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Osaka University
Beyond the ‘Baby Factory’: Construction of Intimacy in Commercial Surrogacy Practices in India

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Yumiko Tokita-Tanabe

Introduction

This paper takes up issues concerning commercial surrogacy in India and discusses how both the surrogate mothers and their clients attempt to construct a sense of intimacy that goes beyond a commercial contractual relationship. Previous studies on commercial surrogacy in India focus on its rapid growth in recent years due to the effects of global capital giving rise to escalation of medical tourism and cross-border reproductive services (Palattiyil et al. 2010). Scholars critical of surrogacy employ the term ‘surrogacy industry’ in the context of expansion and penetration of global capital, describing and analysing how economically disadvantaged women of the Global South are exploited as they become surrogate mothers (Vora 2009a; Hibino 2011) and are treated as ‘disposable objects’ (Majumdar 2014: 277).

In this paper, however, I suggest that in order to deepen our understanding of transnational commercial surrogacy, we need to consider not only its politico-economic aspects but also the indigenous concepts of the body, socio-cultural notions and practices regarding mother-child intimacy, as well as how these concepts, notions and practices are negotiated and transformed within commercial contractual relationships. In so doing, we discover that mother-child intimacy, which is often taken for granted as being based on a biological/genetic bond, can consist of other kinds of bond in the age of globalization of bioscience and technology. We also find that surrogate mothers are not to be considered merely as ‘victims’ of the effects of global capital, but as agents of social transformation in some cases, as they together with their clients construct new intimate relationships.

In the presentation, I first give an account of what commercial surrogacy involves along with its brief history, statistics and legal status in India. I then discuss how some previous studies have considered commercial surrogacy in terms of expansion of global capital that exploits socio-economically vulnerable women of the Global South. I argue that although it is important to view commercial surrogacy as a form of exploitation, in order to have a more comprehensive understanding about it, we also need to know about the indigenous notions of the body, human reproduction, relatedness between persons, and mother-child intimacy. Finally, I look at the possibilities of construction of new relationships in surrogacy arrangements in which the surrogate mothers and the clients forge a new kind of intimacy and new notions of the family in the age of bioscience.

Commercial surrogacy in India

Commercial surrogacy is an arrangement whereby a surrogate mother becomes pregnant and gives birth on behalf of a client who cannot become pregnant and hands over the child/children to the client in exchange for payment by cash or/and kind. Commercial surrogacy began in the United States from the late 1970s to the early 1980s and subsequently become more popular (Smerdon 2008: 16-17). In India, the first case of surrogacy was reported...
in Madras (officially named Chennai since 1996) in 1994, but it is unclear whether it involved payment of any kind. Other countries that permit commercial surrogacy are Malaysia, Thailand, South Africa, Guatemala, Russia and Ukraine (Bailey 2011: 716). The US has different laws regarding surrogacy according to each state. There are no precise statistics about the number of surrogacies practiced in the world. In the US, it is said that the annual number of children born from surrogacy in 2004 to 2008 roughly doubled from 738 to 1400 (Gugucheva 2010: 4). However, it is unclear how many of these cases involved commercial transactions.

There are no precise statistics for surrogacy in India, and it is near impossible to accurately grasp its scale. According to a report in 2012, over 25,000 children were born through surrogacy at that point in time and 50% of these cases were commissioned by people from outside India (Shetty 2012). The cost of commercial surrogacy in the US ranges from 59,000 USD to 80,000 USD, whereas that in India ranges from 10,000 USD to 35,000 USD (Nelson 2013: 241). Hence, low cost of commercial surrogacy in India attracts clients from many parts of the world. It is also reported that commercial surrogacy in India is marketed along with a packaged sightseeing tour, making it more attractive to potential customers (Sama 2010: 161).

In recent years, concerns over the rapid expansion of commercial surrogacy have led to media reports labelling India as a ‘baby factory’ (Jayaraman 2013) promoting ‘wombs for rent’ (Haworth n.d.). Transnational or cross-border commercial surrogacy has also become the latest hot topic for many researchers. The increase in commercial surrogacy in India is often attributed to the development of bioscientific technology (Bharadwaj and Glasner 2009) and the Indian government’s promotion of medical tourism (Matsuo 2013a, Matsuo 2013b, Hibino 2013). In 2002, the Confederation of Indian Industry collaborated with a multinational consultation company to estimate the immense commercial profits to be gained from medical tourism (Chinai and Goswami 2007). The government continues its efforts to establish India as a ‘global health destination’ (Ibid.), attempting to attract medical tourists around the world by improving the infrastructure of airports and training highly skilled English-speaking medical experts.

Clients from outside India include those from countries in South Asia, Southeast Asia, Middle East, Europe, Africa, as well as Australia, Canada, and the US (Sama 2010: 160). There are also Japanese clients. Many of the clients from these countries choose to come to India because either surrogacy is illegal in their own countries, or it is cheaper than in their own countries. Another reason is that there is less chance of facing litigation over the custody of the child after birth. Some American clients come to India instead of having surrogacy arrangements in the US in fear of having to deal with a surrogate mother who might change her mind and claim custody of the child (Vora 2013: S102). Many of the medical institutions which provide surrogacy services to non-Indian clients are located in metropolitan cities, such as Delhi, Mumbai, Bangalore, Chennai, Kolkata and Hyderabad. However, the most famous surrogacy institute in India is Akanksha Infertility Clinic, established in 2002, in the town of Anand in the western state of Gujarat. In smaller cities, such as Bhubaneswar, the state capital of Odisha in Eastern India, surrogacy services have just begun to be openly advertised. In such smaller cities, surrogacy arrangements are sought by mainly middle to upper-class Indian clients.

Today in India, there are said to be over 500 Assisted Reproductive Technology (ART) clinics (Shimazono 2013), but the regulations regarding surrogacy are still inadequate. The ethical issues of surrogacy have not been sufficiently well addressed, and the regulations are still in indefinite and experimental stages (Unnithan 2013: 288). There are no laws in India to date regarding surrogacy. In September 2008, the ‘Assisted Reproductive Technology (Regulation) Bill and Rules’ was drafted by a twelve member committee, consisting of members of the Indian Council of Medical Research and medical experts of the Indian government’s Department of Health, and
became a matter for public debate (Smerdon 2008: 42). The Assisted Reproductive Technology (Regulation) Bill and Rules was subsequently amended in 2010 and 2013, but it is still at a draft stage. According to some women’s rights groups in India, the present draft requires further public scrutiny and discussion since it encourages the use of ART, underlines the standpoint of medical institutions and clients, and does not take into adequate account the welfare of surrogate mothers and children born of surrogacy arrangements.

Commercial surrogacy as exploitation of affective labour

Amrita Pande argues that commercial surrogacy in India should be considered as a type of wage labour (Pande 2010a) based on women’s care work (gestational services) to be categorized together with the wage labour of nannies and household helpers (Pande 2009b: 142-145). She contends that surrogacy is a socially stigmatized ‘dirty’ and ‘sexualised’ care work (Pande 2010a: 155) whereby poor women of the Global South are exploited due to the global expansion and infiltration of reproductive technologies. Kalindi Vora refers to surrogacy as involving ‘commodification of vital energy’ and argues that it is an ‘affective biological labor’ that alienates the surrogate mothers from their own bodies (Vora 2009a).

In connection with exploitation of women of the Global South, scholars point out the problem of ‘stratified reproduction’ and race. Stratified reproduction is a hierarchical system that supports and maintains the health, reproductive capacity, experience of giving birth and raising children of some women at the expense of rights of other women to be mothers (Rapp 2001: 469; Pande 2014: 51). Regarding the issue of race, it has been suggested that US media and public discourse about commercial surrogacy as a global industry tend to represent Indian women as a ‘poor racialized other’ (Markens 2012: 1751). In many cases, clients from the Global North select surrogate mothers from the Global South whom they consider as racially and socio-economically inferior, rather than finding surrogate mothers in their own countries, whom they see as racially equal and whose socio-economic status is not so different from their own, in order to be in a superior position and avoid problems over custody of the child. Amrita Banerjee argues that such practice is leading to the formation of a ‘transnational reproductive caste system’ (Banerjee 2014: 113). Transnational surrogacy in India is said result in stratified reproduction not only at the global level, but also at the local or community level within India (Deomampo 2013).

It goes without saying that the problem of exploitation of women of the Global South and stratified reproduction due to effects of global capital is important. However, we cannot sufficiently explain the rapid increase of commercial surrogacy in India and the social changes related to it only by analysing such political and socio-economic factors. In order to arrive at a more comprehensive understanding of commercial surrogacy in India, we also need to know the indigenous meanings of the body and the human reproductive process.

We should also have insights into how mother-child intimacy is socio-culturally constructed according to indigenous notions of relatedness. Pande and Vora’s explanations about commercial surrogacy as a type of labour are well argued; but we should note that what is significant about surrogacy is precisely the fact that it cannot be completely commoditized in the form of wage labour. Commercial surrogacy practice involves both commoditization and intimacy. That is why it is problematic or even disturbing to so many of us, as most cases of affective labour (including sex work) are, and is full of ethical issues that cannot be easily resolved.

Affective labour is aptly defined as ‘work that aims to evoke specific behaviours or sentiments in other as well as oneself, rather than it being merely about the production of a consumable product’ (Ditmore 2007:171). The specific sentiment in the case of commercial surrogacy is the mother-child intimacy, which is contested and negotiated between the parties involved, namely the surrogate mother, the
client and medical experts. How then can we begin to unravel this complex combination of commoditization and intimacy? Let us take a look at some ethnographic and journalistic accounts of commercial surrogacy in India.

**Notion of the body and construction of mother-child intimacy in India**

In a clinic in Anand in the state of Gujarat in western India, Raveena agrees to become a surrogate mother for a South Korean couple living in California. Anne, the client, wants a baby girl, but Raveena says even before the ultrasound test that the baby will definitely be a boy, and indeed the baby she gives birth to is a boy. Raveena says that Anne only gave the eggs, whereas the blood, sweat and effort are all Raveena’s own, so it is obvious that it will take after her (Pande 2009a: 379).3

The reason for Raveena’s conviction is that since she was already a mother of two boys before she became a surrogate mother, the baby she would give birth to in the commercial surrogacy arrangement would also be a boy due to her bodily constitution. Amrita Pande, who conducted the ethnographic fieldwork on which this account is based, argues that Indian surrogate mothers devalue the relationship between the foetus and the biological/genetic mother and emphasize the importance of their own presence by stressing the substances they share with the foetus, such as blood and breast milk, the fact that they nurture the foetus during the period of pregnancy, and the labour that goes into gestation and childbirth (Ibid.: 384; Pande 2009b: 166-168). Thus they highlight the mother-child intimacy from their own point of view.

Anthropological studies point out that kinship based on ‘natural’ biological relations can no longer be taken for granted due to the development of new reproductive technologies (Strathern 1992; Carsten 2000). These studies say that material or substance is the important element in the construction of ‘relationality’ or ‘relatedness’ in kinship (Busby 1997; Carsten 2011). Material here refers not to a neutral or value-free substance, but to the blood and other bodily fluids specific to a person. In the case of Raveena, it refers to her blood and bodily fluids that contain her characteristics as she nurtures the foetus in her womb as a surrogate mother. These substances contain the meaning and value of personhood of the surrogate mother and function as cultural codes. I refer to such culturally coded substance here as ‘substance-code.’

Substance-code mediates the relationship between the human body and its social and ecological environment. McKim Marriott points out that in the Indian context there is continuity between the substances that constitute the human body, the substances that move due to the actions of the body, and the substances that constitute the body which is acted upon (Marriott 1976). In this way, substance-code links one person to another, or to others, both materially and socially. According to the Indian notion of the body, the boundaries of the body are open; all things and beings, including humans, are constituted of substance-codes that move fluidly across boundaries; and the body is a temporary node in this flow of substance-codes (Tokita-Tanabe 2010).

Human beings exchange substance-codes by performing various actions. For example, if a person cooks something, the substance-code that constitutes that person’s body becomes a part of the food. When another person eats this cooked food, the substance-code of that food, together with the substance-code of the person who cooked it, is taken in by the person who eats it. In the same way, substance-coders are exchanged when persons share space, give-and-take gifts, touch each other, and converse with each other. The construction of relatedness between persons extends beyond blood relations, such as family and relatives, to neighbourhood relations, as people give and take things from each other, converse with each other and share space with each other on daily basis.

In this way, from the Indian point of view, the body is formed by the exchange and flow of substance-codes, and it is embedded in relatedness through exchange, flow and
extension of substance-codes. Human reproduction is based on the same logic. During my fieldwork in rural Odisha in Eastern India in the early 1990s, I was told that the human body is said to be formed by the mixing of the male sperm (birja) and the female secretions (raja) during intercourse. There was no mention of ovum or egg in the village people’s accounts. When a child is formed, the sperm becomes the bone and the female secretions become the flesh. When the body dies, it is cremated and bones remain. According to village people’s explanations, the cremated bones of ancestors are washed away in water, then they subsequently rise up to the sky as water vapour, forming clouds and fall back down to earth as rain and become part of rice in the fields. The rice is eaten by the descendants and becomes sperm in male descendants, forming the bone of the offspring when the male descendants get married and have intercourse with women ideally from the same caste (jati). Men plough the rice fields and bring the rice grown on their own land to the house. Women who marry into the house cook the rice and feed it to the family as well as to the ancestors. In this way, human beings are embedded not only in social relationships across generations and affines, but also in the religio-ecological relationships with ancestors, rain, land and crops (Tokita-Tanabe 2011: 112-113).

Exchange and sharing of substance-code enable fieldworkers to become part of the network of relatedness. For example, when my husband and I were doing our first fieldwork in Odisha in 1991, we were told by our host family that we were ‘their people’ because we had lived with them and ate the same food as they did (Tokita-Tanabe 2011: 54). We continue to maintain our relationship with the host family through e-mails and remittances in times of their need and meet with some of the members at least once a year to catch up on what is going on in our mutual lives. Thus, the construction of relatedness in India is not restricted to blood or marital relations, but expands and extends to others by giving and taking of things, sharing space, keeping in touch through e-mails, phone calls, skype, facebook and so on. As I will go on to explain, it is precisely this expansion and extension of relatedness through the exchange and flow of substance-codes that is significant in understanding commercial surrogacy, mother-child intimacy and construction of intimate relations between surrogate mothers and clients in India.

We can say that according to the Indian worldview, a human being is not an autonomous individual but a distributed ‘dividual.’ Substance-codes that constitute a body are partible and are exchanged. Of course, it is not that the concept of the autonomous individual does not exist in India (Mines 1994), or that the concept of a partible person does not exist in the modern West (Konrad 1998). We cannot explain everything by employing a straightforward dichotomy between the modern individual and the Indian dividual.

However, the idea that human beings live in an open-ended state of relatedness that goes beyond the borders of an individual body clearly differs from the normative view of the modern West that presupposes and is based upon the existence of the autonomous bounded individual. We see a marked difference between the modern Western notion of the body and the Indian notion of the body in the practice of cross border commercial surrogacy, where there is a clash of values between the clients and surrogate mothers leading to problems of mutual misunderstanding and bitterness.

**Problems of cross border commercial surrogacy**

Problems of cross border commercial surrogacy are often taken up as sensational news by the media. For example, on 28 July 2011 the BBC World News reported a story called ‘Womb for rent: A tale of two mothers.’ It is a story about how the differences in thinking and attitude between the surrogate mother, Sonal living in Gujarat, and the client, Carolina from Ireland, regarding surrogacy leave a bad aftertaste. Carolina is unable to bear children after suffering from cervical cancer. She desperately wants a child, and is introduced by Akanksha Infertility Clinic to 26 year-old Sonal
who has already had one experience of being a surrogate mother. Sonal spends time in the clinic away from her husband and two children during the period of surrogacy arrangement. Her husband is a vegetable vendor whose monthly income is 1,500 rupees. By becoming a surrogate mother, Sonal earns 300,000 rupees. She believes that with this money she can provide her children with better educational opportunities, build a new house, and be happy. When she first decided that she wanted to be a surrogate mother her husband objected but she persuaded him.

The doctors at the clinic discourage intimacy between the clients and the surrogate mothers, but during Sonal’s pregnancy, she and Carolina become friendly and Carolina gifts her with a mobile phone and so on. But their relationship takes a completely different turn after the birth of the child. The child is taken to a nearby hospital straight after birth for safety reasons, and Sonal is refused permission to see and breastfeed the child. She is very hurt about the fact that Carolina employs a nanny for the child and does not let her take care of the baby. Carolina later asks Sonal to send over some breast milk but Sonal refuses. She says that if Carolina can employ someone to look after the baby, she can also get someone to provide breast milk. She is very upset that she is told to send over the breast milk and not allowed to spend time with the baby.

On the other hand, Carolina legitimizes her actions as a difference in culture. She says that it may be normal in Sonal’s culture that the surrogate mother becomes the nanny and breastfeeds the baby, but in her own culture it is ‘too close to home.’ She is eternally grateful to Sonal for what she has done for her but insists there has to be some kind of a ‘cut off point’ in their relationship.

What we should note here is that whereas the client feels the need to cut off the relationship with the surrogate mother, the surrogate mother cannot understand why such a cutting off is required. When she became a surrogate mother for the first time, Sonal had to hand over the baby after breast feeding the child for three days never to see the baby again. From this unhappy experience, this time she has convinced herself from the beginning that the child belongs to the client and she is prepared to give up the child and eventually forget about the birth after she has handed over the baby. So she does not feel that she has lost her own child. What makes her sad is the fact that the relationship between her and the client is cut off after the birth, and her effort of nine months of pregnancy has thus gone to waste. Sonal waited for Carolina to ask for her help in taking care of the new-born baby, but Carolina employed another woman as a nanny. It seems that since Sonal had constructed a good relationship with Carolina over the nine months of pregnancy, she expected that the relationship will continue in some way after the birth.

However, from Carolina’s point of view, it is precisely the continuity of this relationship that must be cut off. It is not clearly mentioned in the BBC article, but we can assume that the eggs came from Carolina and the sperm from her husband. They are the child’s biological or genetic parents. When the child is born and appears clearly in a manifested form, the child grows up as an independent biological body, which is in what can be termed as a ‘blood relationship’ between the mother, father and child. For the clients, the presence of a surrogate mother becomes problematic because the surrogate mother shares blood with the child in another way during the nine months of pregnancy and is in another type of blood relationship. This problem is related to the issue of ownership or custody of the child.

What is further problematic is the social stigma attached to commercial surrogacy in India. Sonal stayed in the clinic in Anand without letting her husband’s parents and her neighbours know about it. The BBC article says that some people in India consider surrogacy the same as adultery. This can be understood from the logic of substance-code. Needless to say, it differs from the adultery involving actual intercourse, but it is not difficult to surmise from the logic of substance-code underlying the Indian notion of the body that the mixing of substance-codes of a man and a woman who are not married to each other constitutes a kind of
adultery. There is also a societal attitude that women employing their bodies in surrogacy as a means to earn money are engaging in a kind of prostitution, and the media often depict surrogate mothers as akin to sex workers. The parallel drawn between surrogate mothers and prostitutes is not limited to India (Shore 1992). In another case from Anand, Sapna becomes a surrogate mother in order to earn money to help build a house for her husband’s parents in the village. Sapna’s parents live in the nearby city of Ahmedabad, but she does not tell them that she has become a surrogate mother because she is afraid that they might think their daughter is sleeping with an American (Pande 2010b: 298).

In coastal Odisha, where I have been conducting fieldwork since 1991, infertility clinics are springing up in urban areas and advertisements about ART have become prominent in recent years. In my interviews in Odiya language with two Brahmin women residing in the Odisha’s temple city of Puri (one of the four most important places of Hindu pilgrimage), one of them, a retired ayurvedic doctor whose son and daughter-in-law are living in Bhubaneswar (Odisha’s state capital) told me that she has seen advertisements about ‘surrogacy’ (English term was used) in Bhubaneswar but does not know much about it and it must be for people who are desperate to have children of their own. The other woman, a retired school teacher, told me that she has read about surrogacy, but has never seen it advertised in Puri. The reason she gave was that the people of Odisha are ‘conservative’ (English term was used) and so they would not like their neighbours to know that they are involved in a surrogacy arrangement. She said that they would probably rather go to a clinic in the nearest metropolitan city, Kolkata, which is just under an hour’s flight away from Bhubaneswar. Neither of the women I interviewed was keen to discuss the topic any further, clearly indicating that it was improper and distasteful. Both only spoke of the necessity of couples to have children and did not mention the plight of surrogate mothers.

I have not heard of a case of infertility treatments involving artificial insemination or in-vitro fertilization in rural areas. When I asked a woman in her late forties who grew up in a village and is now living in Puri what she thought about new reproductive technologies, she said, ‘That kind of thing is done for “hybrid” (English term used) cows (as opposed to desi or indigenous cows) to have offspring. It’s not good have a child by putting something inside you with an “injection” (English term used) when you don’t know from whom it has come. In the olden days, women prayed, fasted and suffered for ten to twenty years to get a child. Nowadays, if they don’t have a child within two to three years of marriage, they use an injection to get pregnant. People nowadays have neither patience nor endurance. It’s obvious that they will not get a good child by doing such a thing. Why don’t they understand such a simple fact?’

The ‘people nowadays’ that the woman criticizes are the new urban middle class who are rapidly increasing in India today. The new middle class have suddenly come to a lot of wealth particularly since the 2000s and are upwardly mobile and highly competitive. Many women of the new middle class have joined the paid workforce and marry late, so if they have the financial means they can resort to new reproductive technologies. Many of them work outside and come home to manage the housework. They have to take care of the children and their education, and not only that, they have to take care of their husbands’ parents if they are living with them. It would be difficult for such women to perform the votive rituals that rural women undergo to conceive children, even if they wanted to do so, since the rituals involve strict fasting.

While surrogacy arrangements are still rare in the eastern state of Odisha, they are rapidly increasing in the western state of Gujarat where the financial rewards for surrogate mothers are very attractive. Vasanti, who agreed to become a surrogate mother for a Japanese couple at Akanksha Infertility Clinic, received 8,000 USD in instalments. Her husband’s monthly income is about 40 USD, so the money earned from becoming a surrogate mother is a vast sum. Women say they become surrogate mothers
because their families are in distress so they are doing nothing wrong. Most of them say that they want to give their children a good education. After becoming a surrogate mother, Vasanti lives in a newly constructed house with her family, and her children go to English medium schools. She says she became a surrogate mother because she did not want her daughter to become one (Wallis 2013). By going to an English medium school, her children will have more educational, employment and marital opportunities and will be socio-economically better off. Health insurance is not readily available or well organized in India, so it is not only poor lower class women who become surrogate mothers out of necessity. Middle class white-collar working women also become surrogate mothers to pay for expensive medical fees for their family members (Bailey 2011: 719).

By becoming surrogate mothers, some lower class women in India are getting vast sums of money which they could not have dreamed of until recently. The positive aspects are that the women and their families’ livelihoods are ameliorated, and the women are able to invest in their children’s education and have more say in household affairs. But there are also negative aspects. As we have discussed, commercial surrogacy is socially stigmatized and surrogate mothers and their families must move to new places to live. They receive such a vast amount of money; they are spoken ill of or even ostracised by their old neighbours (Wallis 2013). Moreover, once they receive such a huge sum, it paves the way for further need in cash, and surrogate mothers are often pressurized by their husbands, families and relatives to undergo second or third surrogacy arrangements. Thus, there is no doubt that commercial surrogacy is giving rise to rapid social changes in India, but we cannot say that it is linked to women’s empowerment across the board.

I mentioned in the previous section that mother-child intimacy is constructed by the flow and exchange of substance-code according to the Indian notion of the body. Raveena, the surrogate mother, gives more emphasis to the sharing of substance-code between her and child and less importance to the biological/genetic mother-child relationship. This is contrary to the behaviour of the client Carolina asking the surrogate mother Sonal for breast milk to feed the baby. Carolina sees no problem in getting Sonal to extract her breast milk to feed it to the baby. From the modern Western point of view, breast milk is simply material and there is no significant difference between the breast milk of the birth mother and that of any other woman. However, from the Indian substance-code point of view, breast feeding by the birth mother inserts the substance-code of the birth mother into the baby and has a substantial impact on the formation of the baby’s body (Lambert 2000; Matsuo 2013a).

But we should also note that according to the same logic, once the baby’s body leaves the body of the surrogate mother after birth and grows up without being fed with her breast milk and her touch, the baby will not have any exchange or sharing of substance-code with the surrogate mother and their relatedness and intimacy will fade away. That is to say, a child born of a surrogacy arrangement is formed by an insertion of egg and sperm into the body-person of a surrogate mother, remains in her womb for nine months, after which it passes through and leaves her behind after birth. In this way, the mother-child intimacy of the surrogate mother and the baby in the womb can be seen as a temporary one or a mere passing phase.

The medical experts in the clinics explain the process to the surrogate mothers as follows. ‘Think of your pregnancy as having a guest in the spare room of your house. If you have a spare room in your house and a guest comes, you will do your best to treat the guest very well, won’t you? The guest will stay in the room for nine months and then leave’ (Matsuo 2013a: 41). Shimazono also points out from his fieldwork carried out in Delhi, Raipur, Kolkata and Hyderabad as follows. ‘In the practices of surrogacy, doctors, middle-persons, caretakers of surrogate mothers’ homes stress the image of the mothers’ body as a “temporary dwelling” for the children of others’ (Shimazono 2013). In India, it is normal to receive guests with the utmost hospitality, so it is not surprising that
Indian surrogate mothers treat the babies of the clients with special care.

Of course, for the surrogate mothers, giving birth by surrogacy arrangements may not differ experientially from giving birth to a child of their own. According to Hibino, the surrogate mothers all say that the process of pregnancy and childbirth in surrogacy arrangements does not differ at all from being pregnant and giving birth to their own children (Hibino 2013: 258). However, as long as the logic of receiving a foetus as a guest in a spare room of the womb, treating it with hospitality and sending it off, is an acceptable rhetoric for surrogacy, surrogacy arrangements will continue to increase in India. Based on her fieldwork in North India, Kalindi Vora points out that one of the conditions that makes the development of transnational surrogacy in India possible is the fact that in the process of surrogacy, surrogate mothers envisage their wombs as ‘empty space’ where a ‘guest fetus’ resides temporarily (Vora 2009a: 271; Vora 2009b).

Construction of new kinds of relatedness in surrogacy arrangements

Not all cases of commercial surrogacy in India end up with cutting off of relationship between the client and the surrogate mother. For example, thirty-year-old Rubina was a bank clerk in Kolkata when she found out about Dr. Naina Patel’s Akanksha Infertility Clinic in a television programme and decided to go to Anand (Haworth n.d.). Rubina has two sons and one of them has a heart problem so she needs a large sum of money for his medical treatment. Dr. Patel makes Rubina the surrogate mother for an American couple, Karen and Thomas. When Karen gets to know about Rubina’s pregnancy, she phones her every week from the US and asks how the baby is doing. Karen pays the surrogacy fees and also rents a two-bedroom flat for Rubina and her family, hires a cleaner for them, and sends gifts of clothes for Rubina and toys for her sons. Karen goes to India five weeks before the baby is due to be born to spend time in the flat with Rubina. Rubina says that she and Karen have become like sisters. Rubina gives birth to a boy at Dr. Patel’s clinic. Karen says she first thought of having a surrogacy arrangement in her own country, the US, but she did not quite get along with the surrogate mother candidates. Instead, she is attracted by the kindness and sincerity of Rubina and the clinic staff. Since she is a Buddhist, Karen feels closer to India because she thinks the people there share her beliefs about reincarnation. After Rubina gives birth to a boy, Karen starts arranging for another surrogacy in India for a second child in India. She is angered by comments that surrogacy in India is a cheap and easy option. She says having a surrogacy arrangement in India is by no means easy since she suffered enormously from the heat and mosquitos during her stay there. She was also constantly worried about the health of Rubina and the baby, and says one must be very keen and resolute to have a surrogacy arrangement in India. Karen e-mails a photograph of the son every week and plans to invite Rubina to her house in the US for his first birthday. She says she hopes that the son will maintain a relationship with the mother who gave birth to him (Haworth n.d.).

There are other cases where the client and the surrogate mother continue their relationship from the time of pregnancy to after the birth. Raveena, mentioned above, says that her client Anne came to India when Raveena was eight months pregnant and spent two months with her together like a family. They keep in touch frequently even after Anne returned to the US, and Raveena treasures the white gold and diamond earrings which Anne gave her as a token of their friendship. Raveena is certain that the friendship between her and Anne is a long lasting one, and Anne and her husband will take care of the health and education of Raveena’s son whom she gave birth to before becoming a surrogate mother (Pande 2009a: 388).

Of course, it is by no means certain that the relationship between the client and the surrogate mother will be long lasting. But the expectations of surrogate mothers are large. Pande points out that there is a great element of hopeful imagination on the part of surrogate mothers regarding the continuation of
relationships between them (Ibid.). Since the relationships cross borders of class and nations, their continuation requires effort by both parties concerned. However, what is certain is that a new kind of relatedness is being constructed as the clients give gifts to the surrogate mothers, send them remittances, converse with them over the telephone, send them photographs of the baby, and the surrogate mothers accept them and return their affection. The flow of substance-codes in the form of gifts, remittances and photographs, and exchange of substance-codes through telephone conversations and other forms of communication lead to creation of intimacy between surrogate mothers and clients.

In this process, surrogate mothers as well as the clients are agents of social change as they construct intimate relationships across borders of class, race, and nation states. If the parties come to a mutual agreement, the relationship may become a lasting one. At the same time, however, we should note that the surrogate mothers and their families are often ostracized by their relatives and local communities due to the vast amount of money gained from surrogacy. Thus, the introduction of new reproductive technologies leads to both the construction of new relationships and the breakdown of pre-existing social relations.

**Conclusion: Beyond the ‘baby factory’**

In this paper, I tried to show how commercial surrogacy is transforming mother-child intimacy in India today by discussing how the indigenous notions of the body and human reproduction unfold in relationships involving both commoditization and intimacy in practices of new reproductive technologies.

I pointed out that the Western clients value biological/genetic ties with the child whereas the Indian surrogate mothers devalue these ties and emphasize a mother-child intimacy based on substance-code exchange. In fact, Western clients have severe anxieties about not being able to bond with their children born from surrogacy arrangements and forming mother-child intimacy, even though they are genetically linked to the offspring (Tainton 2013).

The ideal of the modern nuclear family based on biological ties, established from around the mid-nineteenth century to the mid-twentieth century, is being questioned in the twenty-first century, the age of bioscience and technology. Until the twentieth century, the biological base of human reproduction was taken for granted as ‘natural’ and mother-child intimacy was also taken for granted as something natural. But with the intervention of bioscientific technology, the biological basis of mother-child intimacy has broken down, as there are now three possible types of mothers, namely the mother who provides the egg (genetic mother), the mother who gives birth to the child (birth mother), and the mother who brings up the child (social mother, the client in the case of commercial surrogacy).

The new kinds of mother-child intimacy contain the possibilities of opening up new visions of the world. Of course, it is important to point out how transnational commercial surrogacy is exploiting women of the Global South in increasingly invasive ways. In the past, the relationship between so-called ‘developed’ and ‘developing’ countries involved the former exploiting the latter in economic trade and political domination. But today, due to the rapidly growing cases of transnational commercial surrogacy, people from economically rich and politically powerful countries are becoming directly linked to people from economically poor and politically less powerful countries in deeply personal ways. In other words, the relationship between the so-called first and third worlds is no longer contained within the public sphere of the market and governance, and is spilling over into the more private sphere of human reproduction, family and mother-child intimacy.

Needless to say, there are cases where the cash transaction results in cutting off of the bond between the surrogate mother and the child; but the mother-child intimacy cannot simply be waved away by the client handing over money to the surrogate mother, no matter how large the sum may be. A person born from
a surrogacy arrangement may want to find out who his/her birth mother is when he/she grows up and finds out about it. We hear many cases in the Global North where a child born from donated sperm tries to locate his/her father.

The kind of relationship constructed between the surrogate mother and child differs from case to case according to the wishes of the clients and the surrogate mothers themselves. The construction of intimate relationships between people that are cross-border or transnational inevitably expands their awareness of the world with its differences in class, race, nationality, culture and so on, resulting in more profound forms of cultural exchange. It is indeed possible that a new vision of the family, life and the world will result from such new interaction between persons of the Global North and the Global South as they come together in surrogacy arrangements and create new kinds of mother-child intimacy that go beyond the ‘baby factory.’

References


Shimazono, Y. (2013) “Indo ni okeru dairi kaitai to seimei rinri no jinruigaku: Kolkata to Hyderabad no chosa kara (Surrogacy in India and the Anthropology of Ethics in the Life Sciences: Analysis of Fieldwork Data from Kolkata and Hyderabad).” Presentation at Global Collaboration Center (GLOCOL) Faculty Development Seminar, 19 November 2013.


NOTES

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2 The rapid increase in commercial surrogacy in India may also be due to the fact that amongst countries in Asia it is only openly permitted in India and Thailand.

3 It is possible that the accounts from Anand are exceptions rather than the norm in surrogacy practices in India, since they have been so widely reported by journalists and researchers due to Dr. Patel’s campaigns and public relations activities. Since I have relied on secondary sources, the surrogate mothers taken up in this article have already been selected as ‘interesting’ cases that are easy to analyse by previous writers on the topic. In order to consider the significance of ‘substance-code’ analysis more rigorously, I need to conduct a comparative analysis of surrogacy practices in other countries. I also need to conduct extensive fieldwork among non-Hindus in India to find out whether or not the notion of substance-code is applicable.