators often found themselves trying to reason with intended parents who were caught up in the kind of whirlwind of emotions and hope that can make for bad decisions and unjustified risks. The same overwhelming demand that Dylan had so welcomed because it made his job of finding clients for new untested destinations easier was seen in a different light by those who were more careful about their work as a potentially dangerous driver of bad decisions, irresponsible actions and inevitably heartbreak. Ray argued that he could still relate to how tempting it can be to believe any sale pitch that promises you a child:

> When you're clamouring to become a parent, your thinking goes out the window, common sense and everything, you're just focused, you try everything. Thinking back on it…it's just other people making money out of you!

Nonetheless, even though restricting their operations and their clients' options could be frustrating, it was considered rewarding. Gabriella had seen her approach actually help her business because, even if she was not always able to capitalise on every opportunity, her business enjoyed the perks of a stellar reputation:

> Overall I think you've got a reputation, people know you, when the BBC have called you up and talked to you, you know you've got something going right, it's a good pat on the back. I think, if you're happy with the way business is growing, that's a good sign too.

What these international facilitators have in common is the fact that they all had their own children through cross-border surrogacy and in the process became ambassadors for surrogacy or even activists for its consumer populations. It is

possible that this had made them more attentive to risk and more cautious in their evaluations.

The contrast between this approach and the more adventurous and short-term approach was evident when Dylan tried to convince Gabriella to work with him to take clients to the Bahamas. When Dylan was pitching the Bahamas to Gabriella as another potential new destination, Gabriella turned it down despite its perfect position as a well-known Westernised holiday destination that was close for her mainly US based clients to travel to because it came out short on the medical front. Gabriella explained to me that the hospitals in Nassau did not have an NICU (neonatal intensive care unit), which is used to support premature babies. This is a crucial piece of equipment for surrogacy where premature births are very common.[21] Dylan might have been willing to overlook such an issue, Gabriella explained, but for her it was a big red flag that she could never ignore. What if a newborn's life was on the line, and they did not have the equipment to save it?

Chasing windfalls

Evidently other international facilitators were less worried about what could go wrong and loved the adventure and the gamble of brokerage work. In his negotiations with Gabriella, Dylan was pushing for bigger risks and justifying them with lucrative outcomes. Indeed, Dylan's attitude towards the business and its challenges in the face of regulation was profoundly different from those I described above. He was excited and boastful about his ability to find a way around any restrictions placed in

[21] A NICU (neonatal intensive care unit) is crucial due to the high incidence of premature births in surrogate pregnancies. The exact reasons for this are not fully understood. The prevalence of multiple pregnancies in IVF is considered one major reason.

his way. For Dylan, risk and chaos constituted opportunity. A great negotiator and inventive thinker with nerves seemingly of steel, Dylan had become a kind of specialist in finding new destinations or arrangements for surrogacy and then selling those packages in large volumes himself, as well as being a wholesaler for other, less adventurous international facilitators. While others might be looking for an existing set-up or ideally even something resembling laws that allow surrogacy, Dylan is happy to operate without any kind of safety net. In fact, I had the impression that he preferred things to be a little bit complicated, as it would give him more control. He had confidence in his own ability to smell trouble and to stay out of its way, but also to see and seize an opportunity where others had overlooked it.

Given Dylan's background, it was not altogether surprising that he had set up successful businesses in the more volatile end of the surrogacy spectrum. Not only does Dylan describe himself as a serial entrepreneur, he has a long history specifically in making money out of moving people between the Global North and South. One of his best known previous business ventures had been the contracting of IT workers from India to work on projects in the US, a practice known as ‘body shopping’ (Xiang, 2007). It is worth mentioning that body shopping, like surrogacy, has also attracted controversy over issues of exploitation. Dylan's description of himself as a serial entrepreneur went a long way in describing his whole disposition. He has no particular passion for surrogacy but was attracted to the business because it was an exciting, new and lucrative way to make money, something that animated Dylan. But this was also a man who loved to travel, see new places and work closely with people from different walks of life.

Dylan is not alone in making his business at the frontier of low-cost surrogacy: Dev is another example. He learned the importance of embracing risk when he lost out on the windfall of surrogacy in Nepal:

> I did not go to Nepal until earlier this year because I knew it was not solid, there was a lot flimsy. But I ended up going because I thought maybe I had made a mistake not going there. So I went to Nepal very late and unfortunately then… [surrogacy got banned there]. You know, the website is not even ready, but we had six or seven cases already and a few lined up for the coming months. So what I've done is I've moved all of them to Cambodia now…

This experience taught Dev the importance of entering new markets quickly and efficiently, rather than going in late. He was one of the first brokers to begin taking clients to Cambodia, where there was far less certainty than there had been in Nepal, and he remains involved in a range of elaborate schemes to circumvent bans in Thailand and India.

Some laws have several loopholes, so skilled individuals can work around them in ways that best suit their needs. Take, for example, Dev's answer to my question about surrogacy in Thailand, where a full ban had recently been imposed on commercial egg donation and surrogacy:

> Sometimes Bangkok can be done, but you've gotta do it illegally, meaning, I mean, there is a legal way of doing it, if you come with your own donor who is your wife's sister or relative or whatever, I don't care, but you bring your own donor. They do the stimulation there and self-cycle, and that's fine. But they can't get a surrogate mother. If they do, they have to show them as their wife, and it's a risk that they have to take. Otherwise for them it's Cambodia and that's it.

What Dev is saying here, via impressive manoeuvrings, is that, despite the ban in Thailand, surrogacy and egg donation are both still an option for foreigners in its capital Bangkok. He describes a continuum of options ranging from the more legal to the much less so, first saying that egg donation is illegal, but quickly pointing out that it can be done if one brings a relative as the donor. He then says that hiring a surrogate mother is not possible, only to add quickly that it is actually possible if the client is willing to take the risk of presenting the surrogate woman as his wife. He then mentions Cambodia as a way of concluding that there is always the next destination. The limitation on commercial egg donation, I later find, can be by-passed through the same method – present the donor as the wife of the intended father. This careful arrangement of yes, no and maybe, coupled with creative legal talk and a keen eye for detail, allows Dev to offer possibilities where many others would accept defeat.

Dev was not listing mere theoretical options – these were real commercial scenarios. During one of our conversations, while I was with him, he received a panicked email from a doctor handling one such case. He explained to me that the donor (for whom a more accurate term would be 'vendor'), a Caucasian woman flown into Thailand for the 'donation', was worried about signing papers while she was still in the country, as it would leave a paper trail, but that they needed this paperwork to be signed:

> They need the donor to sign on behalf of the wife, as a wife [and not a commercial donor]. And the donor has not agreed to that, which is fine, fair enough. So I've told them, let the husband sign, send me the form, get her to sign it when she goes back. She doesn't wanna sign it while she is in Thailand, she is worried it will come back to her. So she said send me the form once I'm back at home. So this is crisis management. I tell you, this is what happens.

These frustrations were apparently quite common, but they did not pose any real hindrance to the business because Dev was never really thinking long-term. The rewards, he figured, might have been short-lived, but they were impressive while they lasted. While Dev was right to predict the shutting down of Nepal's surrogacy business, Dylan had already made his profits there by the time this happened.

Consecutive unexpected bans had demonstrated the futility of meticulous planning in the face of politics. Success emerged not as a matter of having a perfect plan – it was about always being one step ahead of the game or, as Dylan told me, two: 'When you are in this business you need to have plan A, B and C!' The likes of Dylan and Dev survived the restrictions put in their way because, as described above with reference to Karen Ho's ethnography of Wall Street bankers, they built their businesses to be lean and mobile, established with minimum commitment so they could be picked up at a moment's notice and moved somewhere new. Ho argues that the volatility of markets meant that banks would inevitably lose money from time to time because it was hard to predict accurately the need for their services in different global locations.

But rather than make efforts to stabilise the market, the banks instead, much like Dylan and Dev, became experts at riding the wave of the cycle of booms and busts (see Chapter 7 for the impact of this on the low-cost surrogacy industry). Ho argues that, while recessions can mean significant losses for the banks, 'at the same time, because they cut their losses so swiftly and attempt to be the first entrants into new businesses, generating new markets, they also chase windfalls' (Ho, 2009, p. 283).

Banks have become so well-rehearsed in making quick returns and even quicker exits that they are no longer motivated to do their part for the health and stability of markets. Kirstin Petersen, in her account of African pharmaceutical markets, goes even further to argue that some agents in volatile global markets can become so well adjusted to making profits from speculating in the booms and busts, rather than from stable businesses, that they in fact begin to encourage that very volatility (Peterson, 2014). For such actors their work is thus not a matter of balancing risk with opportunity. Rather, due to their particular set of skills, for them risk itself comes to constitute opportunity.

World as market

The constant search for new destinations and business models adds up to a shared view of the world as one big potential market for reproductive tissues and labour, divided up into the consumers and producers they can connect. Dev's description of how he has positioned himself in this global marketplace is telling:

> I am in a good position because I have the option of putting them into any country that I feel is fit for their consumption. Like for example India, unmarried couples from Sydney are not even allowed to the country, they can come as a tourist, but they can't get a surrogacy visa. So that's out of the question, and for them the obvious choice is Bangkok or Cambodia. Do the IVF in Bangkok and create the embryos, ship them to Cambodia or do everything in Cambodia. Royals go to Mexico and do it there. The cost in Mexico is about one third more than the cost in Cambodia or Thailand. [...] There's a lot of intricacies in all of that. Every citizen who applies with us needs to be slotted according to where he or she wants to go. [emphasis mine]

It is important for Dylan, Dev and others like them to have these different options, as it allows them to offer their clients a destination catalogue where prices can be

weighed against convenience, luxury and safety. In fact, Dev explained, surrogacy is not all that different from other the consumer choices people make:

> I tell people [that] doing surrogacy in India is like buying a family sized sedan, buying a car outright. Whereas in Mexico it's like buying a luxury car, but if you do surrogacy in the US it's like buying a Ferrari, second-hand, perhaps. That's the price difference. You can come down to India. These guys are staying in one of the best five-star hotels, affording a nice holiday. Doctor is looking after them, I'm looking after them, everything is happy, right?

For surrogacy's global brokers, establishing new destinations for the extraction of life as surplus, finding ways to get around regulations in existing destination countries and packaging it all up for their clients was all in a day's work. Successful global facilitators were known and respected for their knowledge and connections. When I was interviewing Dev, Dr Sid, a fertility doctor whose clinic recovery room we had been using for the interview, came in and started listening. He gave Dev a pat on the back and said: 'He is a champion, you can question him on any country.' Dev replied with a humble smile: I'm not a champion, I think I've just got a little more experience than others. But Dr Sid carried on: 'He has conquered a little more of the hardships!' and they both chuckled. 'That is important, I guess' said Dev with what was by then a much bigger smile; 'Some people specialise in one place and I've down a little bit more. My [Australian] passport allows me to travel freely across the globe so I can be a bit more... adventurous.'

Surrogacy brokerage as hustle

As my knowledge of global surrogacy as a particular kind of industry evolved, so did my understanding of its ambitious businessmen. I came to think of the work of Dylan,

Dev and other more adventurous brokers as a particular kind of hustle in making a profit at the constantly expanding frontier of what the combination of biotechnology and globalisation allows. The term ‘hustler’ ‘covers a peculiar semantic and social space’ (Wacquant, 1998, p. 3) and conventionally carries negative connotations of illicit business and aggressive tactics. Louis Wacquant has described hustle as

> …a field of activities that have in common the fact that they require mastery of a particular type of symbolic capital, namely, the ability to manipulate others, to inveigle and deceive them, if need be by joining violence to chicanery and charm, in the pursuit of immediate pecuniary gain. These activities span a continuum that goes from the relatively innocuous and inoffensive […] to the felonious, […] all the way to the downright criminal. (Wacquant, 1998, p. 3)

The definition is vague, Wacquant argues, because the hustler is by definition

> an elusive and slippery character, difficult to grasp and pin down in reality itself, precisely in that his trade consists in many instances in unobtrusively inserting himself into social situations, or in spinning about him a web of deceitful relations, just so that he may derive some more or less extorted profit from them. (Wacquant, 1998, p. 4)

Wacquant was writing about black American ghettos, and while I borrow his descriptions of the hustler character, I by no means imply that the work that facilitators like Dylan do in surrogacy is of the kind of criminality and violence that Wacquant describes. Facilitators worked for the most part through email, international travel and meetings with lawyers, doctors and clients. The affinity of their work with hustling lies not in substance but in form, in the importance of networking, being informed, seizing opportunities and manipulating people and situations to their advantage. Key identifiers for surrogacy hustlers are the brave taking on of new markets and the use of unorthodox methods in providing their

services, coupled with a business model that combines working within the confines of the law with working around it or even against it.

The world of hustling stands in contrast to wage labour only in theory, as the boundary between the two is hardly firm in reality, argues Wacquant (1998). The work of many international facilitators is an example of the blending of these two spheres in everyday practice. Any firm dichotomy between hustling and other facilitation work would be artificial. Even Dev runs some if not most of his business by taking clients into established surrogacy destinations in the same way Gabriella does. On the other hand, facilitators who like to distance themselves from the murkier aspects of some surrogacy markets nonetheless often work to set up new destinations in places they would feel comfortable working in.

The term ‘hustle’ is increasingly being used outside its original context and meaning. The increasing replacement of stable lifetime jobs by the so-called gig economy of combining various casual jobs and the overall move towards flexibility has seen the hustler character increasingly being used to describe highly driven and determined individuals who employ creative hands-on approaches and manage several competing projects to achieve their ambitious goals. The protagonists of this chapter are a bit of all of the above, global explorers of a frontier of business in the human body, straddling with skill and creativity the fence between black markets and white, the legal and the illegal, the conventional and the unheard of.

Conclusion

What the different origin stories of international surrogacy facilitators - former intended parents and others - have in common is the identification of a moment of opportunity: the demand for the fertility of low-income women, coupled with technological advances that allowed it to be harnessed, had created the potential for a whole new market, and with it a business model to facilitate such encounters. It was enough both to turn those involved in surrogacy into its businessmen and to invite businessmen from other fields into surrogacy. The global surrogacy market and its facilitators were thus in some ways mutually constitutive of each other right from the start. And indeed, as surrogacy became more organised as a business, the market continued to expand rapidly both geographically and in volume. Not only were more and more people seeking out surrogacy services due to, amongst other factors, rising levels of infertility or the increasing acceptance of alternative families, but there was a growing range of options on offer for them. In the course of only a few years, international surrogacy facilitators went from unpaid advisers helping intended parents book their flights and get doctors to return their calls to being effectively in charge of the industry. In the process, they changed the face of transnational surrogacy, taking the business to new horizons, geographically and morally, as I discuss in the following two chapters respectively.

7. Making markets, breaking markets

‘The basic human requirements are, apart from your food, shelter and clothing, the next comes procreation where it’s a basic biological need for any animal. It needs to procreate and it needs to continue its lineage. When the government is trying to regulate something so basic as that, it is going to be a very big difficulty.’ (Arun, specialist ART lawyer, India)

Introduction

The end of the surrogacy boom in India signalled a new era in global low-cost surrogacy. It was no longer a phenomenon confined to a specific location and history, but something that could be taken to new places, set up in a short period of time and turned into a profitable new market that attracts international clients. I have described in previous chapters how surrogacy markets began to crop up in destinations across the world. The quickness and range of such moves should not be taken to suggest that setting up transnational surrogacy in a new destination country is easy. Quite to the contrary, each new market has come with its own arrangements and associated challenges and it is the brokers’ resourceful approach and willingness to take risks that makes new markets happen.

This chapter tracks these arrangements and developments, mixing accounts of what happened in places like India, Nepal, Thailand, Cambodia and Mexico. All these destinations had their own local dynamics and circumstances that impacted the events that surrounded them. However, looking at them together reveals important

patterns regarding how the global low-cost surrogacy industry survives despite attempts by state governments to ban it, how it moves from one place to the next, as well as the mechanics of the booms it creates and the chaos it leaves in its wake. In keeping with previous chapters, this chapter combines scholarship from anthropology with that of economics. While the two disciplines are often in disagreement about how best to understand economic action and interaction, I have found the two perspectives to be mutually informative for analysing the dynamics of surrogacy markets. While economics provides frameworks for thinking about broad patterns and processes, ethnographic insight uncovers their local contexts and often complex and counterintuitive background.

Making markets

The Indian surrogacy industry's move to Nepal, as recounted by the professionals involved, provides an insight into how new destinations come about. Not long after India's restrictive visa regulations were announced, whispers began circulating of surrogacy becoming possible in Nepal, and soon there were reports of the first Western babies being born there and being allowed to exit the country. I was fortunate to speak to the international facilitator who had orchestrated these first surrogate pregnancies and thus opened up an entirely new kind of surrogacy market. Brimming with pride, Dylan explained to me how he had taken commercial surrogacy to Nepal:

> They [gay and single parents] can no longer do surrogacy in India legally, so I set up in Nepal after the visa rules. I was the first to do surrogacy in Nepal for US parents; the first baby born there was through me.
>
> As soon as the new visa rules [for India] got announced, I started looking at other places, and then Nepal came up. So we started looking into that

> seriously and finding ways to set it up. I spent a lot of time in Nepal. It took us about one year to get first conception in Nepal. It felt so quick at the time! But looking back it was a whole year…

What Dylan is referring to here was in fact a highly complex operation. He took advantage of the porous border between India and Nepal to split up the surrogacy process between the two countries. Surrogacy was not, strictly speaking, legal in Nepal. As one facilitator explained to me: 'The way the Nepalese government agreed to do it is, it would only be what they called medical tourism, where the surrogate herself could not be Nepalese; they fly them in from India.' Clients would drop off their gametes in India, where all the expertise and technology-heavy aspects of the process were carried out: embryos were created, implanted into surrogates and monitored. Once the surrogate was in the fifth month of pregnancy, she would cross the border into Nepal and give birth there once the baby was due. Some clinics would open up satellite clinics in Nepal, and the doctors would fly over to do the embryo transfers there, but only to Indian surrogates who had travelled there to work as such. Either way, the clients would pick up their babies in Nepal, get their exit documents and leave the country, all without ever falling under India's visa restrictions. The surrogate would make her own way back across the border as if nothing had happened at all. This additional step was not ideal for the industry, but it allowed it to remain operational and highly profitable.

Dylan explained to me how an elaborate combination of simultaneously working with and around governments allowed his new model to succeed:

> The paperwork for Indian surrogates in Nepal and the other way is very simple because there isn't a real border between India and Nepal: it's a free flow of people. They don't even need ID to come to India. And Indians don't need any

> visa to go there. As for the exit papers, we work backwards from the US Consulate. They are the ones who decide in the end, and they tell us what they need and we work from that. We have a close relationship with them, so they will inform us in advance of any changes.

The details were shrouded in secrecy, but surrogacy professionals related many theories about how exactly this arrangement with the Nepalese government was reached. The accounts converge on the point that it had been a simple matter of certain high-ranking Nepalese officials or politicians being paid handsomely for making surrogacy operational in Nepal in an expedited manner. But there are other theories.

One need not have wondered whether intended parents would agree to partake in such an elaborate scheme. Due to the overflow of clients, as well as of technology and expertise, from the large but recently closed down surrogacy industry just south of the porous border in India, the Nepalese market experienced an instant boom. In fact, this Nepalese arrangement was started even though there was another destination - Thailand - available at the time. The real genius in the arrangement was in the fact that Nepalese surrogacy still relied on the experience, expertise and technological facilities of Indian clinics, thus keeping Indian doctors involved in the business and guaranteeing an established level of service for intended parents. It offered an outlet for all the technology and expertise that had been built up in India but for which there was no longer a market there:

> The Indian clinics had got so pissed off, the big ones had lost their huge market share that they started talking to Nepalese government. And a consortium of about four key players in India put together apparently about 300,000 dollars of money to bribe the Nepalese government to introduce a surrogacy law. So that was all done behind closed doors and the market...the entrepreneurs had sort of set up in Nepal quite quickly. (Phil)

For Dylan, too, being able to ‘fall back on Indian medical tech’ was important because it saved him the time and investment of setting up entirely new clinics and allowed him to keep working within his existing partnerships with Indian doctors. He and other global surrogacy brokers were relying on Nepal only as a cheap and unregulated space, adding expertise and technology from their existing networks. As soon as news broke of the first babies successfully exiting Nepal with their new parents, indicating that the viability of this new format was now established, there was a sudden huge influx of doctors and facilitators, bringing in large numbers of clients from all over the world. Nepal became the next big thing in global surrogacy, and everyone wanted a piece. It seemed like the transnational low-cost surrogacy had found its new perfect global hub.

Yet Nepal’s position as the new global hub for surrogacy came to an end even more suddenly than it had begun. In April 2015, a devastating earthquake hit the region, leaving many victims and destroying huge areas of the country. When the eyes of the Nepalese government and the global media suddenly turned to the surrogacy business in the aftermath of the earthquake, the response was confusion and outrage. Media reports of Israeli intended parents and newborn babies being airlifted out while surrogates were left behind in the chaos dominated news headlines, turning public discussion to the value placed on some human lives over others (Kamin, 2015; Stoffel, 2015). The rhetoric of global sisters helping each other was fast becoming an impossible sell for the industry.

I spoke to Dylan at the time of these events. He was not pleased but not overly stressed either, hoping the negative coverage would blow over and that the world would soon have something else to be outraged about, leaving him to carry on with his business. ‘Nepal as a destination is not going anywhere because of this,’ Dylan argued; ‘We have decided to give it three months out of respect, to let the country heal, but then we will resume our operations there.’ This was before sudden bans became the norm in the low-cost surrogacy business. Dylan's concerns post-earthquake had to do with infrastructure, such as airfields, roads and hospitals, rather than legislation. He weighed up the likelihood of various scenarios in his head, only to conclude that, whatever the outcome, he would come out on top:

> Surrogacy will be a hot topic now for the Nepalese government because of all the media coverage. It's in their face now, but they also have a lot on their plate, so it is probably not going to be a priority. The world’s eyes are on Nepal now. Perhaps it will attract some investment into that poor country – who knows what might rise from the debris! I don't think they will legislate against surrogacy, but if they do then we will just find somewhere else. I always think a step ahead so I would not be out of business. (Dylan)

While Dylan was hopeful that the young yet booming surrogacy industry in Nepal would survive the sudden crisis it had been plunged into, he was also confident that even if it did not, his business would. He could simply move on and set up commercial surrogacy in the next unregulated low-income country on his list. He was both wrong and right. Not long after our conversation, Nepal banned surrogacy in August 2015. But due to his many other arrangements, Dylan’s business, indeed, barely felt the impact.

The comfort of reliable demand

Dylan's confidence in the industry was calculated and one shared by other international facilitators like him. Unlike clinics, they were not tied to working in India, and they anticipated that if they moved their operations to a new destination, their global client base would follow. Indeed, the surrogacy professionals who built their businesses in the Indian surrogacy market had learned an important lesson in their work: people are willing to go very very far in their pursuit of parenthood. Seeing clients invest their life savings in surrogacy, risk criminalisation, lose their jobs, travel between continents and face significant risks all to finally have a child of their own had instilled in many the confidence that the industry could not be shut down.

The willingness of clients to bend to the demands of the industry had over time been confirmed in the context of price. I first came across this when discussing the prices of low-cost surrogacy with consumer activists. Many expressed to me their confusion over the way global markets had developed. They had hoped that the rapid growth of the industry and the introduction of new providers would eventually bring down the price of low-cost surrogacy even further. Indeed, one would have expected prices to drop because of economies of scale, whereby the cost advantages that enterprises obtain due to their expanding scales of operations reduce prices for the consumer. The increasing number of clinics involved in surrogacy was also expected to raise standards and lower prices due to increased competition.

However, this price drop never happened in surrogacy and in fact prices began rising as the industry gathered steam. ‘It’s becoming more and expensive!’ explained Dave,

a small-scale international broker and gay family activist: ‘It used to be twenty percent of US cost and now it’s forty to forty five percent of cost.’ Dave, who had his own children through surrogacy in the early days of the Indian industry, had benefited from the drastically lower prices in the country. It had been his only option to become a parent since there was no way he would have been able to afford surrogacy in the US. He could see low-cost surrogacy rapidly becoming something that only very wealthy clients could afford.

I discussed this price increase in Chapter 5 in the context of the addition of various intermediaries and services to the low-cost surrogacy package. What had started as a simple transaction between the clinic and the intended parents quickly became a vast range of services that were expensive but touted to intended parents as essential. Whether or not the various case managers and hotel services were in fact necessary, part of the rise in prices could be explained by such additional services. Dave, however, rejected this explanation, arguing that the cost of additional services was nowhere near high enough to justify the kind of price increase the market had experienced. Surrogacy providers were raising prices, Dave argued, because they could.

One way to describe the relationship between price and the demand for a product or service is as a measure of the ‘price elasticity of demand’ (Gallo, 2015). A commodity or service is considered price-elastic if a small rise in price results in a large drop in demand. Surrogacy, by this measure, is relatively price-inelastic, as demand remains largely unaffected by increases in price. This is because globally the demand for surrogacy services still far outstrips supply. As a result, international

facilitators and clinics have the liberty to set prices according to what they can charge, rather than what they need to charge to meet their costs. For example, surrogacy packages in Mexico were much more expensive than the same services had been in India. Gabriella explained to me that this difference was due to the relatively high desirability of Mexico as a destination:

> Gabriella: A lot of it depends on where people want proximity. I work in Mexico, which is very easy to get to from the US and they have state-of-the-art clinics. The cost is obviously more than India used to be, probably another USD 30,000 more than India.
>
> E.L.: Why does it cost more? Stronger economy?
>
> Gabriella: No, it's because in Mexico they have good facilities and they recognise that people from all over the world, especially gay couples, need surrogacy. You know what, they go with what the market will bear. If you're from Japan, from Spain, from France, and you're gonna pay 80,000 dollars, then guess what, everyone else has got to pay that too. So that's what's happening with prices also internationally. [emphasis mine]

So, while location and convenience were important factors, prices were mostly defined by whatever intended parents were willing to pay. This elasticity is capped only above a certain threshold, when prices become too similar to those of high-end destinations such as the United States, and it no longer makes sense for intended parents to travel to other destinations. The industry is aware of this and works carefully to maintain a balance between maximising profits and keeping up demand. Indeed, if the higher fees of surrogacy in Mexico made sense for Gabriella's mainly US-based clients, they were too much for Dev's mainly Australian clients, for whom additional travel costs cancelled out the benefits of a low-cost destination:

> The cost in Mexico is about one third more than the cost in Cambodia or Thailand. Plus the expense of travel for a couple from Australia to Mexico is about 5500 - 6000 USD. So that's an expense. You're going there twice, plus the accommodation, then you have a 20,000 dollar expense, just on top of the

> surrogacy cost, which is $50,000 in Mexico, that comes to $70,000 total. You can get exactly the same thing done, surrogacy, in the US for 100,000 dollars. So why bother? (Dev)

Mexican surrogacy clinics had little motivation to lower their prices in order to better attract Australian clients because the huge demand from the neighbouring United States was already keeping them working at full capacity.

The surrogacy market, its professionals believed, would show the same kind of elasticity when it came to risk and inconvenience as it had for price. The first clients of transnational low-cost surrogacy had come to India to create their babies with little to no information, security or control over what would happen. From a legal perspective, the Indian business itself had come to life and thrived partly because of, and often in defiance of, regulatory restrictions in the intended parents' home countries (Everingham et al., 2014). Those who could not legally hire a surrogate at home travelled to India to have their babies there, only to rely on the courts to prioritise the best interests of the child and grant citizenship and parenthood rights, even against its own laws. The presence of risk and the unknown had not stopped the business from taking off in India, so there was no reason for anyone to fear it would stop it in the industry's uncertain future.

If anything, I was told by international facilitators, it would be easier to set up new destinations now because, even if the countries and doctors were new, the international facilitators themselves had long 'take-home baby' track records to show. Facilitators emphasised their own role and played down other variables as a way to convince their clients that they would get the same service wherever their

surrogacy ended up taking place. Dev, an experienced and well-connected broker, explained to me that new surrogacy destinations and the complications they entailed were a matter for the professionals to contend with, not for the client to worry about. Intended parents simply needed to trust facilitators to get them a baby, no matter how complex or even absurd the set-up might look:

> At the end of the day you've gotta trust your judgements and instincts and team. Having a baby is a very easy thing. It's the exit process, the stress during the pregnancy and the aftermath of the pregnancy is what gets people. It's like going on a flight - you trust the pilot to fly the plane, right? Doesn't matter if he is an Egyptian or a Jordanian pilot, right. He'll be flying a Boeing 747 and you will get to your destination. I'm the pilot, let me handle this, you do your job, where you handle your things. (Dev)

The disregard of risk evidenced by intended parents is well illustrated by the fact that Dylan had received requests for surrogacy in Nepal immediately after the earthquake hit the country in 2015, even though much of the country was still in crisis and under rubble:

> The clients have no fear! They are so up to date on these issues, they read the news and Google and they know what's going on and that it's the poor who are affected and the modern buildings are fine. These are new hospitals so it's fine. They are inquiring when we start again. (Dylan)

According to international facilitators, it was often the intended parents who pushed the boundaries of global surrogacy. Clients were not worried about going to Thailand, even at a time when it was already strictly speaking illegal. But the doctors were, as they were the ones who could get in trouble if something is wrong: 'People just want a family, and then all common sense goes out the window' (Dylan). While Dylan joked about the fact that many of these people were not in their most critical and

cautious state of mind when they came to him, not everyone found it funny. Adam, another international facilitator, argued that the willingness of consumers to commission surrogacy in risky or illegal destinations was not a matter of courage and independent research, but of severely impaired judgement as a result of their involvement in an emotional and manipulative trade:

> I think the intended parents do go to these destinations. Intended parents who are given all sorts of promises from people who are supposed to be professionals, and they explained to them that it's not dangerous, that it's such-and-such and lots of different stories. I think that they are, I wouldn't say brainwashed, but they tend to believe what they want to believe. If a professional tells them that it's safe enough and that's the only way they can fulfil their dream of having a baby. So yes, they would go for it. (Adam)

Consequently, Adam believed that, as professionals, international facilitators shared a responsibility and a moral obligation to help their clients make sensible decisions in a confusing world. If the risks were revealed to them appropriately, Adam argued, intended parents would agree to wait for a better arrangement to come along:

> If I, as a professional, sit in front of a client, telling him 'Look, it's not legal. I wouldn't advise you to go into it.' I haven't met a client that would tell me, 'No, no. Let's do it, even if it's not legal.' They just don't say that.

Again, the key to the difference between Dylan's and Adam's attitudes might lie in their respective backgrounds. Dylan came to the surrogacy business after a string of other somewhat similar and lucrative enterprises that were profiting from brokering between cheap Indian labour and demand for it in Western countries. Adam, on the other hand, was a gay man who had once been an intended parent himself and was still actively fighting for the reproductive rights of homosexuals. So where Dylan saw a market demand unfettered by cost or danger, Adam saw his own former self,

desperate, in some ways vulnerable, and willing to believe anyone who would promise him a family.

The power of this desire for a family of one's own resonated throughout the business and was especially pronounced in conversations around restrictions on access. I spoke to Arun, a successful specialist Indian surrogacy lawyer, around the time when the Indian industry had already closed down most of its business and the first spin-off destinations that the business had moved to had introduced full bans. Arun had a keen social scientific interest in surrogacy and had given significant thought to the dynamics of the enterprise. He was not surprised to see the business carry on despite and around the law, attributing much of the commercialisation and criminalisation of surrogacy to the mismatch of understanding between what mattered to people and what mattered to governments:

> It is very difficult for governments to actually intervene in this kind of arrangement. Because the basic human requirements are, apart from your food, shelter and clothing, the next comes procreation, where it's a basic biological need for any animal. It needs to procreate and it needs to continue its lineage. When the government is trying to regulate something so basic as that, it is going to be a very big difficulty. It is simply like a stream of water flowing down - any way you try to stop it, there will be some way it will just keep finding a way around and move forward. But that's something the governments are not able to understand, politically they're not able to accept that part. They are required to regulate one way or the other and not every time does it work out great. (Arun)

Many people, Arun argued, wanted to be parents more than they wanted to be law-abiding citizens, more than they valued their reputations and their life savings. Until there was another way for these people to have children, industry professionals and activists argued, surrogacy was too big ever to be completely banned.

Makings of a good market

How, when and where the surrogacy markets relocate to is not an arbitrary matter. The routes through which the various agents and segments of the surrogacy industry move are determined by geopolitics and regional socioeconomic circumstances, as well as by old migration patterns, tourism habits and flight schedules.

An international facilitator's main client base can play a significant role in these decisions, especially when it comes to location. For Gabriella, as already noted, Mexico was a favourite destination:

> It's the proximity for Americans. It's very easy to get to Mexico. There are clean beaches, it's a lot closer to American standards, at least in these beach places. And that's what people want. They don't have to do a sixteen-hour flight, they can do a three-hour flight and be in Mexico and come back home if they need to come back home. It's more familiar. Even in college, for spring break it's known that you go to Mexico, and people go there on a holiday. (Gabriella)

For Australian clients, Asian destinations were cheaper and also closer to travel to, saving on time and money. Moreover, Mexico seemed daunting and distant for Australian clients, whereas Asian destinations were popular holiday destinations with positive connotations for Australians of relaxation and familiarity. For them, the Westernised city of Bangkok in Thailand had thus been a perfect destination to start a family.

Quality and inequality

The desirability of a new surrogacy destination for its professionals and its clients was also contingent on price, a factor that hits most starkly at the heart of the global

surrogacy industry and, in a way, loops back to the discussion of regulation. However, the industry's relationship to cost and income is more complex than is immediately obvious. There is no doubt that the low-cost surrogacy industry seeks out low-income destinations. Without cost savings, low-cost surrogacy would have lost its selling point compared to well-established and stable surrogacy destinations in parts of the US. Poverty helps drive down costs and ensures a steady stream of highly motivated women signing up to carry babies for others. Moreover, economic precarity is often coupled with other factors such as a lack of opportunity, education and legal rights that make a perfect field for surrogate recruitment and management. Together, such circumstances mean that surrogate women do not need to be paid very much for their services and that they are unlikely to make demands regarding their health and welfare.

Poverty alone, however, is not enough, because surrogacy also relies on the existence of wealth. It relies on biomedical infrastructure and the presence of English-speaking, ideally Western-trained doctors, but also on investment, five-star hotels, security personnel, air-conditioned chauffeured cars, regular international flights and many other practicalities and amenities that cater to the demands of the industry and its clients. It was common for brokers to be drawn initially to a destination due to its prices and lack of regulation, only to discover that the industry could not function there. In discussing Mexico, Dev told me he had also looked at the region more broadly: 'The other options are Guatemala, Peru, but the level of service… It's not only surrogates but the doctors and the trust that you have.' Dylan had considered Bhutan for a while, but the country turned out not to have a US consulate, which was crucial for getting exit papers for the babies. Laos was on the

horizon but never made the list due to the lack of convenient flights and medical infrastructure and instead found its place in other Asian markets, as women from Laos were trafficked in batches to countries like Thailand and Cambodia to work as surrogates.

The useful contradictions of this combination of poverty and wealth are illustrated in the fact that the surrogacy industry is drawn to countries that have well-developed private health-care systems. Indeed, while private health care is important for medical and reproductive travel because it provides the experience and infrastructure necessary for the right level of service (Deomampo, 2016), it also is often responsible for creating the crippling debt that drives local women to act as surrogates. Through different pathways, privatised health-care systems in countries with significant socio-economic inequalities provide the transnational surrogacy industry with both its highly skilled experts and its willing reproductive labour.

Just as potential surrogates need to be poor but not too poor (as discussed in Chapter 3), low-cost surrogacy destinations need to be cheap but still up to the standards of Western expectation. Indeed, surrogacy relies on the presence of a particular kind of inequality - poverty and precarity combined with wealth and privilege - to function most successfully and profitably as an industry. This inequality provides a balance of good service and cheap labour, but if the gap is too extreme wide and the prosperous classes too small, it will not be able to support the industry. It is therefore no surprise that some of the most successful surrogacy clinics have been located just outside major metropolitan cities, where the amenities, connections

and infrastructure of Westernised urban centres are nearby, yet prices and local standards of living remain attractively low.

Perceptions and stereotypes about a destination are revealing of this dynamic. While intended parents are attracted to the affordability of a destination, they are less keen on many of the uncomfortable connotations that affordability can bring. Gabriella revealed the complexity of some of the issues she had to consider when she told me about trying to figure out whether joining a potential new destination in Kenya would be a good idea. Dylan had managed to get the government there to agree to surrogacy on paper - something Gabriella considered important - and had offered Gabriella the opportunity to partner with him and buy surrogacy packages from him there on a wholesale basis. This was a tempting offer, but Gabriella could not help but worry that America's history with African slavery could become an issue for American intended parents: 'I've already had people tell me that they have concerns about Kenya. For some people they feel that it's another form of slavery... Someone said that to me and I'm like "Oh great!"' (laughs). The racial histories of exploitation and abuse sat uneasily with American intended parents, despite industry efforts to present low-cost surrogacy as an equal exchange between global sisters.

Conversations around the viability of Kenya as a surrogacy destination pushed to the fore the carefully hidden, deeply problematic relationships between surrogacy, inequality and race that I discussed in Chapter 2. In a meeting with Dylan about this potential partnership in Kenya, Gabriella expressed her concerns about the possible impact of the racist stereotypes many Americans have about Africa on the arrangement. She feared that many Americans would have an issue going to Africa

and using black surrogates because they associate the region with poverty, sickness and HIV. The other professionals in the room with us - all experienced in the industry - nodded in worried agreement. Race and racism run through the surrogacy business in many threads that usually place darker skinned women in the role of the surrogate. There are limits to clients' acceptance of this, Gabriella seemed to think, and using black surrogates in Kenya might go beyond those limits for her American clients. In these roundabout ways, it was at the global limits of the surrogacy industry that its core was forced to become most starkly revealed.

Tactical choices

With competing demands, finding the perfect destination could be an elusive task and a losing battle, leaving international facilitators to prioritise according to their own values, as well as based on what was available to them. Most also end up offering surrogacy packages in a catalogue of destinations to accommodate different client needs, even if that meant working through other facilitators rather than having a direct presence in the country, the practicalities of which I discussed in Chapter 6. Despite having these options, international facilitators understandably favour and also promote destinations where they personally already have arrangements. While they are likely to have invested in a destination they feel most comfortable working in, working directly with clinics also saves them having to pay a cut of their fees to the partner. As a result, asking international facilitators which destination they thought was best for low-cost surrogacy would elicit a range of answers depending on where that individual was working. Thus Dev would always promote Cambodia, where he had working arrangements. He followed this up with a warning about the

scams and dangers of going to Mexico, arguing that the doctors there scammed intended parents out of money and faked results:

> Mexico has got its own bad reputation for a lot of other reasons. Even the doctors make money on it. They'll send you a Whatsapp message and say the courier guy has the tank [with cryopreserved embryos] but he needs a few dollars and I paid fifty dollars on your behalf. You know, that kind of ransom law, even the doctors do it. And the intended parent then won't say no, they can't say no. Then it becomes really embarrassing for us.
>
> Things like, they'll send you fake reports. I'm asking the doctor send me a proper scanned report and not a picture of the screen without the name of the patient. I say, 'Doctor, can you make sure that the patient's name is on the screen as well?' He says, 'I'm busy.' So why can't he just hold the phone properly. It's suspicious things like that, and the doctors will fake a pregnancy. It's not a country that I would trust, even if I had the last option. I guess it's got its own reputation and people are afraid, it's there, people know that it's a bad country. (Dev)

Gabriella, on the other hand, would assure me that she had no problems working in Mexico, which she described as a convenient and familiar location for Americans. Instead, she would advise against going to Cambodia due to the lack of regulation and oversight there.

Life-cycle of a destination

If finding a destination country for low-cost surrogacy and setting up operations was difficult, the real challenge was keeping a destination, once established, from being banned as soon as business volume built up. At the time of my fieldwork, the industry had begun operating with almost an expectation of the next ban. Indeed, a closer look at previous low-cost surrogacy destinations reveals a fairly consistent trend, from the discovery or establishment of a new destination to a short-lived boom followed by a sudden crackdown by the local government. This pattern takes the

shape of a kind of life-cycle of beginning, boom and bust, only to start all over again somewhere new.

Icebreakers

When a broker decides a new destination is suitable, they will slowly and quietly begin selling surrogacy packages to that country, often without ever advertising the destination on their website and only telling intended parents about the new opportunity directly. In the beginning any new destination is unknown and uncertain, so relatively few dare to commission surrogacy there. It is common to have rumours circulating about what is happening but it can be difficult to get any concrete information. However, the real test of a new surrogacy market is not getting intended parents into the country but getting them out with their baby. This creates something like a twelve-month lag between the first packages being sold and the safety and reliability of the arrangement being proven. Talking to the media about Cambodia, Daniel Carrington of an Australian-based surrogacy agency referred to these first clients as ice-breakers: ‘The waters will be tested in Cambodia when the first babies are born next year, when parents will be looking to exit the country. Somebody has to be the icebreaker’ (Murdoch, 2015). According to Carrington, in such situations it was up to the intended parents to weigh the risks of engaging in surrogacy in unknown destinations, and brokers may or may not choose to inform them of potential dangers.

Managing a boom

Once the existence of a new surrogacy market is widely known, image management becomes paramount. The key to the longevity of a boom was to work without attracting too much of the wrong kind of attention. Pictures in the papers of miracle babies with their happy parents were good, whilst reports of huge baby factories, mixed up embryos or abandoned children were potentially disastrous. The key here was to manage the boom in a way that would allow it to last as long as possible – ideally, forever.

According to some of the international facilitators I spoke to, not everyone knows how to be smart about this work. In a meeting with Gabriella over her potential partnership with Dylan selling surrogacy in Kenya, a new destination he was setting up at the time, he emphasised the importance of quietly doing business while still keeping this new destination concealed from others in the business. When the first babies were born, the whole thing would become public anyway, and everyone would rush to get in on it. Gabriella was on the same page: ‘Yeah, you don't want the floodgates. Then it gets messy and it blows up. You want to keep it quiet as long as you can.’ Controlling who had what information was paramount to make this operation a success. Dylan even emailed me on the evening following our conversation asking me not to write about these new destinations or even to tell anyone about them until he had properly established himself there. But he was also realistic and knew that he had to get as many surrogacies done as quickly as possible, because the inevitable rush would come. At the end of the meeting Dylan turned to Gabriella: ‘Let me do a few hundred on Kenya, then we look elsewhere.’

Dylan knew from bitter experience just how dangerous those floodgates could be. He had learned this lesson in Nepal, where he had spent considerable time and effort setting up a surrogacy business, only to have it shut down by a sudden ban. To Dylan's frustration, Nepal's phenomenal success had been its downfall. Large international agencies came in almost overnight and flooded the country with business. Dave, who runs a small brokerage agency that focuses on personal attention and care, was also working in Nepal when this shift from small-scale operations to large agencies took place, calculating that this powerful entry by the industry's established greats had doomed the destination's prospects:

> The problem was entry into Nepal by established businesses with branches established around the world. They are more profit-driven, large international businesses focused on making money. They had more marketing money behind them. They bring the price up as they establish themselves as the leaders in that market. Vivo IVF and GlobalBaby, for example. They are less personal. (Davel)

Dylan too felt that these large agencies were the biggest enemy to his business, but there was little he could do. As this exchange between Dylan and Gabriella shows, both knew all too well that it would be impossible to control the influx of business and its problematic consequences once the floodgates had opened. Large numbers of foreign intended parents would commission surrogacy, driving up demand and prices while driving down quality of care and even basic standards.

Indeed, while surrogacy booms in various destinations have varied to some extent due to local particularities, they have many of the same symptoms. There is a sudden influx of investment, expertise, technology and various businessmen. Everyone is working hard to get into the business because the huge demand makes

it incredibly lucrative. For local doctors, this can be a windfall unlike anything they have ever experienced. Speaking of the initial boom in India, one fertility specialist lamented that everyone suddenly seemed to be in IVF: ‘A friend of mine recently opened a clinic. He is a dermatologist! I know for a fact he has no qualification!’

Such a sudden boom would, in itself, eventually attract attention, but it also created scenarios that would catch the eye of the global media and cause public outrage. Indeed, even more dangerous than the gradual growth of surrogacy into too large an industry, or the eventual legislation that would take many years to process, was the threat of scandal. This was often a matter of how the vulnerable reproductive labour for such booming markets was recruited and managed. Clinics would hire under-age or medically unfit women to carry multiple pregnancies and engage in other practices that looked to the world like gross exploitation. According to Dave, such practices became more common as the business grew:

> The catalyst [for the ban] in India was the growth of the profitable business. Fear of more and more women being exploited. There were cases of women not paid or getting sick and not receiving any care. Egg donors and surrogates who were turned out to the street with no money. This raised alarm in India that the process was exploitative. (Adam)

The intended parents were also vulnerable. Doctors who took on too much work could mix up embryos or give intended parents the wrong baby, leaving them with heartache and the very real risk of not being able to take their child home. This issue is so common that some doctors are known for having made numerous mix-ups, with rumours about warrants for their arrest or court cases against them circulating in the industry. The world never hears of most of these incidents. Every now and again,

however, someone panics and turns to the media in the hope that the attention will put enough pressure on officials to resolve the issue.

The high-profile cases that follow inevitably end up kindling debates around women's reproductive rights, global inequalities and child-trafficking. They are also simply embarrassing for the countries involved, as they are shown to be either complicit in this controversial trade happening within their country, or revealed to be altogether unaware of what goes on in their country's fertility clinics. As a result, they are often detrimental to the surrogacy industry, causing significant frustration for its proponents and professionals:

> Usually the scandal [that leads to the exposure and banning of a surrogacy destination] starts with a real scandal. Like something happens, something bad happens. It's just that intended parents... I don't want to blame anyone because you can't blame them because they are under huge stress and in a huge problem, and their way of thinking is 'I'll do anything I can to solve it.' And 'anything you can' is going to the media and going to the embassy. Usually these are the cases that ruin it for everyone else. But I'm not saying that I'm blaming these intended parents. I don't know what I would have done in their case. (Adam)

There were, however, rare but notable occasions when the behaviour of intended parents proved very difficult to defend. Such behaviour was, in fact, the source of some of surrogacy's worst scandals. There was the case of an Australian couple abandoning one of the twins they had had through surrogacy in India (Bagshaw, 2014). They took the girl but left the boy, arguing that they already had a son and thus had no need for another. While it may not have made headlines outside the two countries involved, the case resonated with the medical and anti-surrogacy activist communities in India. Perhaps most notorious was the complex and layered case of

Baby Gammy, a twin boy born to a Thai surrogate in Bangkok, commissioned by an Australian couple. The story broke, to huge international scandal, when it was alleged that the intended parents had abandoned Gammy, who suffered from Down's Syndrome, only taking home the healthy twin. Pictures emerged of the boy in the care of the Thai surrogate, and a very successful crowdfunding campaign was set up to pay for his care. Back in Australia, the intended parents faced court proceedings. It turned out that the case had been more complex and there was reason to believe that the surrogate had grown attached to the baby and had refused to give him up. While this would have spoken in the intended parents' favour, it then emerged that the father had a past conviction for child sexual abuse. The story dominated the news headlines for weeks.

Rarer and less well documented are cases of outright criminality or oddity. Possibly the most curious of these was the 2014 case of a 24-year-old Japanese man, Mitsutoki Shigeta, who was found to have a dozen surrogates pregnant with his babies in Thailand, while simultaneously commissioning surrogacies in neighbouring Cambodia as well. A total of sixteen of his babies had been born by the time Shigeta was arrested. The large international fertility clinic chain who arranged his Thai surrogacy reported the man to the authorities when they realised the extent of his reproductive ambition. Agency founder Mariam Kukunashvili explained her concerns to the reporters:

> As soon as they [surrogates] got pregnant, he requested more. He said he wanted ten to fifteen babies a year, and that he wanted to continue the baby-making process until he's dead. (Rawlinson, 2014)

Indeed, Shigeta had also been interested in sperm-freezing so that he could continue his reproductive quest into old age. The case raises numerous questions and is full of contradictions, making concrete answers hard to come by. Shigeta himself has argued that he wanted a large family and wished to use his offspring to gain political power. The authorities investigated alternative scenarios, such as child-trafficking or exploitation, but found no evidence of either. After significant deliberation, in 2018 the court finally decided that there was no legal cause to arrest Shigeta or deny him full custody of the children. Wrong though it may have felt, there were no laws against having a large family through the aid of assisted reproduction. The case was challenging for the courts and for the public debate on several fronts, stretching and challenging understandings of privacy, the right to family life and moral policing, as well as starkly exposing the limits of family law in the face of industrialised on-demand low-cost reproduction.

The knee-jerk reaction

Each of the recently banned low-cost surrogacy destinations had their own scandal that led to their sudden and forceful end. Rather than going through long legislative debates about surrogacy, which would leave all parties time to prepare for what is to come, these bans have come in the form of court orders or government edicts. In Thailand, surrogacy clinics were raided and doctors investigated. In what has been by far the strongest response, Cambodian authorities arrested and actually sentenced to jail a prominent Australian international surrogacy facilitator Tammy Charles, together with her two local colleagues.

Typically such bans are followed by a period of confusion, debate and, for many, panic. While a ban can come into effect almost overnight, a surrogate pregnancy lasts almost nine months, and the entire process can take well over a year. This period between a ban and the birth and exit of the last babies is difficult for everyone involved and characterised by a panicked sense of the unknown. While stressful for doctors and international facilitators, it is most difficult for the more vulnerable parties in the trade: the surrogate women and the intended parents. Surrogates lose the certainty of their payments and care, and might even become afraid of prosecution. Their isolated and disadvantaged position in the business leaves them especially vulnerable, yet their welfare is rarely a top priority in the authorities' crack-down operations that are ostensibly carried out to protect them.

The international facilitators I spoke to had more experience of, and possibly also more interest in, the challenges facing the intended parents, who are suddenly left uninformed and relatively powerless as they try to ensure the safe birth and transfer of their long-awaited child. International facilitators tried to help their clients as much as they could, but despite the guarantees many of their agencies offer, there was often little they could actually do to secure the release of embryos, babies and paperwork. The uncertainty of closed destinations often affected gay intended parents the most, as the local government would often not recognize gay parenthood or single parenthood, thus challenging the intended parents' claim over the child. Dave argued that overseas low-cost surrogacy for gay couples was basically a leap of faith. One can hope that everything will be OK and the ban will not happen until after they have left the country with their child, but when it comes down to it, there is really no safety net in place for them if things go wrong. Dave went on to describe

the aftermath of the closing of the Bangkok surrogacy industry as a feeding frenzy. One of his client couples had to sell their home to pay for intensive care for their baby when prices were raised from US $700 per day to US $4000.

Those who have embryos in banned countries face similar despair. It is hard to describe the value a frozen healthy embryo has for a couple seeking surrogacy, especially for those struggling with infertility, and thus the power held by those who are in possession of them. To many these embryos, even if donor conceived, are the closest thing they have ever had to the family they desperately wish for. In the case of a couple's own genetically related embryos, their creation is often the result of years of painful and costly IVF cycles, and there might be no hope of ever having any more. The heartbreak over destroyed or lost embryos can be devastating both financially and emotionally for intended parents.

The combination of high stakes for the intended parents and the ending of a windfall for local surrogacy businesses can have drastic consequences. Local clinics, lawyers and agents could see an end to their transnational business and, unchecked by the need to maintain reputations and relationships, decide to squeeze what they can out of the intended parents still involved. 'They are trying to get the last out of you,' said Dave; 'They have you over a barrel, a form of blackmail – you have to pay.'

During my fieldwork in India, I happened to witness the power held by these embryos in a predicament that arose immediately following the closing down of surrogacy operations in Nepal. I was spending time at a Mumbai fertility centre when Dylan, who partnered with the clinic, came over for a visit and to check up on the progress of ongoing work. The doctor there, Dr Sid, had bad news: the surrogates had been

prepared for embryo transfer, but there were no embryos to transfer because, despite arrangements having been made to ship them from Nepal, they had not arrived. The case had a somewhat complex history. The client couple had initially contracted to do surrogacy in Nepal because, having been married for less than two years, they had not qualified for Indian surrogacy visas. Their frozen embryos were already in Nepal when the country suddenly banned the business. In that time, however, their two years of marriage were up, and so the decision was made to move the embryos to India and complete the process there because, at the time, surrogacy was still legal in India for couples married for two years or more. But according to Dr Sid the Nepalese clinic was now refusing to hand over the embryos, insisting the surrogacy be completed there somehow and they be paid. The clinic had considerable leverage because it was holding the embryos in their possession. Moreover, the shock of the sudden end to the sudden fortune that Nepalese surrogacy had represented made them dangerous and unpredictable. Dylan was shocked: ‘This is a hostage situation!’ To make matters worse, Dr Sid had already prepared the surrogates: ‘They told me the embryos were coming and I should prepare the surrogates so I did, and now I’ve reached the point of no return where I have to prepare them but the embryos are still in Nepal!’

Dylan was disappointed in Dr Sid for not having planned ahead better. ‘You should have waited until you had the embryos here! You cannot just assume!’ he exclaimed at Dr Sid, still friendly, but clearly frustrated. A deflated Dr Sid tried to defend himself:

> Yeah... but I couldn’t have imagined that they would just refuse to hand them over. I spoke to the agent just now outside, and he said that tomorrow he will go and get them, and I told him you should already be there and have the

> embryos and be on your way back! This is so stressful for me! And the parents!

Dylan jumped in, now visibly shocked, to confirm with Dr Sid whether or not the parents knew. Dr Sid:

> No! Imagine if they did, they would worry sick! But how long can we keep this under wraps if we can't get the embryos! That man is playing a dangerous game. I told him, it's illegal now. Accept it and release the embryos! But he is hoping they will reverse the court order...

This was bad. There was only a brief period during which they could hope to hide from the parents the fact that, not only had their future babies not been placed in a womb, they were being held hostage by a desperate doctor in Nepal. Dylan, however, was not one to be played games with. He had industry-wide power, political connections, many years' experience and the willingness to push boundaries to get things done. During the meeting, Dylan gave instructions to proceed as if the embryos would be dispatched from Nepal that very night. I never found out exactly how he made it happen, but as far as I know the embryos arrived, the surrogacy went ahead, and the parents never knew how close their family dreams had come to a nightmare. Most other such hostage scenarios, however, came down to intended parents having to comply with such demands in order for their embryos or babies to be released.

Ban as regulatory failure?

It was hard to find anyone who benefitted from these sudden bans, as surrogates, intended parents, babies and the industry were all negatively affected by the shock

and its lingering aftermath of uncertainty. Indeed, even those who were in favour of regulation would often be critical of how governments acted. To many in the industry who were interested in running commercial surrogacy as a legitimate commercial business, consecutive bans were a symptom of regulatory failure. Surrogacy lawyer Arun argued that bans are attractive to regulators because of their simplicity as a legal technique. ‘Governments all over the world are trying to regulate it now. But what regulation here means is a ban. It’s the easiest way of regulating things, and that’s what they’re trying to come up with.’ Adam, an international facilitator, but perhaps first and foremost a gay family activist, was less diplomatic in his assessment:

> It’s very difficult to find a government that would be able to go through a legislation process without lots of opposition for cross-border surrogacy. I think that’s the main problem. What happens is that, as soon as someone sees that there is a country in which there is a legal vacuum, this country would boom in the next few months, but then some scandal appears and it’s only a matter of time until the political pressure will be unbearable for the government and they will take action. And usually this action, instead of regulating the whole thing, would be just stopping it. Don’t ask me why. I think it’s stupid. (Adam)

Adam's comment captures the short and repetitive life-cycle of low-cost surrogacy destinations and points to one of its crucial elements - the sudden boom that comes out of nowhere, and the immense pressure that it puts on the local state government. Regulators, overwhelmed by the complexity of the issue and under severe public and international pressure, respond with a knee-jerk reaction and ban the business altogether.

Bubble culture

In the aftermath of the ban, questions are asked about what went wrong and fingers pointed at the perceived culprits. While people in the industry can usually point out a particular scandal or incident that led to the ban, they recognise that it was the series of events that led to the scandal that set in motion the near-unstoppable sequence of events. ‘It was just a matter of time,’ I was told over and over again. The string of consecutive bans, first in India, then in Thailand, Nepal and Cambodia, has created a situation where even brand new destinations have come to be approached with a sense of imminent threat. Once I began seeing patterns in how the actions of the industry provoke such drastic reactions from destination governments, I started to wonder how the individuals involved could not realise their own crucial role in the boom-bust cycle and work to prevent it from repeating itself. I struggled to understand why, despite evidence of the destructive impact their practices were having on the business, the industry just kept repeating the same pattern of creating sudden booms that were bound to provoke a ban. Would it not make more sense to approach new destinations more carefully so as not to repeat the scandals and ensuing bans experienced in previous markets?

I was apprehensive about approaching the topic, but to my surprise found that surrogacy international facilitators were both aware of it and ready to discuss it openly. While some liked to point the finger at anyone but themselves, others accepted their part in the industry’s issues but offered considered and reflective reasoning for their behaviour. Adam, for example, told me that he was aware of how

much of the industry sees his agency, GlobalBaby as responsible for what happened in Nepal, but that given the chance, he would not do anything differently:

> At some point it would be shut down… And everybody knows that, so when there's a new place, yes, everybody goes there immediately, and yes, it probably affects the result... But I don't know, if we had only done half of the cases we did, I'm not sure that they wouldn't have closed the market anyway. Maybe it would have taken a bit more time, but at the same time we were able to put more people in, so maybe we got the same numbers in the end. (Adam)

For Adam, and most of the other international facilitators I spoke to, the sudden ending of the boom was inevitable. Someone at some point would mess up, whether a doctor, an intended parent or an international facilitator, and the window of opportunity would close again.

It all, I was told, came down to demand. The same inelastic demand that international facilitators could always rely on for business, no matter how complex or uncertain their arrangements, also constituted a threat to the industry's long-term survival in its countries of operation. Rising infertility rates, coupled with the growing acceptance of same-sex parenting and the decrease in stigma associated with surrogacy as a result of celebrity use of the procedure, were all factors contributing to the ever-growing, insatiable and increasingly unmanageable demand for affordable surrogacy options. Several industry professionals argued that, even in India, where the business had been established and public for many years, it was the sheer volume of clients, and the issues that kind of boom brought with it, that eventually tipped the balance of public and political opinion against it. Seemingly, there was simply too much demand for cut-price surrogacy in the world for any one country to be able to cater to it.

As I came to understand the industry's dynamics better, I realised that what had initially appeared to be a reckless and self-sabotaging economics was indeed a conscious tactic aimed at maximising results within the constraints of the industry. Rather than seeing themselves as responsible for getting surrogacy banned in destination countries, international facilitators saw themselves as mostly powerless to stop the future bans from happening and thus compelled to join in and worsen the frenzy of activity so as to make the most of the limited window of opportunity. The clock, as far as the industry was concerned, was ticking from the moment the first baby was born, and they wanted to get as many babies born and out of the country before the time ran out. Adam shared with me his rationale for making decisions about volume:

> GlobalBaby was accused of ruining new destinations, because when GlobalBaby comes, it comes with a mass of clients, and then it becomes too crowded. We can't accept that accusation because, if there's a new destination, of course we won't say to one couple, 'Oh yes, you can go' and the other couple, 'No you can't.' We are trying to do whatever's necessary to help as many couples as we can, and we already know these days that it's a limited time offer, you know? (Adam)

This was a widely held attitude amongst industry professionals. The shared expectation of a ban, when translated into individual business goals, made for a problematic market dynamic and eventually became a self-fulfilling prophecy.

As I suggested in Chapter 6, the dynamics of economic 'bubbles', and especially the relationship between booms and crashes, is usefully explored by Karen Ho in her ethnography of Wall Street investment bankers (Ho, 2009). Ho observed a similar paradox: the bankers in her research could predict, with significant accuracy, the

peak of a bull market and know to expect a crash. Yet they would carry on with the values and practices that helped generate that crash. The expectation of a crash on the horizon did not make the investment bankers in Ho's ethnography any more cautious or less prone to risky deals. Nor did it provoke any kind of reflection on their own contributions to the unsustainability of the market. If anything, it further intensified a corporate culture where a generalised reckless expediency characterised by high-risk, high-reward deals was already the norm. Bankers were induced to make the most out of the present at the cost of mortgaging the future. Her observations ultimately led Ho to see booms and crashes as co-constructed:

> the normative, everyday practices on Wall Street that constructed the bubble also prefigure, and ultimately create, the 'inevitable' bust. Not only are bull and bear markets deliberately made, but the stage of the bust is set in motion by the strategies of the boom. (Ho, 2009, p. 286)

This realisation led Ho to challenge the often perceived relationality between booms and busts as naturalised cycles and rhythms, rather than being linked consequences of the same cultural practices. The sense of transience during a boom creates what Ho has termed a 'bubble culture' of expediency 'that is based on generating quick short term rewards' (Ho, 2009, p. 291). 'Bubble culture' certainly works to describe the frenzy of activity around new surrogacy destinations. Indeed, despite referring to demand as if it were a force of nature, international facilitators, eager to obtain as large a slice of the market as possible and charge higher fees, actually contributed further to the demand themselves by advertising these new opportunities as fleeting from the start. For example, one facilitator's website packaged the good news of Nepalese surrogacy in the same announcement as the warning, 'Good news for the

unmarried, singles, gay, lesbian you can now do surrogacy in Nepal. Contact us to commence. Best hurry before the opportunity disappears.' The permanent sense of transience promoted by such 'get in while you can' pitches and uncertainty helped drive consumer demand further, thus intensifying the boom and setting the scene for the end.

Like Ho's investment bankers, international facilitators like Adam and Dev were motivated to 'ride the wave for as long as the good times roll' (Ho, 2009, p. 288) because, if they did not, someone else would. They would lose out while others cashed in, and the ban would inevitably still close down the destination at some point. The result was a kind of tragedy of the commons, where, in the absence of state regulation or local community control, individual acts of self-interest end up depleting a shared resource. It is precisely this bulimic culture of expediency, of getting as many babies born and out of the country as quickly as possible, that can then become detrimental to the industry's own sustainability in its destination markets. Ho's argument, however, can help us to think about the seemingly reckless actions of international facilitators like Adam in a different light, namely as a calculated move to make the most of the present opportunities in an environment dominated by competition and uncertainty.

Impacts

And so, one after another, destinations kept closing their doors to the surrogacy industry, leaving its clients and businessmen to look for a new home for their various aspirations. This created ongoing cycles of feast and famine, and it could be

exhausting. Even if one has the political connections and know-how, exploring new markets can be risky, time-consuming and potentially frustrating. Lots can go wrong: negotiations can fail, medical or other infrastructure can turn out to be inadequate, surrogates may be too malnourished or too demanding of welfare and compensation, local doctors may be either incompetent or greedy, politics can get in the way. At the end of it all consumers may simply not welcome the new destination. Time after time the industry professionals, activists and hopeful clients felt that they had found a new destination and hoped that over time it could develop into another India, only to have those hopes quickly dashed, even though they realized that some destinations take longer to work through the cycle than others.

This transient quality and emphasis on expediency prevented any of the many new destinations from coming anywhere near what India had been. India, with all its imperfections discussed in Chapter 5, had nonetheless established itself as a reliable and relatively well-functioning system for transnational surrogacy arrangements. There were guidelines, procedures, precedents and an army of various experts to manage the many aspects of a surrogacy journey, placing Indian surrogacy in a kind of steady state. This was not to be the case in the many destinations the industry transferred to. Everyone in the industry agreed that there was no place like India. Outside of doing surrogacy in the US, which most intended parents could not afford, India was the closest the industry had ever got to having a regulated system in place, even though only in the form of guidelines. Brokers would reminisce about what the industry had lost:

> When India closed for alternatives then it opened up new markets. Thailand and so on. These couples who were left out of India are still trying to find a home. It's very difficult for them. Nepal – gets shut down, move on, get about

> a year in the new place, then gets shut down… They are still just wandering in wilderness… (Dave)

Dave's sentence drifted into a sigh. Indeed, the current situation is a far cry from the kind of organised steady state that India had reached. If anything, it seems matters are getting progressively worse. Increasing pressure to find destinations for the business to move to meant that meeting the ideals of oversight, safety, quality and convenience was often not possible. These developments can make life challenging for the industry, especially for brokers whose facilitation work was part of a wider advocacy and activist mission for reproductive and family rights. Not only were they under constant pressure to find new destinations for the intended parents they were trying to help, they were also occasionally involved in various high-stress situations of intended parents getting stuck in foreign countries or their embryos or babies being held in legislative limbo. For this reason, some agencies were beginning to be more careful about which destinations they entered. The income might have been lucrative but, depending on the international facilitator, not always worth the potential for reputation-destroying crises or the moral responsibility over babies and parents stuck in faraway lands with no certainty about their future.

Others, however, embraced this aspect of the business because it gave them a market advantage. They had accepted the constant uncertainty and mobility of global surrogacy markets as a reality that they could turn into their competitive advantage rather than try to change. One of the more extreme arrangements to come out of the post-India era of surrogacy saw surrogates hired in Laos and sent as medical tourists to Thailand or Cambodia to receive embryo transfers from Indian doctors, splitting up

the surrogacy process between countries which, taken separately, would not have allowed commercial surrogacy but had no way of policing the surrogacy industry's activities once they had been split up and reassembled in these creative ways. The details of such increasingly complex arrangements were discussed in Chapter 6, but it is important here to recognise their destabilizing impact on the industry.

The gap between governance and commercial surrogacy is growing increasingly wide as a result of these increasingly common multi-territory arrangements, making it look less like medical tourism and more like human trafficking. Indeed, the needs and rights of surrogate women, egg donors, babies and intended parents are becoming increasingly difficult to protect or even monitor in the biotech wilderness in and in between the various low-income and low-regulation countries that make up global surrogacy's future. Putting a stop to these developments by bringing commercial surrogacy into the realm of legally regulated practice is going to be an uphill battle for any government, whether in countries that provide surrogates or those who commission the babies. Demand, I was told, will eventually override any obstacles set in the business's way - a statement that has come to be a mantra for the industry. As long as there is such overwhelming demand, there will be people happy to make low-cost, no strings attached surrogacy happen. I asked Dev about the future of surrogacy. Expressing no concerns about the ongoing efforts to curb the business, Dev instead based his argument on the fact that people will always want to have babies:

E.L.: Will transnational surrogacy carry on?

> Dev: Will people want to have babies in the future? I think yes. So if they have fertility issues, what will happen? They'll have to find another destination. It will happen and keep happening.

Conclusion

When surrogacy was restricted and later banned in India, it not only moved on to new destinations, it also took on an entirely new shape, as power over the industry shifted from doctors to international facilitators. Some of these facilitators work hard to secure surrogacy destinations where the business might have a long-term future. Others embrace short-term booms and continue to inject scandal and unpredictability into transnational surrogacy. Both are bolstered by the willingness of intended parents to take risks and invest resources in arrangements that often sound incredible in their disregard for law and welfare. The intended parents are left trying to make decisions in a situation over which they have little control, and the recruitment and treatment of surrogate women in some of the resulting scenarios has come to resemble human trafficking more than anything else. In the next, and final, ethnographic chapter, I will turn my focus to the perspectives of international facilitators to try to understand what sense they make of this new reality that they themselves have created.

8. Activism and entitlement

> ‘If there is a right to freedom, then there should also be a right to reproduction. Even animals have that right. Why should the government prevent it for their own people?’ (Indian fertility doctor)

Meeting Dylan

I was several months into my Indian fieldwork before I spoke to the first international facilitator. I had initially focused my interest on the Indian surrogacy clinics and it was after I discovered how much the business had changed since the Indian visa restrictions were introduced, and how those changes had placed international facilitators at the epicentre of global low-cost surrogacy, that I began reaching out to them in the hopes of an interview. Dylan, the Indian-born American man behind one of global surrogacy’s major commercial agencies, was the first to agree to an interview. By the time I got to interviewing him, I had learned enough about the industry to know how significant this conversation would be. In my research, both online and in fieldwork, his name or the name of his agency kept cropping up in ways that suggested that this was someone important for reasons that were not immediately obvious. Discussion threads on an Internet forum would refer to him, struggling clinics would tell me that setting up a partnership with him would ensure their survival, and activists would mention his name when discussing where the business was going. It was not that he seemed to be in charge, but that his presence almost seemed to permeate the business. I was hoping to learn, through Dylan and

other international facilitators like him, what it meant to make a living in the global bioeconomy.

Despite having followed his extensive online presence, our first conversation took me by surprise. Dylan was talkative and very straightforward in his answers - the polar opposite of most people I had met so far in my research. The doctors, lawyers and agencies I had approached had often made for very challenging and guarded interviews, if any agreed to speak to me at all. I kept finding myself staring up a wall of silence or being subjected to sales pitches by struggling clinics hoping I could be convinced to bring them business and investment.

Dylan, however, told me from the start that he would not only answer all my questions, but that he wanted to help me understand this business and his work. His candid nature and very special position within the industry meant that our exchange and the many contacts, opportunities and experiences that followed made this one of the most significant interviews of my fieldwork. Dylan had the kind of energy and conviction in his voice to make anyone believe that, in meeting him, they had become a part of something special, exciting and important. In our conversation, as well as in those that followed, Dylan described his work in India and elsewhere, covering amongst other things his double life between India and the US, his extensive contacts in the global gay community, as well as his work with several European and African governments. His eyes constantly glancing at his phone, it always seemed like Dylan had a million things to do at once but that somehow he still had all the time in the world to answer my questions.

I was as puzzled by this enthusiasm as I was by the open and detailed way the international facilitators I spoke to talked about their work. The world of low-cost commercial surrogacy is a strange one, full of controversy and polarised opinion. These individuals operate in an industry that has been variously accused of glorified baby-selling, trafficking in motherhood and the exploitation of Indian women whilst also heralded as a beacon of reproductive rights and the acceptance of homosexual families. Why were they so willing to let me into their world? Moreover, what can we learn about the industry, its global movements and moral dilemmas from the individuals who connect the babies and the money that make the surrogacy world go round? How do international facilitators see their work and their place in the industry?

Helping people

Even though their approaches vary, with some being more careful and less willing to break the law, while others embrace the risk of elaborate schemes, different facilitators are in effect doing the same thing: looking for unencumbered access to the surplus fertility of low-income women and the technology and expertise to turn that into a consumer market for their wealthy clients. In scanning the world in pursuit of new surrogacy destinations, global surrogacy's international facilitators join similar prospectors from other biotechnology businesses, such as pharmaceutical trial companies and even organ traders who are all looking for the value in human biology made available by socio-economic inequalities and mediated by lax regulation, corruption or weak law enforcement. Though they may operate in different legal realms and use different methods, they all share the crucial common factor of using

biotechnology to turn human bodies into a source of surplus value. This is not necessarily a good grouping to belong to, and the middlemen of surrogacy do not always enjoy a great reputation. The blame for what is perceived to be an overly commercialised and exploitative business is often placed on international facilitators. But how do they themselves feel about that?

Despite what their views and actions might suggest, international surrogacy facilitators resist and resent being seen as heartless and greedy. In fact, they themselves feel that they were a force for equality and opportunity for groups who had very few people to turn to. Crucially, they tend to count both the intended parents and the surrogates in with those groups. The overarching discourse to which individuals involved in commercial surrogacy subscribe is a romanticised one of mutual help between two parties in need. This was something all international facilitators valued, took pride in and continuously emphasised: they are important to the people they help, they transform lives and worlds, and they make dreams come true.

As I learned more about international facilitators, I began to realise the extent to which these individuals themselves considered their work to be one of social activism for the promotion of reproductive rights. Indeed, when I asked successful facilitator Gabriella if she ever worried that, with destinations introducing bans one after the other, the business would eventually run out of new places to move to, her answer showed a surprising take on the industry:

> Yeah, sometimes I think like that, maybe, eventually, but you know what, there's a lot of countries! I think that as human beings we don't wanna be in a place where we feel like there's nowhere to go. It reminds me of abortion in

> this country [United States] where people would go from state to state looking for a doctor…

In comparing the restrictions on access to surrogacy to the restrictions on access to abortion, Gabriella was shifting the terms of the conversation over surrogacy to that of a broader struggle over reproductive freedom, its much broader affected publics and contested histories.

Gay rights

Nowhere was the struggle over reproductive rights and privacy more starkly present than in the provision of surrogacy services to male gay intended parents. Male gay couples constitute a significant proportion of the global demand for surrogacy. This is partly due to the fact that they cannot conceive without the help of a surrogate, so any gay couple wishing to have a child will necessarily need to turn to assisted reproduction. While gay families have become significantly more common in recent years, gay men often still face significant additional legal and social barriers to accessing reproductive services or adoption, making them more likely to turn to overseas providers. Even that can be difficult, as several low-cost surrogacy destinations do not allow surrogacy for gay or single men.[22] As a result, access to surrogacy for gays is both politicized and highly contested. Those who facilitate such

[22] While the surrogacy industry is generally friendly towards this key client base, I did come across doctors, lawyers and even a facilitator who openly admitted that, while they did not have anything against gays having children and would happily help them, their main priority were heterosexual couples struggling with infertility. Such arguments were often expressed with reference to what was considered natural, where a heterosexual couple's desire for a child was considered a desperate need, while two gay man wishing for a child was seen as a lifestyle choice.

access thus often frame their work in terms of gay activism. Several surrogacy facilitators, such as Adam and Dave, who were gay themselves, had experienced the discrimination first hand and thus felt a very personal connection to their work.

With some facilitators, the connection to activism was strong and very sincere, as they spent significant energy and resources on trying to make parenthood accessible to groups they perceive as unfairly discriminated against. Their personal backgrounds and attitudes have shaped their approach. Some actively campaign for reproductive rights in their own countries, have a strong media presence and support research as much as they can. Several in this group told me that their end goal in the business was to do away with the need for their role. The best and safest way to do surrogacy was in a well-regulated setting in one's home country, so that was always the aim. International facilitation, it was hoped, was just a temporary solution until the intended parents' home governments and publics came to accept surrogacy as a socially benevolent practice.

Even brokers without such a personal history had often developed a strong relationship with the gay community. When I asked Dylan to describe his clients, he told me that many clients came to him because of their 'alternative lifestyles' (being homosexual or choosing to become a single parent). Dylan grew increasingly loud, animated and indignant as he explained that these groups gave him so much business because 'Almost the whole world is against them having children!' In this hostile world, he would help create families for those who are shunned by others. 'My business is to help people! I help these people have babies and nobody cares about them; they want a family like everyone else.' This was a powerful moral statement

that was a common, albeit not uniform thread running through surrogacy professionals' representations of their work. Dylan's clients had welcomed his strong pro-gay reproductive rights rhetoric, and his reputation gradually spread by word of mouth. He told me with excitement that he is now the 'go-to guy' for gay surrogacy in the US: 'I even get invited to places! I am now going to Provincetown for this big LGBT event, and I will meet lots of prospective clients there. The people who already had children through me invited me.' Provincetown, a popular holiday town in New England, in the US, is well known for attracting large numbers of gay holidaymakers. Dylan's contacts in the gay community mean that he can get invited to such spaces to further promote his business. He may not be gay himself, but Dylan's interest in gay issues and his ability to relate to his clients has guaranteed his success with this key market segment and turned him into a vocal advocate for gay rights.

Infertility

I experienced this world of surrogacy brokerage as assistance and activism when I visited a small agency in London run by a couple of South Asian heritage. Ray, the life and soul of the business, was a small and animated man of Indian heritage who brokered surrogacies to India with support from his wife Kimmy. They invited me into their small London home, from which they operated the business, to experience their work first hand. Ray is arguably a social activist first and businessman second, his mission being to help those from minority ethnic or lower socioeconomic backgrounds. One of the main challenges of his work, he argued, was that the two factors often go together. The focus of Ray's work stems from his acute awareness of the further disadvantaged position that members of minorities were in when trying

to find a gamete donor or surrogate, or even when accessing IVF, something he himself had painfully experienced.

The additional challenges that individuals from minority backgrounds can face have been shown to be significant (Becker et al., 2006; Culley et al., 2012, 2006; Inhorn and Fakih, 2006). In addition to the socio-economic barriers that often restrict minority access to medical care in general, cultural issues can place restrictions on the kinds of fertility technologies minority individuals can avail themselves of or place the additional burden of complete secrecy on the process. It can also be harder to find a donor match that could produce a child who looks similar to their parents and thus will not attract attention or stigmatization (Culley et al., 2013; Rudrappa, 2015). Ray and Kimmy both felt that their South Asian background specifically had played a role in their struggles to find a surrogate in the UK due to other people's preconceived ideas. In the UK, where commercial surrogacy is banned, surrogates are often found through special gatherings where potential surrogates and potential parents mingle. Kimmy described to me her initial enthusiasm at finding a surrogate at such an event, and how she gradually realised she was not going to:

> In the UK, when we went to the meetings with the agency, man, it was tough. We found quite a few surrogates when we first started out in the UK, we joined up with the agency, and obviously they said she'd want to meet us. But going by the name Ray and Kimmy, she thought, you know, that we were… white. So we got there and she saw us and she then went "oookay, wasn't expecting her..." So we sat down and she checked with other couples and when we're leaving we say, "Well, are you gonna help us?" And she says "Nah, I'm gonna help the other couple". So obviously you can see what happened there. Being Asian is a drawback and being Asian and poor made it double.

According to Kimmy, the few other Asian couples they met at these meetings all gave up on looking after a while because they felt no surrogate would help them. Ray and Kimmy eventually had children through surrogacy in India. They started facilitating Indian surrogacy mainly to help others like them, people whose class or ethnic background prevents them from accessing surrogacy in the UK, further highlighting the role of personal histories and experiences in shaping facilitators' interactions with surrogacy in their business ventures. So while Ray and Kimmy now work with people from different backgrounds, a large part of their business involves helping couples from Asian backgrounds find surrogacy in India.

While sitting in on one of their surrogacy parties, small gatherings where they invite couples over to their London house for an evening of Indian food, surrogacy advice and sometimes even to meet the Indian doctor they partnered with, I indeed met people from very different social, economic and ethnic backgrounds. One couple specifically stuck in my mind from that meeting. They came early, before the food was prepared, before the table was set, and they did not stay for the party. They were a Pakistani couple, probably in their forties, who had moved to the UK a few years ago. The husband worked at an electronics business, and the wife was a homemaker without a home to make. They had been trying for a child for many years with no success. They were under severe pressure from their family finally to have a child and felt excluded from the community due to their predicament. Not having a child had come to dominate their lives. The wife did not speak any English, so he translated as Ray told them that they needed to wait at least five years and become citizens of the United Kingdom before they could do surrogacy abroad. Otherwise they would risk not being able to bring the baby back with them. As they discussed

their options, or lack of them, with Ray, they both had to stop speaking every now again to fight back the tears and keep themselves composed. All the time Ray sat with them and assured them: ‘We will find a way for you; eventually you will have a family’.

I could see them both glance over every now and again at Ray's young son, who was not feeling well and had fallen asleep in the lounge under a fluffy throw. I wondered about the love and care they would give to their long awaited child. I weighed up in my head their odds of finding a surrogate mother in the UK. I watched large shimmering tears run down the wife’s cheeks. Surrogacy is a business, and a morally contested one. But that night in that London living room it was also so many other things. More than anything, it is so enmeshed in these different worlds across the globe that it becomes hard to disentangle it from them and the different meanings it takes on in these various incarnations. The work of bioethicists, regulators and academics has often set out to disentangle surrogacy from these contexts so it can be analysed for what it is in itself. The representations of people like Dylan, Gabriella and Ray work to keep surrogacy firmly grounded in such stories, and they use them to problematize the narrative of exploitative commercialisation that threatens their business.

It is through such encounters and in the context of personal histories that the popular figure of the greedy and heartless baby-broker begins to lose its rigid shape. While all these people had built businesses out of global low-cost surrogacy, they had done so in the context of moral worlds in which their work was not only acceptable but socially desirable and benevolent. For many, these moral worlds had grown out of

their own personal histories. In this world of happy families and smiling babies, the darker side of the coin of surrogacy that I had witnessed in India all but faded out of sight.

The beautiful exchange

Convincing though such experiences and accounts are, they focus on the benefits of surrogacy for the intended parents, which, however, are rarely questioned. Instead, critics of commercial, especially low-cost surrogacy tend to take issue with how the process affects surrogate women. Interestingly, in the context of the shared discourse within which the international facilitators, clinics and intended parents operated, surrogate women were included in the group of perceived beneficiaries. When most professionals in the surrogacy business - doctors, lawyers and agents, as well as facilitators - reflect on their role in the business, they often make sense of it within the framework of an idealised market economy that can provide everyone with what they lack. It was an exchange of financial security for reproductive potential, or put in starker terms, money for babies, between two parties who each had a surplus of what the other lacked. Issues of exploitation and inequality in these transactions are brushed off as glitches in an otherwise good system, the fault of greedy or unprofessional individuals, rather than an indication of a fault in the system itself.

Surrogacy as choice

The ideology of surrogacy as mutual exchange becomes distilled into a matter of free choice. Most brokers readily accepted that giving up a child can come with its

emotional challenges and that the business could at times be exploitative, but they maintained that it was the free choice of surrogate women to take up the opportunity. If they chose to do so, then no matter what difficulties they may face, it must be better than the alternatives. There are, indeed, multiple ways in which becoming a surrogate can from a certain point of view be considered to constitute choice, even reproductive choice: it is a choice to reproduce for someone else for wages, but also an aspect of her own reproduction through the option to school her children. In that latter choice, then, is also implied a choice not to reproduce the social position of economic precarity and vulnerability but to let her own children grow up to lead better lives as a result of a better education. It is this choice to separate her own reproduction from the reproduction of her undesirable conditions of existence that must, in the mutual benefit view of surrogacy, be afforded to the surrogate.

Ethnographers of Indian surrogates and Indian women's health organisations have challenged this discourse, arguing that the industry narrative of agency and choice can present surrogacy as a benevolent force in the lives of surrogate women because it simplifies the context within which surrogacy operates. Laura Harrison takes issue with how the industry's framing of surrogacy as an exchange ignores the fact that in most arrangements the intended parents are far wealthier than the surrogates. In such framings, the intended parent's lack of children is set against the surrogate's lack of the economic means to portray herself as an equal and elevate the contractual exchange between two profoundly unequal parties into the arena of women 'helping one another' (Harrison, 2014, p. 154; Pande, 2010; Ragoné, 1998).

The interdependence between the two parties, Harrison argues, does not constitute equality or a level playing field.

Some challenge the very terms of the debate, such as ‘choice’ and ‘agency’, as alien to the realities of the surrogacy setting. For Alison Bailey (2011, p. 723), talk of choice is a kind of ‘discursive colonization’ that obscures the injustice behind these choices. Bailey uses a quote from Pande to highlight the rejection of ‘choice’ by surrogate women in India: ‘Who would choose to do this? I have had a lifetime’s worth of injections pumped into me. Some big ones in my hips hurt so much [...] But I know I have to do this for my children’s future. This is not work, this is majboori [a compulsion].’ The nuances implied by majboori but denied by choice talk are, according to Bailey, important for understanding Indian surrogacy. She quotes Pande:

> Most surrogates’ narratives downplayed the choice aspect in their decisions to become surrogates, as if they are saying ‘It was not in my hands, so I cannot be held responsible, and should not be stigmatized.’ They do this by highlighting their economic desperation, by citing higher motivations or by emphasizing the role of a higher power (God) in making decisions for them. (Pande 2009b: 162, in Bailey 2011: 723)

The debates around surrogacy, covered in more detail in Chapter 2, are complex and heated. Crucially for the industry, those who criticise the surrogacy, whether in academia, politics or public debates, come to these issues from very different backgrounds and consequently take issue with different aspects of the business and often disagree. Even the relatively small sample of the surrogacy debate that this thesis has touched on often generates opposing arguments, each claiming to help

protect women. The opponents of surrogacy are not a unified group with a shared discourse.

The industry is very skilled in using the divisions within surrogacy critic circles as evidence of the weakness of the arguments against surrogacy. Adam, for example, admitted that as a gay man he may not be able to relate to these issues fully, but he also pointed out the irony in the fact that it was liberal and feminist critics who were essentially lobbying to control what women did with their bodies. He found that, while criticism from conservative and anti-gay sources was to be expected, he was surprised to see attacks on the industry

> coming from very liberal wings, you know, feminist wings, that are telling women what to do… I don't know, maybe psychologically maybe women have more problems with that, but seriously I think that lots of women understand today that there is a way to do it in which everybody wins.

Such comments confirm observations by Sibylle Lustenberger (2016), who has pointed out that, while the body of criticism addressing Western feminism's approaches to the emancipation of non-Western women is important, its arguments take on a different role in these conversations. In the hands of the surrogacy industry, talk of agency and paternalism is used to draw a veil over the power asymmetries that structure these surrogacy arrangements.

The better evil

The importance of choice was often discussed by international facilitators, not without reference to the kinds of structural contexts that create the context for such acts of tied up agency. Dylan had especially strong opinions on the matter, and he

considered such factors irrelevant. For all the big global processes and power relations, surrogate women are still left with the choice of either becoming surrogates and being paid, or not. In Dylan's view, surrogates cannot change the political economy of the world, and nor can he. Dylan would argue that nor can the policymakers, or at least there has been no sign of their commitment to do so. Dylan's conviction about his work being ‘good work’ was partly due to his acceptance of what he saw as the facts of life: the world was imperfect and unfair, but to challenge it would be futile. The only thing anyone could do was to try to make their way in it as best as they could. This included the clients, the surrogates, the doctors and himself, all of whom were in Dylan's view simply trying to make a living for themselves with whatever they could get their hands on.

This sense of a lack of meaningful power over, or perhaps equally a lack of interest in, the socio-economic precarity of the populations from which the industry recruited its reproductive labour was revealed in a conversation between Dylan and his business partners. Dr Sid, one of the fertility doctors he partners with in India, was telling a story about a recent conference on assisted reproduction in India. He was describing the failed attempts of government representatives to win support for the recent ban on surrogacy:

> The government people were there trying to hold important speeches and say that, right guys, isn’t it nice that we got the gays and singles all banned from here so they aren’t coming here to have babies. And one guy got up and said “Well Sir, do you know that because of this rule, now 200,000 children have not gone to school in India?! Everyone stood up and clapped!

There was approval and laughter in the room. ‘Because these women, they don’t take that money and take it to the pub, they spend it all on their family! The husbands are losers, but the surrogates give it all to the family’, said Dylan. ‘Yeah, most of them put it into education. They put down a fixed rate deposit and from the earnings on that they pay for the school. And then by the time the child has to go to college there is enough money in the account to pay for that’, added Sid. The conversation carried on for some time about all the ways women use the money they earn from surrogacy and how regulation is stopping that money and the good it does in lifting not just individual families, but entire populations out of poverty and disenfranchisement.

Gabriella’s account of her recent visit to a surrogate house makes a similar argument, extending it to the knock-on effects the decline in surrogacy numbers has had on egg donation:

> On the surrogate side, I’m hearing that there are surrogates that really want intended parents to come, but there’s no business. That’s for money. Even when I was with Dylan in India we went to this surrogate house, and this woman has these egg donors who are available. And they were asking me, do you have any clients back home who would be interested in us? And here they are waiting around at a surrogate house hoping that someone will like them because they need cash for school. I was, like, didn’t know what to say. I have clients but they wouldn’t have been interested in them, and so the woman who was running the surrogate house, she had to let them go because there was no business for them.

In such representations, the surrogacy industry becomes reimagined as all but an international development initiative. This is reminiscent of similar narratives of rescue and development that used to dominate the highly commercialised markets of transnational adoption and to some extent still do (Frekko et al., 2015). Indeed,

brokers would often argue that surrogacy was beneficial for low-income economies. There was always the next destination ready to open its doors, I was told, because medical tourism was an industry that many struggling economies were hoping to break into. A thriving reproductive industry would be one way to achieve that aspiration.

With his trademark flare for the dramatic, in the aftermath of the Nepalese earthquake of 2015 Dylan turned the criticism of its surrogacy market on its head to argue that the presence of the industry would help rebuild the country:

> And for Nepal this is important because it's a source of income. Parents who go there spend a lot of money on hotels, restaurants, shopping, transport everything. Nepal depends on tourism, and so it's not a problem. The airport was the first thing to be fixed, you know?

Adding to the narrative of surrogacy as good for the health and well-being of otherwise unhealthy lower-class Indian women (discussed in Chapter 3), Dylan even argued that surrogacy had saved the lives of surrogates in Nepal because their brief encounter with the standard of living, and the more reliable structural engineering, of global elites while they were gestating babies for them, meant that they were saved from the rubble of crumbling low-quality buildings:

> Now, with the earthquake, it's been all over the news: when the Israelis airlifted all these surrogates out they were all Indian! Each and every one! And they were all safe because the hospital is a modern building, so they said 'the baby saved my life.'

In Dylan's view, the moral outrage over surrogacy in India and calls for a ban were symptomatic of a view of Indian women and their exploitation that was not internally

coherent. He explained to me that it would be better for a woman to become a surrogate than to become a prostitute because as a surrogate she can make more money with less trauma, stigma and abuse. He made this point strongly when commenting on the situation of surrogacy in Nepal and the issue of Nepalese surrogates:

> The funny thing is lots and lots of Nepali women are doing it [surrogacy] already, but in India! These women come from Nepal to work here as prostitutes, lots of them. Because Nepal is a very poor country. So we offer the alternative to be a surrogate instead, and of course they take it. I have no issue with it because the alternative for them is to be a prostitute. Think of this alternative.

But while, Dylan argued, prostitution was rampant and nobody said anything, surrogacy somehow kept cropping up in public debates and in the media. This enraged Dylan: 'If they say the Indian woman's body is somehow sacred and we cannot have this exploitation, then why allow prostitution? If a million prostitutes are allowed, then why not 10,000 surrogates? As long as prostitution continues, I feel they have no right to ban surrogacy!' Dylan did not acknowledge the fact that many of the organisations that had been critical of surrogacy also found prostitution problematic, and that there are structural and historical factors that make the regulation of prostitution more complex. In his view, the public and political opposition to surrogacy was simply the work of people who privileged their social ideals over reason and compassion.

To a degree, Pande's criticism of the application of Western moral judgements about Indian surrogacy seems to make a similar argument:

> These (Eurocentric) portrayals of surrogacy cannot incorporate the reality of a developing-country setting—where commercial surrogacy has become a

> survival strategy and a temporary occupation for some poor rural women, where women are recruited systematically by a fertility clinic and matched with clients from India and abroad. In such a setting, surrogacy cannot merely be seen through the lenses of ethics or morality but is a structural reality, with real actors and real consequences. (Pande, 2009a, p. 144)

The crucial difference between Pande and Dylan is, of course, in their respective agendas. Pande is inviting us to look beyond surrogacy to situate its moral dilemma elsewhere, in the structures of oppression that create the contexts within which the business can thrive. This is a conclusion that many researchers of low-cost surrogacy have reached in various forms - that the issues of exploitation in the industry are not problems of surrogacy, but problems of the wider socio-economic context of inequality and precarity. As Kalindi Vora has argued in her analysis of surrogacy in the context of the broader economics of outsourcing, the biological value of the bodies used by various bioeconomies is not arbitrary but tied to the value of that person as a worker:

> If you can't find work, you sell something else; the going price for an organ or for gestation by a surrogate is thus partially determined by the seller's own value in the marketplace. (Vora, 2015, p. 145)

Dylan is choosing to overlook the bigger picture because he is building a business and protecting a market that is in large part rooted in the global and local inequalities that Pande and Vora criticise. This is reflected in their respective judgements of the business: for Dylan, it is a good thing; for Pande it is 'not good or evil. It simply exists' (Pande, 2008, p. 74). But this difference in agendas does mean that one interpretation is necessarily less worthy of attention than the other. If anything, we can learn from the representations of surrogacy professionals how the very structural

injustices that Pande describes can become the assembly line for a global bioeconomy, packaged in the rhetoric of choice.

Rescue and charity

For many, however, these complex inequalities and their implications speak in favour of the global surrogacy market rather than against it. This is where the economics of the transaction, so carefully underplayed most of the time, make a powerful appearance in a surprising context: the framing of surrogacy as an equally beneficial exchange, or even as charity. Indeed, the reality of isolation, control and medical intervention that most surrogates experience can be hard to deny even for the most enthusiastic proponents of surrogacy. Many supporters, especially intended parents, activists and agents, openly accept that the industry's treatment of women is problematic and that the experience must be very difficult for the women involved. They nonetheless justify the continued existence of the status quo and their participation in it by framing surrogacy as an exchange through which intended parents and surrogate women come together to help each other in an unfair world.

This framing rests on the premise that the compensation surrogates receive for their service is large enough to transform their lives, justifying any medical, emotional or social harm, and clearing the other parties to the transaction of moral responsibility over everything from selective reduction to separating the surrogate from her family in the hostel for months. The dynamics and impacts of this narrative have been widely studied and criticised by anthropologists (Deomampo, 2016; Pande, 2014; Vora, 2013b). This framing portrays surrogate women as desperate, poor, sick and malnourished, while emphasising the transformative effects of proper nutrition, rest,

educational opportunities and medical care.

The framing of surrogacy as something that transforms the life of the surrogate in the same way it does for the intended parents is a contested one. Many question the reality of the kind of socio-economic transformation that the surrogacy fee can actually facilitate in a world where debts, unreliable employment and the rising cost of living can make large amounts of money disappear without a trace (Rudrappa, 2015). Indeed, the financial benefit of surrogacy, while impressive when expressed in years of regular wages, in reality fails to elevate the class and socio-economic status of the women and their families in any real sense, nor does such a niche business address larger structures of inequality such as caste and gender hierarchies within Indian society (Banerjee, 2010). The free-market idealism that dominates industry discourse overlooks or even obscures the extent to which it is the social and economic subordination of women that forces them to sign up as surrogates in the first place (Pande, 2009a). Moreover, in this view, it is this same liberal market ideology of global neoliberalism that has supported if not created the systems of global inequality that make Indian surrogacy so affordable and accessible to wealthy Western clients (Vora, 2015).

Surrogacy clinics work equally hard to present their work as non-exploitative and even as charitable, their paternalistic discourse of rescue reframing surrogacy as social work that rehabilitates otherwise idle and desperate surrogate women as self-sufficient and professionalized workers while helping childless couples – a win-win situation (Harrison, 2014; Pande, 2011). Intended parents, on the other hand, emphasise how the sacrifices made by the surrogate are matched by their

motivations to improve the lives of poor Indian women and save them from other, potentially degrading forms of work. Such discourses have far-reaching consequences, as they 'naturalise and justify an economic arrangement that is fraught with inequality' (Harrison, 2016, p. 166).

The othering and flattening narrative of rescue is, interestingly, a point of convergence between those who condemn surrogacy and those who condone it. As Markens has observed,

> for those who condemn the growth of the transnational surrogacy industry in India, 'poor' racially-different Indian women need to be saved from exploitation; for those who condone the industry, poverty becomes 'noble' as women make 'choices' to empower themselves by their participation in surrogacy arrangements. As a result both frames are informed by gendered, as well as paternalistic/colonialist assumptions about women in India. (Markens, 2012, p. 1751)

The use of rescue narratives and feminist emancipation ideologies in particular to justify imperialist 'civilizing' missions is not a new phenomenon (Mohanty, 1988; Spivak, 1988). Transnational adoption, perhaps the most direct predecessor to transnational surrogacy, has historically relied on almost identical discourses of heroic Westerners rescuing dark-skinned babies from starvation and neglect (Briggs, 2003, 2012; Treitler, 2014). These respective discourses misrepresent the reality of the vast majority of adoption and surrogacy motivations – the intended parents' need for a child, rather than the child's need for a home.[23]

While dominant, discourses of rescue are in no way uniform or subscribed to by all

[23] In fact, many adoption agencies today have started actively moving away from rescue narratives. See (Frekko et al., 2015) for an example of such communicative policing in Spain.

those involved. Intended parents can resist any implication of heroism or rescue, either on their part or the surrogate's, and insist on the surrogate simply doing a job she is hired for (Deomampo, 2016, p. 63). Still, framings that present surrogacy as something more significant and intimate than a commercial contract maintain their salience in industry narratives and largely go uncontested by those who disagree.

The exploiters are not us

Not everyone wanted to play down the especially commercialised nature of low-cost surrogacy compared to altruistic kin-group arrangements. In defending low-cost surrogacy, some even went so far as to argue that, due to the highly commercialised and streamlined nature of the industry, it had less potential for abuses than many arrangements in high-income countries:

> I think there's a risk of exploitation of surrogates in any country. I think there is a greater risk where there is not a sort of an agency involved to help manage it. So in Australia, for example, because it's totally a do it yourself model, as it is in Canada really, and the UK as well, [there] is in a way a greater risk of exploitation because there is no official screening process in place and surrogates are, we've seen, taking advantage of intending parents and vice versa because there is not a professional in between the two to manage that relationship. So I think the assumption that a woman from an undeveloped nation is more likely to be exploited because she is poorer is not that valid. Because she is being screened. (Phil)

Phil's words are interesting in the context of the screening practices discussed in Chapter 3, where the accounts of doctors and activists showed that, while one purpose of surrogate screening is to ensure her physical and psychological health, surrogates are in fact screened to be docile, obedient and passive. Instead of insuring against exploitation, surrogate screening in India and in other low-cost

destinations can in fact help choose those women who are most likely to allow themselves to be subjected to exploitative practice.

Others, indeed, were more realistic than Phil, accepting the prevalence of exploitation in low-cost surrogacy, but arguing that it is no different from the exploitation of workers that happens in other industries. Dave, whose agency prided itself on trying to minimise such issues, argued that it was often difficult for his agency to ensure the fair treatment of surrogates because the exploitation of labour was ingrained in the system:

> India's main resource is human resource. Both educated and unskilled. Unskilled labour is always going to be exploited in the lack of regulation. Same issue in Bangkok. Abuse in this situation is just always going to happen - whether it is in the field, in factories or in the clinic undergoing procedure.

This acceptance of the potential for exploitation and abuse was, however, usually coupled with insistence that such issues could be avoided if only there were a commitment to good practice. There was significant conviction to these statements, as expressed here by Adam:

> I, from our experience, and we have experience from hundreds of surrogates. Show me one surrogate that, at the end of the process... Let's say two years after the process, you ask her to think back and tell me, do you feel that you were exploited? Really I don't know any surrogate... Of course there are people that were exploited, but I mean our surrogates, the ones that we treat as we treat. Like they are supposed to be treated. If you ask her, there is no surrogate who will say 'Yes, I was exploited, my body was used.' No, they all say 'I'm so happy that I was able to help them, and I'm happy that they were able to help me to build my house,' or 'to give education to my kids.'

When pushed further on the matter, Adam conceded that it was indeed difficult to monitor the treatment of surrogates reliably in low-cost destinations. He explained

that for this reason he tries to keep as much of the entire process in-house, so as to have more control and oversight over what happens. Mostly, however, that kind of involvement is not possible because of how quickly and unpredictably the business moves. What is needed, according to many, is local regulation, or in its absence, industry-wide standards of ethical conduct. Some, like Dave, had given this considerable thought:

> I myself and colleagues have pushed for a long time to get standards of ethics to self-police. If the business can step up, then we can avoid scandals. This could provide a framework for future laws. We need ethical care of the surrogate and protection for her, but also for parents. Ensuring surrogate is aware of the agreement she is making. She is signing a document in English and she will not understand, so we have to get local lawyers. You can explain the medical procedure, but really what you want to explain is her relationship to the baby. They know how pregnancy works, but they need to know legally and morally that baby belongs to the couple. You wanna make sure that's quite clear. Then that she understands the procedure itself. If you take the time to explain that then those are not complicated points, but they need to be spelled out. Second point is to make sure she is sufficiently compensated: 1200 to 1500 dollars. Often the surrogate finds herself alone after delivery. So we have to make sure that the relationship lasts beyond birth. This works in the benefit of everybody – her cooperation might be needed later for legal things. There is just a real need for oversight.

The idea of a kind of Fair Trade low-cost surrogacy, of being able to benefit from the regulatory and economic benefits of low-income destinations while sidestepping exploitative practices, is indeed an appealing one for many. Research by bioethicists has found it to be a complex idea both in theoretical and in practical terms, mostly because, as Pande argued, issues of exploitation in surrogacy are often so tied up in systemic and structural issues as to make surrogacy, with its embodied involvement and vulnerability, highly problematic (Humbyrd, 2009; Kirby, 2014; Panitch, 2013).

For now, experience suggests that the dream of industry self-regulation is likely to be unrealistic. In a situation where even government bans and criminal cases have failed to reel in the industry, the lure of lucrative profits will likely override any non-binding professional agreement. This is especially the case since even those who are aware and critical of the treatment of surrogates and other reproductive labour in low-cost reproductive industries nonetheless carry on operating within them, whether for commercial or activist purposes.

Crime without criminals: the moral entitlement to break the law

The shared discourse that emerges from these varied arguments of activism, choice, exchange and rescue, of surrogacy as a mutually beneficial arrangement that women should be freely allowed to engage in, is a crucial pillar of the global low-cost surrogacy industry. Indeed, as I discussed in the Introduction, ideologies of choice and privacy were part of the foundation of the moral discourse that made transnational surrogacy acceptable in the first place, with intended parents who travelled abroad rejecting portrayals of themselves as criminals and instead having their actions framed as acts of individual freedom, choice, privacy and the right to family life in the face of draconian restrictions in their own countries.

Legal and bioethical scholars have pointed out that such a response is to be expected in a morally pluralistic society and that, in scenarios where there is widespread opposition to a law, it might even be considered part of the democratic process:

> When there is an intellectually irresolvable plurality of moral viewpoints, there will not be a common basis for coercive constraints justified uncontroversially in a particular common concrete view of the good life.... Therefore their legal

> prohibition should always be under moral suspicion in a secular pluralist society. (Engelhardt, 2011, p. 129)

Regulation in democratic societies, these scholars observe, should be about reaching a compromise between diverse values and interests, the absence of which undermines the authority of the law (Engelhardt, 2011; Pennings, 2002; Wellman, 1994). The novelty of assisted reproduction and the deeply divided ethical debates that surround it make such compromise impossible. Indeed, some scholars have argued that the recognition of such moral contestation of regulation might explain why state governments are often notably lenient in their enforcement of regulation regarding the use of assisted reproductive technologies, including surrogacy by intended parents. Eric Blyth and Abigail Farrand (2005) have suggested that such 'pragmatic tolerance' is not an oversight but a way for the state to reconcile the need for a legal consensus with the demands of an open society.

However, that same shared and co-created discourse of privacy and choice also served to justify the machinations of some international facilitators in getting around restrictions, or even breaking them outright, serving as the basis of arguments that seek to undermine the moral authority of surrogacy regulation. Indeed, industry professionals and clients who engage in activities that either intentionally bypass regulation through the use of loopholes or are even strictly illegal use this discourse not only to justify their actions as morally acceptable, but also to resist identifying themselves as criminals. Criminologist David Matza (1967) has investigated such scenarios, whereby those breaking the law do not identify themselves as criminals, in his analysis of white-collar crime in the United States. Matza argues that, for the

most part, white-collar criminals are not committed to a life of crime. Rather, they are generally disapproving of criminal acts and recognise them as wrong, otherwise living their own lives by the law. The criminal act happens due to what Matza has described as a temporary drift out of a normally law-abiding routine and into delinquency, rather than as the full-time pursuit of criminal conduct overall.

More recently, Simon Mackenzie (2004) has used this concept of drift to understand how antiquities dealers make sense of trading in looted goods despite the practice being illegal. His work can help make sense of the global low-cost surrogacy industry because the two businesses, though seemingly different, have a lot in common. Both operate in the context of steep social inequalities between provider and consumer nations, and both markets have both legal and illegal spheres in which agents often work simultaneously.[24] As is the case with surrogacy, the antiquities traders in Mackenzie's (2004) study traded mainly in licit items and in fact generally preferred to do so. However, due to the structural mechanisms of the antiquities trade, dealers, curators and collectors are continually presented with the opportunity to do wrong and reap lucrative benefits from doing so. Since these individuals operate in a market where the wrongful acts of buying illicit goods are commonplace, it is easy for them to drift into crime because it is unremarkable. It is normalised and even routinised, something that happens all the time. Mackenzie's analysis can help us better understand the actions and rationalisations of surrogacy facilitators.

[24] Kirstin Peterson has argued that such parallel operations are in fact quite common, as in some trades and regions especially, the practices of a purely so-called legitimate trade and a black-boxed illicit one have become increasingly intermingled (Peterson, 2014).

Between restriction and regulation

The nuanced relationships facilitators have with regulation become apparent in the way they approach new destinations. Unlike what one might expect, for most brokers the search for destinations or inter-country arrangements is not a simple regulatory race to the bottom. Despite the business's reputation for thriving off the lack of regulation, most professionals in fact considered the regulatory situation in a potential destination country very carefully. However, they did so in complex and unexpected ways, not necessarily looking to set up their businesses in the least regulated destination possible. The ideal scenario for international facilitators was a low-cost destination where the government regulated commercial surrogacy favourably by making it legal for all demographics (including gay and single parents), as well as ensuring minimal rights for the surrogate and imposing minimal obligations on the industry. The reality is, however, that most countries in the world do not have any regulation for surrogacy, which benefits international facilitators, as regulation in most cases means restriction or an outright ban. As a result, it is the unregulated low-income markets that appeal most to the surrogacy industry. However, while the industry benefits from a lack of restrictive regulation, it does not like to operate under the cloud of uncertainty that this brings with it. Something small can be enough to make the difference, as evidenced in Adam's explanation for why he took his agency to Nepal in full force, but decided to stay out of Cambodia:

> In Nepal there wasn't a legislation but there was a cabinet decision. For us that's enough. We can trust that the cabinet decision is something that we can work with. Of course we are not... We will not wait until there is proper legislation about it because it will probably never happen. So we will go into places if we feel secure even if it's not a hundred percent regulated, OK?

Adam did not feel the same kind of confidence for Cambodia because of the absence of any regulation regarding surrogacy in the country at the time:

> Since the beginning we figured out Cambodia was going to be a rerun of what happened in Thailand, for instance. Because there wasn't any legislation, there was a legal vacuum. So we made a decision not to go into Cambodia. It looked a bit dangerous and, as it seems, it happened the same way. We are looking for countries that are able to at least have some regulation about surrogacy, because if you don't have any regulation it's a matter of time, and not a lot of time until it will go out of business.

Dev, meanwhile, was selling surrogacy packages to Cambodia using as surrogates Thai women recruited through networks established during Thailand's own short surrogacy boom. He was running the operation both ways, taking Thai women into Cambodia and Cambodian women into Thailand. Moving surrogates back and forth across the border was working, but it was not ideal, so Dev was hoping to get Cambodian government recognition for surrogacy so he could recruit local women. Dev argued that the law was never interpreted correctly, and he had instructed his lawyer to draw up clarifications, using his political connections to press for a different and for him more favourable interpretation. He was doing this even though he was already successfully operating in Cambodia while there were cost and administrative benefits to being able to hire local women, Dev also preferred the sense of stability that a legally recognised arrangement would bring with it, even though he was managing to do business in its absence.

This scenario, of not wanting to limit one's activities due to regulation while simultaneously looking for the security afforded by government approval, was a common theme in the low-cost surrogacy industry. In the absence of favourable

comprehensive legislation for surrogacy, the industry thus seeks out unregulated destinations where it hopes to achieve some sort of governmental recognition. Most of the professionals I spoke to were in negotiations of some sort often with several potential destinations countries. Who they were negotiating with exactly was a highly confidential matter and depended on the general approach of the professional involved. Some were more adventurous than others.

Law and other moral scales

The complex ways in which facilitators approached regulation shows a more nuanced relationship with law than is immediately obvious. Facilitators in fact embrace regulation and the security it affords, but they also find specific laws restricting access to surrogacy to be unfair and thus illegitimate and their crimes against such regulation as unproblematic. Mackenzie puts such normalization of criminal acts down to the power of a 'prevailing market discourse' that supplies individuals with an alternative moral scale of reference to that of regulation:

> In the 'periodic breaking of the moral bind to law arising from neutralization and resulting in drift' (Matza 1964:181), the moral bind to law is displaced by the interviewees with reference to another moral scale - one that is managed by the prevailing market discourse which supports perceptions of entitlement to make illicit purchases. The concept of entitlement, enshrined in law and with its importance thus greatly magnified, filters into the social domain and is there, with the use of neutralizations, manipulated. This manipulated entitlement provides moral and social alternatives to legal entitlement. (Mackenzie, 2004, p. 264)

Just as the art dealers in Mackenzie's (2004) work rationalised their purchase of illicit artefacts by arguing that they were entitled to do it, the brokers, doctors and intended parents involved in exploitative or illegal surrogacy arrangements worked within a

discourse that both rationalized and normalized their behaviour. This rationalising discourse centred around ideas of privacy, reproductive freedom and free market values. A consequence of this was that those in the surrogacy business felt entitled to benefit from low-cost surrogacy and perceived regulation as unjust and therefore illegitimate. This, in turn, was used to further rationalise the various approaches taken to get around the law or even break it.

Indeed, surrogacy professionals often expressed their sense of frustration with the public outrage and regulation that hinders their work and which they view as unjustified:

> Almost every country in Europe doesn't allow it, and seriously, there is no reason for that. You just need to properly regulate it, but they are really trapped in these strange conceptions. (Adam)

Dev argued that Western governments simply did not like surrogacy and were setting up obstacles wherever they could:

> Infertility is a growing problem, a phenomenon across the world, and irrespective of whatever you say, Western governments would never allow it, they don't like surrogates, or the word 'surrogacy' at all. In fact there was a forward [email] someone sent that said, if surrogacy wasn't allowed two thousand years ago, Jesus Christ wouldn't have been born! Or would never have got a birth certificate! [laughs] That whole story would have just ended in the legal soup somehow…

Having a strong anti-government stance was common in this group, some being more vocal about it than others. Having struggled first with IVF and then with surrogacy for many years, Ray, for example, never missed an opportunity to exclaim that UK regulations were set up to stop people having families and therefore

discriminated against the infertile. Indeed, Ray referred to the Human Fertilisation and Embryology Authority, the governing body for assisted reproduction in the UK, as ‘the enemy of the infertile’ for what he perceived as a state-sponsored restriction of reproductive rights. Dylan, for example, even went so far as to argue that it was the regulators or anti-surrogacy activists who should be ashamed of themselves for putting ideology above the facts of life and thus denying other people the chance to improve their lot in life. Following Matza (1967) and Mackenzie (2004), the reason international facilitators and the fertility doctors they work with are able to drift into illegal activities without identifying themselves as criminals is that they feel entitled to carry out the criminal act because they see regulation as unfair or irrelevant. They refer to an alternative moral framework – that provided by the shared and co-created industry discourse of surrogacy as a benevolent force of reproductive and social justice – to delegitimize regulation and reframe their actions as morally unproblematic.

Mackenzie’s work might have significant implications for attempts to regulate global low-cost surrogacy, or even just to curb its more exploitative incarnations. This sense of entitlement by offenders, Mackenzie argues, severely limits the restraining effects of prohibitive regulation:

> Criminal legislation used to try to lever a market into a position where it effectively self-regulates is a measure of dubious merit where the actors in that market have constructed, normalised and routinized shared paths to an impression of entitlement to perform the prohibited act. (Mackenzie, 2004, p. 253)

Indeed, in my conversations with the professionals in the low-cost surrogacy industry, regulation emerged in a new light, as a set of rules or obstacles around which one needed to find a way by making use of loose definitions or procedural loopholes, rather than as a statement with any real moral or political authority.

Conclusion

It is hard to deny the significant internal coherence of the attitudes that together make up the discourse of low-cost commercial surrogacy as a morally acceptable endeavour, no matter how selective their arguments or how uncomfortable their implications may be at times. In order to understand what drives the drivers of global surrogacy's expansion, we need to account for the complex situated morality and the particular political consciousness that form the context of the work of global international facilitators. Each of these actors has their own personal understanding of the worth and nature of their work, their own approach and hopes for where the business might be going.

As I got to know the international facilitators of low-cost surrogacy better, I discovered in our long and often very considered conversations that the complex moral world they inhabit and promote escapes any easy interpretation or categorisation. Their willingness to share the details of their work with me makes more sense in this context. They invited me into their world because to them, while it was admittedly imperfect, it was nonetheless a morally benevolent one that was under threat from groups, individuals and governments who would not take the time to consider all angles.

The creation of babies, the reproduction of the next generation, is rarely if ever not political. What was surprising was the enthusiasm and inventiveness with which some facilitators and other surrogacy professionals had embraced that aspect of their work and the complex ideologies of equality, tolerance, fairness and liberty that they employed to reframe their controversial and often criticised work as involving the pursuit of reproductive freedom and equality. The existence, strength and influence of this discourse of entitlement well beyond circles that can be considered criminal, when coupled with the ease with which the industry resists regulation, highlights the important role persuasion, rather than simple criminalisation, must play in attempts to steer commercial surrogacy away from exploitative practice. These industry attitudes towards surrogacy can be variously seen as either appalling or pioneering, depending on one's political inclinations and positionality, but for the study of surrogacy and emerging bioeconomies more generally they are definitely fascinating and important.

The world of surrogacy attracts many colourful characters to fill the various roles that make up the chain between surrogate and client. It is difficult to evaluate the impact such various brokers have on global surrogacy and on the people involved. To an extent they provide a stabilising and streamlining force that this unregulated and volatile business needs. But they also introduce into global surrogacy a new level of speculation and complexity that not only has the potential to subvert government attempts to regulate the business, but also makes responsibility and accountability all but disappear in layers of law, geography and people. The world of global surrogacy is not without its scandals, and the elaborate webs woven by networks of middlemen can be as much part of the problem as they are (at least advertised to be) part of the

safety net. The fact that most of the time we cannot quite tell which is symptomatic of the issue.

9. Conclusion

‘What a view, huh?!’ exclaims Prakash proudly, as he steps out next to me on the balcony of the modern Mumbai skyrise. We are in his flat for a dinner meeting between his nephew Dr Sid and several important international surrogacy facilitators. He hands me a delicate glass of fine whisky and stands next to me, taking in the warm humid evening air and the glorious Mumbai sunset. It feels as if we are floating above the city. Below, wrapped in the haze of pollution and dust are streets with luxury cars and more beautiful houses. Right next to them are the haphazard blue plastic rooftops of the nearby slum, where people live in crowded and unsanitary conditions, barely eking out a daily living.

Prakash points out various landmarks and neighborhoods as well as the slums, with equal enthusiasm. A warm cheerful man in his sixties, Prakash is ‘Dr Sid’s uncle and the powerhouse behind his ambitious plans for a future in the assisted reproductive industry. Having made his fortune in Mumbai real estate development and the production of Bollywood films, Prakash is a man with various kinds of power and influence. He has come to let me know that it is time to be seated for food.

Dinner is served by Dr Sid’s wife and aunt. The servants had been sent home after they prepared the many dishes we enjoyed. Indeed, the entire evening was notably private. There was not a single servant in the luxury flat, no one manning the lift that took us up there, no one to park the car. There would be no outside eyes and ears around this meeting, for which they had, to my surprise, invited me as a researcher. Dr Sid had invited Dylan, Gabriella and Vedang to this meeting in order to discuss his

ambitious plan for getting around India's surrogacy ban. He wanted to start providing surrogacy in Kenya in partnership with Dylan. He wanted Gabriella to join them and sell those surrogacy packages to her clients.

Dr Sid explained that Kenyan laws would make it easy for the intended parents to pick up their babies. The issue was Kenya's relative lack of the technological infrastructure and expertise that was needed for surrogacy. Moreover, Dr Sid did not have a medical licence to practice in Kenya. This is where the proposed scheme truly came to life. They would recruit local women in Kenya, fly them to Mumbai in batches for embryo transfers, monitor the pregnancy in Mumbai and then fly the women back to Kenya to give birth. The intended parents would drop off their embryos or gametes in India but not fall under surrogacy laws because the Kenyan women would be treated as medical tourists. Due to the old migration relations between Africa and India, Dr Sid had family in Kenya, and could work with local clinics he could trust.

Dr Sid was clearly proud of his plan and everyone in the room was excited for the prospect of once more being able to work with the experience and expertise of Indian fertility doctors. In the excited discussion of various details, no one ever raised the issue of the welfare of the often illiterate and vulnerable women being flown between countries. Even Gabriella, whose concerns over whether or not her clients would be comfortable going to Kenya I discussed in Chapter 7 raised no such concerns about the surrogate women, at least not at the meeting.[25]

[25] She did tell me in private after the meeting that she felt any scheme involving surrogate women having to travel between countries did not seem right to her.

In trying to figure out if this could be done, no one stopped to ask if it should. High up in the skyrise far above the poverty and precarity of the streets below, surrounded by luxury and comfort, the needs of the women who sustained their trade never came up. That meeting laid bare the essence of the low-cost surrogacy as an industry that is as skilled at capitalising on inequality of various scales, as it is at thinking away the realities of poverty and disenfranchisement that sustain it.

How can the business of creating families, one that brings so much joy to so many, be so deeply problematic? Indeed, the benefits of surrogacy were easy to see throughout my fieldwork in the love that the (by now former) intended parents had for their babies and the happiness they shared. It was a happiness so deep that one could begin to understand how tempting it could be to look the other way and choose not to think about its cost. The benefit of privilege is that intended parents can choose to look away and pretend their babies come with no strings attached.

As this thesis has demonstrated, the surrogacy industry is well equipped to create and sustain this sense of consumption without cost. Surrogacy is presented to the world as a simple matter of renting a womb, a triumph of biotechnology. ‘Wombs for rent’, as surrogacy is advertised to consumers, as it is practiced in clinics and as it is constructed in the accounts of industry professionals, presents surrogacy as a perfect bioeconomic exchange in which the reproductive potential of low-income women is put to work to create children for the commissioning parents. The reality for the surrogate women, who are made to absorb both the embodied and the emotional complexities of this biotechnological triumph, is rather different and has come to cast doubt on the assumptions and representations of the industry as one that is based

on technology and expertise. Care, intimacy, relationships and the many other complications that result from the surrogate's stubborn existence as a person rather than just a reproductive body complicate the image of technological miracle.

The implications of the surrogacy exchange, of babies for wages, speak to a form of commodification that neither intended parents nor governments nor publics are willing to accept, creating discourses of gift-giving, altruism and charity as the industry's response. The relationships that develop, or that are not allowed to develop, around surrogacy imply a connection, real or potential, between the child and its host womb that goes beyond their temporary shared bodily existence. These glitches in the narrative of commercial surrogacy as a source of babies with no strings attached come to light in the occasional scandals and crises I described. The technology of surrogacy might by now be incredibly effective, but there has been far less progress in managing the new social scenarios, relationships and opportunities for exploitation that this technology creates, reflected in the absence of comprehensive regulatory approaches.

Indeed, while some forms of surrogacy seem to fit descriptions of bioeconomy and clinical or biolabour, the persistent complications the industry faces, with their roots in kinship, emotion and love, show the categorisation of surrogacy as a sector of the bioeconomy to be an industry aspiration, rather than lived reality.

Surrogacy, unlike biotechnology companies that are geared towards the production of rentier incomes from intellectual property rights that have inspired concepts such as biocapital, is ultimately about the production of babies. Once born and handed over to their parents in exchange for a fee, the commercial relationship is complete.

While babies are a very particular kind of product and the debate over the commodification of children is ongoing (Spar, 2006), this business model is, despite its reliance on biotechnology and expertise, still more akin to industrial production than the post-fordist speculative economies that authors such as Kaushik Sunder Rajan (2006) and Melinda Cooper (2011) describe. The workings of the commericial surrogacy industry, as explored in this thesis through the actions and perspectives of its professionals, have uncovered an economy that, while it continues to push the boundaries of the commercialisation of biology and of intimacy, does not constitute a phenmenon so profoundly different as to place it into a new conceptual category.

But while surrogacy might not belong to the realm of speculative and future intellectual property oriented industries that concepts such as biocapital attempt to understand, it nonetheless represents a break from fordist industrial production in its reliance on embodied labour. As is the case with other biolabour or clinical labour, surrogacy blurs, if not erases, the boundaries between production and reproduction, self and labour, or work time and non-work time for the labourer, presenting new challenges for labour protections and bioethics alike (Cooper and Waldby 2014). The concept of biolabour, a term I prefer over clinical labour because of its focus on the body rather than the clinic, can help us understand and meet some of those challenges. That said, this novel labour arrangement, where knowledge and technology industries such as pharmaceutical clinical trials and also surrogacy rely on significant numbers of living bodies for the site of their projects, provided by unskilled, often poorly compensated and precarious labour, speaks at least as much to issues of dire socioeconomic inequality as it does to technology and we need to

be careful not to be distracted by this latter aspect from critically examining the former.

Perhaps, then, interrogating the insistence on the ontological newness of commercial surrogacy and the many other market uses to which biotechnology is putting low-income bodies can be important in its own right. Are we so keen to identify in surrogacy an entirely new kind of market because we feel uncomfortable accepting that its issues of exploitation or inequality are not at all exclusive to that particular industry and instead, deeply entrenched in our relationships with each other from the level of the global, in long commodity chains and their sweatshops, all the way to the intimate, in households with often poorly compensated migrant houseworkers?

The way surrogates are treated in low-cost scenarios, the subject of Part I of this thesis, and the way the industry moves around the world and through complex arrangements, which I explored in Part II, are not separate issues. Instead, they facilitate and sustain each other. The separation between the practicalities of the business – of how bodies and relationships are managed in clinics and of how surrogacy markets are organised – and its moral challenges, philosophical questions, conceptual confusions and powerful socio-political implications is an illusion. It is the practice of surrogacy, the daily work of its professionals, that shapes the industry and that both creates and reflects its driving ideology.

The demand by the industry's clients, the intended parents, and the relative apathy of many of them towards where exactly their babies come from fuel the industry's pursuit of new geographical and moral horizons. Moreover, the discourse of the benevolence and fairness of surrogacy and the entitlement of Western consumers to

access low-income women's fertility, a discourse that both the consumers and the professionals of the industry share and co-create mean that efforts to control or regulate the industry globally will continue to be met with challenges. Morally pluralist societies need to work towards moral and legal compromise and focus also on persuasion, including improving access to viable alternative options, rather than just criminalisation, if they are to successfully challenge the discourse of entitlement that feeds low-cost surrogacy.

The technology of IVF does not inherently contain exploitation: it is what we do with what this technology makes possible that determines the way it will shape our worlds. A closer look at the dynamics of low-cost surrogacy arrangements and markets shows that for now IVF has found its place among long-existing local and global systems of gendered and racialized socio-economic inequality, post-colonialism and the free-market ideology that celebrates exploitation under the banner of opportunity. It is difficult to tell whether kinship works to disentangle surrogacy from these systems or to entangle it in them further. I am not arguing that surrogacy needs to be dominated by altruism, or enduring kinship relations between surrogates, the children they bear and the parents who raise those children. As I hope my discussion has shown, it is not obvious that such a format would be beneficial for anyone involved. Surrogates have their own lives and families, even though they are often written out of the picture. But what we do need to think carefully about is whether free-market relations that thrive on inequality are a suitable or even desirable alternative format for conceptualising the relationships within which we bring children into the world.

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