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Poverty and Commercial Surrogacy in India: An Intersectional Analytical Approach

Sheela Suryanarayanan
University of Hyderabad, India, sheelas@uohyd.ac.in

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Abstract

The destination and source countries for commercial surrogacy match world patterns of inequality. India, Nepal, Thailand, Mexico, and Cambodia banned commercial surrogacy, moving the market to other less-developed countries in South Africa and South America. India had a commercial surrogacy boom until exploitative factors led to the passage of the Surrogacy (Regulation) Bill in 2019, which banned the practice. This paper examines surrogacy's monetary, health, and emotional effects on 45 surrogate mothers in Gujarat State, India. The study revealed that a majority (63%) of the very poor women remained very poor post-surgery. Surrogate mothers in poor households had to do at least two surrogacies to be able to buy a property. After surrogacy, some poor households (16%) slipped deeper into poverty and became destitute. The physical effects of surrogacy on the women's bodies were multiple. One-third of the very poor women's health was severely affected. All surrogate mothers reported emotional problems post-surrogacy, and their family members experienced them as well. The poorest of the poor suffered the worst physical effects of surrogacy. This study reveals that the assumption that surrogacy provides income for the very poor surrogate mothers is false.

Keywords

India, commercial surrogacy, women, family health, financial, emotional, well-being, poverty

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POVERTY AND COMMERCIAL SURROGACY IN INDIA: AN INTERSECTIONAL ANALYTICAL APPROACH

Sheela Suryanarayanan
University of Hyderabad, India

ABSTRACT

The destination and source countries for commercial surrogacy match world patterns of inequality. India, Nepal, Thailand, Mexico, and Cambodia banned commercial surrogacy, moving the market to other less-developed countries in South Africa and South America. India had a commercial surrogacy boom until exploitative factors led to the passage of the Surrogacy (Regulation) Bill in 2019, which banned the practice. This paper examines surrogacy's monetary, health, and emotional effects on 45 surrogate mothers in Gujarat State, India. The study revealed that a majority (63%) of the very poor women remained very poor post-surgery. Surrogate mothers in poor households had to do at least two surrogacies to be able to buy a property. After surrogacy, some poor households (16%) slipped deeper into poverty and became destitute. The physical effects of surrogacy on the women's bodies were multiple. One-third of the very poor women's health was severely affected. All surrogate mothers reported emotional problems post-surrogacy, and their family members experienced them as well. The poorest of the poor suffered the worst physical effects of surrogacy. This study reveals that the assumption that surrogacy provides income for the very poor surrogate mothers is false.

KEYWORDS

India, surrogacy, post-surrogacy, women, family, health, financial, emotional, well-being, poverty

FEMINISTS HAVE LONG CAUTIONED that the commercial surrogacy market would move to the poorer countries in the third world, as women would be willing to do it for a lesser cost (Corea, 1985; Andrea Dworkin, 1983). A study mapping the transnational surrogacy markets found that the demand of intended parents from developed countries led to the surrogacy business in South and Southeast Asia (Attawet, 2021). Attawet (2021) concluded that since India, Nepal, Thailand, Mexico, and Cambodia had prohibited commercial surrogacy, the surrogacy market moved to other developing countries in South and Southeast Asia without regulations or restrictions. The markets also moved to developing countries in South America, Africa, and Eastern Europe, Laos, Malaysia, Argentina, Columbia, Kenya, Nigeria, South Africa, Georgia, Iran, and Dubai (Ahmad et al., 2016; Gerin, 2017; Lin et al., 2015; Pereanez et al., 2018). This global movement of the surrogacy market demonstrates a post-colonial pattern of global inequalities.

Andrea Dworkin (1983) envisioned how women from poorer countries would be breeders in what she called reproductive brothels. Strict rules and surveillance imposed on surrogate mothers in the surrogate hostels in India have limited their au-

tonomy and impinge on their emotional well-being (Nayak, 2014). Lozanski and Shankar (2019) examined how the surrogate mother's body in Ukraine and Mexico becomes a site of racialised body space through intervention to manage risks. This racialised body market treats women's "body space" as "risky," "polluting," and "discardable." Women of higher caste and fairer skin were paid more for the surrogacy. Intended parents also demand surrogate mothers of a specific religion, making them specifically bio-available (SAMA 2012). Intended parents from the Middle East region accessing surrogacy in India demanded Muslim surrogate mothers (Suryanarayanan, 2022). Some demanded "chubby" over "skinny" women. Intended parents demanded Christian surrogate mothers from countries abroad, such as Australia, America, and the U.K. (Suryanarayanan, 2022). These demands reduce women's bodies in the Global South to a racialised, risk-prone, easily interchangeable commodity. Previous studies have also noted the unequal positions of the participants in the transnational commercial surrogacy exchange—the elite doctors and intended parents compared to the less educated, low-income class of women from the Global South who provide their reproductive capacity in return for money. Transnational commercial surrogacy is a new iteration of cost-effective outsourcing (Hochschild, 2012; Winddance-Twine, 2013).

Surrogate mothers in India are known to have lower levels of education with fewer alternative employment opportunities, which gives them less of a voice in their experience (Saravanan, 2018; Pande, 2014). Pande (2010) noted that less education reduces the bargaining capacity of surrogate mothers. The surrogate mothers have no say on the number of embryos implanted in their womb, the termination of a pregnancy, their detainment during the surrogacy process, their lifestyle during pregnancy, the interventions during delivery, or the post-birth breastfeeding or nanny care requirements expected by the intended parents (SAMA, 2012, Saravanan, 2018). Further, women could not read the contract drafted in English or retain a copy, leaving them without any proof of the arrangement, making them unshielded to fight a case or go against the clinic. Kabeer (2005) reminds readers that three women's empowering resources—education, employment, and political participation—are essential for women's equality. According to Kabeer (2005), education helps to provide women with access to knowledge, information, and new ideas that are required to question, reflect upon, and act on the detrimental effects of the structures of patriarchy in their lives. Education up to at least the secondary level is required for health care and knowledge changes (Kabeer, 2005). Education helps women to focus on their well-being along with their families.

According to Kabeer (2005), poverty-driven choices result in dependence on powerful others and rule out meaningful agency. Poverty intensifies women's inequalities and is experienced differently and more intensely by women than men (UNWomen, 2018). Most women sign a dependency-prone, power-laden surrogacy contract just for monetary gain, which puts them in a vulnerable situation during the surrogacy. The studies that insist that working-class women participate in surrogacy have not defined poverty effectively in their research. For example, Rozee (2019) took a benchmark of 2 USD or less household income per day to determine that the surrogate mothers were not "very poor." However, the household in India confounds the definitional problem. Using only income levels to define poverty is problematic. In case of indebtedness, sickness, disability, alcoholism, death, or marriage in the household, property ownership acts as a shield protecting households from slipping into abject poverty. Rudrappa (2015) refers to surrogate mothers as working-class women but

has not defined their households according to poverty parameters. Poverty and working class are not mutually exclusive categories. Her work assumes that all working-class women are not very poor, which can be misleading. Similarly, Pande (2014) describes poor women as surrogate mothers but does not define poverty.

Some scholars argue that surrogacy is a means of income that allows poor households to improve their monetary status (Rozée et al., 2018; Pande, 2010; Rudrappa & Collins, 2015). Pande (2010) notes that one surrogate pregnancy equals five years of income for many poor Indian women. Pande (2010) also suggests that surrogacy is another form of labour, an extension of employment, such as factory work or other work in Gujarat. She argues that the money, although seemingly a small amount of Rs 3 to 4 lakhs, is used for important household needs such as buying a house, educating the children, or medical treatment (C.S.R. 2010).

Surrogacy is a risky practice. Woo et al. (2017) reported that surrogacy pregnancies carry higher obstetric complications than normal pregnancies. They examined data from women with two different pregnancy experiences: one with their own child and the other through IVF surrogacy. Their results revealed a comparatively higher likelihood of caesarean section, gestational diabetes, hypertension, and placenta previa in surrogacy pregnancies. Surrogacy pregnancies also had higher use of amniocentesis and the requirement of antibiotics during labour (Woo et al., 2017). According to National Family Health Survey (NFHS)-5 data, women in lower-income groups experience higher mortality and morbidity in India (International Institute for Population Studies, 2021). Hence, it is crucial to examine women's health status after surrogacy.

A comparison of surrogate versus non-surrogate mothers during the prenatal and postnatal stages in India revealed higher levels of depression in the former. Hochschild (2015) observes in her study how women in India somehow managed their emotional turmoil due to their financial needs. Depression was exacerbated by the exploitative conditions within the surrogacy process, exposure to social humiliation, anticipation of stigma, or insufficient support during pregnancy (Lamba, 2018). Consequently, surrogate mothers hid their surrogacy from their social circle for fear of social ostracization and criticism from kin members and the wider community (Karandikar et al., 2014; SAMA, 2012). The absence of a relationship with the intended parents also caused adverse long-term psychological repercussions on the surrogate mothers in return for short-term financial gains (Lamba, 2018).

Taking poverty as the primary analytical axis of women's inequalities, this paper examines the intersectionality of household indebtedness and alcoholism as well as the economic, health and emotional effects of surrogacy on 45 surrogate mothers in Ahmedabad, Anand, and Nadiad in the Gujarat State of India in 2019. The research assesses the health and emotional effects of surrogacy through self-assessment made by surrogate mothers. Self-assessed health indicators are frequently used to examine health inequalities and health care needs (Smith & Goldman 2011). This paper defines poverty based on household income levels, consistency of income and property ownership to assess the monetary effect of surrogacy. A household includes all the people who occupy a housing unit.

METHODS

A snowball sampling method was applied to contact surrogate mothers. The surrogate mothers warned me that it was dangerous to approach the clinics since they were familiar with my work. The first point of contact was a few surrogate mothers

the researcher had known earlier from a previous surrogacy study in Gujarat. These surrogate mothers spoke to the surrogate mothers at various locations in Nadiad, Anand, and Ahmedabad. First, I got their consent over the telephone and asked for permission to visit them and their convenient place of interview. Some surrogate mothers came to meet the author because they were worried about social stigma, while others permitted me to visit their home. Some surrogate mothers gave time and place to visit at their workplace. I informed them of the confidentiality and anonymity of the study. I informed them that they could stop the interview anything they wanted. The women were compensated for the interview with Rs 500. Since I visited most of them in their homes, I took gifts and fruit for their families.

The interviews lasted 25 to 60 minutes based on how much the surrogate mothers shared about their life experiences. The questionnaire was primarily designed by the French and European Observatory for Non-Discrimination and Fundamental Rights (EONDFR). The questionnaire was translated into the Gujarati and Hindi languages. Surrogate mothers who could read and write signed consent forms, while for the other unlettered women, the researcher read out the purpose of the study and oral consent was taken. Care was taken not to probe into issues the surrogate mothers did not want to discuss. Pseudonyms have been used to maintain the confidentiality of the participants.

The major themes covered in the interview were: 1. violation of medical ethics; 2. illegal surrogacy practices; 3. the surrogate mother's socio-economic background; 4. details regarding the surrogacy; 5. motivation to do surrogacy; 6. agency and decision making (decision making to do surrogacy, selection criteria, surrogacy contract); 7. medical aspects; 8. relationship with a) the child(ren) born through surrogacy, b) the commissioning parents and c) the clinic; 9. the psychological; 10. physical; 11. the financial effect of surrogacy on their life; 12. judicial aspects of surrogacy; and 13. their fundamental rights. A structured questionnaire on the topics mentioned above was prepared. The questionnaire covered all these questions. This paper primarily examines the emotional, physical, and financial effects of surrogacy and the intersectionality of poverty, as well as the number of completed surrogacies. Some of the themes during the interviews, which were not included in the questionnaire, were the effect of the surrogate mother's children, alcoholism, indebtedness, and loans.

INTERSECTIONALITY AS AN ANALYTICAL APPROACH

Intersectionality, as a concept coined by Kimberlé Williams Crenshaw (1991), a prominent scholar of the critical race theory, addresses the gaps in understanding the experience of women of colour. As an advocate of legal rights for blacks in the United States of America, Crenshaw found that within legal categories, black women's cases were being closed or ended inadequately without taking into account their specific experiences, giving rise to inherent discrimination. Intersectionality became the acknowledged framework for understanding multiple dimensions of gendered marginalities and discrimination. It has been applied as a framework to understand how relationships between social and economic categories and systems of oppression combine to produce marginalising effects.

Intersectionality is often enmeshed and synonymous with social identities (McCall, 2005; Collins, 1990). Loretta, 2017) explains that intersectionality does not merely enumerate diverse identities but can bring forth multiple forms of oppression. By reducing intersectionality to identity analysis, researchers risk losing intersectional characteristics and factors that may be significant markers of marginalisation.

To understand the complexities of the marginalised, it is important to look at identities and beyond. For instance, educational attainment, employment, property ownership, indebtedness, and alcoholism are intersectional characteristics that play a role in further marginalising women within the poorest of the poor households. Dhawan, Varela, et al. (2016) recognise the applicability of intersectionality in outlining the different forms of discrimination that produce conjunctures of vulnerability and inequality.

Hankivsky (2014) specifies a broad set of questions relevant to applying intersectionality as an analytical approach throughout the research process. The research begins with identifying the study participants and who is being compared with whom; identifying relevant intersectional characteristics and factors would be the next step. Since intersectionality aims to analyse multiple forms of discrimination, the following step suggested is identifying issues of domination/exploitation and resistance/agency relevant to the research question. The data is analysed by examining commonalities and differences across intersectional categories and factors. Variations in experiences, viewpoints, and behaviours must be acknowledged within groups or categories.

In surrogacy, women's bodies are used primarily for their reproductive capacity, and most women become involved in surrogacy for monetary gains. Since these two are universally accepted facts about surrogacy, the paper takes the gender and household poverty of 45 surrogate mothers as the primary focus of the analysis. The study was conducted in Gujarat, the most popular location for surrogacy in India, which also has surrogate homes (hostels). The paper draws on Hankivsky's (2014) analytical framework of intersectionality, taking gender and poverty as the primary axis to examine the multi-level socio-economic and emotional intersections that affect surrogate mother's experience of surrogacy in India.

The 45 households have been divided into three income-poverty categories: 1) "land/house owners" or "not so poor" households that own land and/or house ownership as well as have a consistent, sustainable income flow into the household; 2) "poor" are households that have a consistent flow of income but do not own any house or land; and 3) "very poor" or "poorest;" neither have a sustainable or consistent flow of income in the household nor do they own any land or house. Comparisons will be made primarily between these three groups with multi-level categories and factors. The areas of vulnerability intersecting with poverty included employment status, alcoholism, indebtedness, and the health, financial, and emotional effects post-surrogacy.

Semi-structured interviews were conducted with 45 surrogate mothers who had completed 63 surrogacies and had given birth to 90 babies in Anand, Nadiad and Ahmedabad in Gujarat. Semi-structured interviews define the broad topics and allow space for interviewers to guide respondents into issues that are more significant and relevant to their lived experience. The process resembles a flowing conversation rather than a restrictive question-answer session (Rubin & Rubin, 2005; Choak, 2013). The questionnaire focused on in-depth conversations on surrogacy experiences, basic background individual and household information on socio-economic and household status.

Most interviews occurred in the surrogate mother's house at various urban and rural locations in Nadiad, Anand, and Ahmedabad. Interviews also occurred at their

workplace, in a car outside their workplace, or wherever they felt comfortable speaking. The quantitative responses of the questionnaire were coded, formulated into tables, and the intersections of factors were derived using simple tabulations.

FINDINGS

The findings of the study include: the characteristics of surrogate mothers (education, employment); the surrogacy characteristics (source country of intended parents; surrogate mother's household level of poverty; post-surrogacy changes in income level by classes; indebtedness and loans; income levels and employment status of surrogate mothers; alcoholism; and emotional, physical (health) and monetary effects of surrogacy on the surrogate mothers and their household.

ESSENTIAL CHARACTERISTICS OF THE SURROGACY PRACTICE IN INDIA

The 45 surrogate mothers had been involved in 63 surrogacies and had given away 90 babies to their intended parents. Of the 63 surrogacies, 26 intended parents (41%) were from abroad, and the same proportion were from within India. Another 10 (16%) were N.R.I.s (Non-resident Indians). A more significant proportion (57%) of the intended parents were from abroad: the Middle East, Canada, Europe, U.S.A. and one each from Bangladesh and Nigeria and non-resident Indians.

Among the 45 surrogate mothers interviewed, most (38%) had never attended school or completed only elementary schooling, and one-third had completed middle school. Only 15% of the surrogate mothers had finished high school, and 13% had some higher secondary school. Only 28% of the surrogate mothers had completed Higher Secondary Schooling.

More than one-third (37%) of the surrogate mothers (17/45) were "homemakers," and others were involved in informal work (63%). Some women entered the body market business as ova donors, in drug trials and as surrogacy agents, but this did not provide a consistent income flow despite deteriorating health. Women were primarily employed in the informal sector due to insufficient levels of education, rendering them vulnerable as surrogate mothers.

POVERTY AS THE PRIMARY INTERSECTIONAL AXIS

Almost one-fourth (11 of 45 or 24%) of the surrogate mothers were from "very poor" households.

A large proportion of the women were from "poor" households (19 of 45 or 42%), and one-third were land/house owners (15 of 45 or 33%) (Table 1). All 45 surrogate mothers said they entered surrogacy for monetary gains.

Most (7 of 11 or 64%) of the "very poor" women had slipped deeper into poverty post-surrogacy. The three "very poor" women (Madhuri-1[1], Kinjal-4 and Nitya-2) who managed to improve their household monetary situation post-surrogacy had to repeat surrogacy twice or even three times (Table 6). Half (52.63%) of the "poor" households managed to buy a property after surrogacy. Half of the "poor" households who could buy land/house post-surrogacy (5 out of 10) had to repeat surrogacy to do so.

[1] The number given along with each surrogate mother refers to the serial numbers in Table 6.

Table 1: Number/Percentage of Households by Income Levels

Household income	Number of House-holds	Percentage of House-holds	Definition
Very Poor	11	24.4%	no consistent income and no land or house ownership
Poor	19	42.2%	a consistent flow of money but no house or land ownership
Land/house owners	15	33.3%	land/house owners
Total Households	45	100%	

Some of the "poor" households became "very poor" (16%) post-surrogacy (Gracy-12, Mariam-20 and Neelam-27) (Table 6). Almost all the land/house owners (93.33%) became richer. The "poor" and "very poor" could enhance their monetary situation mainly by repeating surrogacy.

A large proportion of the "very poor" households (64%) remained very poor after surrogacy (7/11). (Table 2). All four "very poor" households that gained upward mobility monetarily had repeated surrogacies. The bulk of the money the "very poor" received after the first surrogacy was spent rapidly on buying consumer items such as a T.V., a refrigerator, and furniture, and hardly any money was saved. Circumstances then forced the women to repeat surrogacy, and these households managed to enhance their monetary situation.

Table 2: Post-Surrogacy Movement between Income Classes

Pre-surrogacy	Very Poor	Poor	Land/ House Owners	Total House-holds	Monetary Situation Improved Post-Surrogacy
Number of Households	11 (24.4%)	19 (42.22%)	15 (33.33%)	45 (100)	30 (62.22%)
Change in household monetary situation post-surrogacy					
Very Poor	7 (63.6%)	3 (15.78%)	0	10 (22%)	4 (36.4%)
Poor	2 (18.18%)	6 (31.57%)	1 (6.67%)	9 (20%)	9 (52.6%)
Land/House owners	2 (18.18%)	10 (52.63%)	14 (93.33%)	26 (58%)	14 (93.3%)
Total House-holds	11	19	15	45	30 (62.22%)

Half of the "poor" households (52.6%) bought property post-surrogacy. Among the 19 "poor" households, three (16%) slipped deeper into poverty, while ten households (53%) managed to buy a property. It mainly was the more stable property-owning households (93.3%) who benefited post-surrogacy. Primarily, surrogacy has not benefited the "very poor" in the sample. All four very poor households that gained upward mobility had to repeat surrogacy (Table 3). Half of the women from "poor" households who could buy a property (5 out of 10) had repeated surrogacy.

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Table 3: Number of Surrogacies by Household Income Level and Change in Household Monetary Situation Post-Surrogacy

Household Income	Number of Surrogacies			Total Number of Households	Monetary Situation Improved Post-Surrogacy
	3	2	1		
Very Poor	1 (9.09)	4 (36.36)	6 (54.55)	11 (100)	4 (36.4%)
Poor	-	5 (26.32)	14 (73.68)	19 (100)	10 (52.6%)
Land/house owners	-	7 (46.66)	8 (53.33)	15 (100)	14 (93.3%)
Total Surrogacies/ Households	1 (2.22)	16 (35.56)	28 (62.22)	45 (100)	30 (62.22%)

INDEBTEDNESS AND LOANS

Indebtedness and loans were an issue during the interviews: Ten women spoke about indebtedness, and eight spoke about loans. Out of the 10, three were "very poor," 5 were "poor," and two were "property owners." Indebtedness increased among all three "very poor" households after surrogacy and two of the four "poor" households. Some of the women from "poor" (3) and "property-owning'" (2) households got involved with surrogacy to clear household debts. Only two of the ten indebted families improved their income levels through surrogacy, and both surrogate mothers had to repeat surrogacy to do it.

- **Banu (3)** was "very poor" pre-surrogacy and built a house after three surrogacies. She repeated surrogacy because they had to get a loan post-surrogacy (Table 7). After seeing a bulk of easy money, her husband got into a habit of taking loans post-surrogacy. Money lenders started coming to her doorstep asking for their money. She went for egg donation whenever she fell short of money to repay lenders.
- **Kinjal (6)** was "very poor" pre-surrogacy; she repeated surrogacy because they got loans after her first surrogacy. The surrogacy money was all spent.
- **Saaba (11)** was "very poor" and slipped deeper into abject poverty post-surrogacy. They bought a house that cost more than she had earned through surrogacy. They got an extra loan to pay for the house. Her mother-in-law fell sick, and they sank into debt. They had to sell the house, lost all the money, and lived in a shack along a railway line in Anand.
- **Gracy (12)** was "poor" before surrogacy and gave all her surrogacy money to an agent to obtain a work visa to Israel. She got an additional loan of Rs 5 lakhs, and the agent turned out to be a fraud. She was "poor" before surrogacy and became "very poor" post-surrogacy. She started to consider surrogacy a sinful practice.
- **Nargisa (14)** was "poor" and bought a house post-surrogacy. But the surrogacy money was spent, and her husband started getting loans. They had to sell the house they had bought. After enjoying quick money, the husband refuses to work hard for lesser

returns. Nargisa refused to repeat the surrogacy or donate eggs, so they became "very poor." "It's one of the worst times," she said.

- **Gayatri (16)** was a traffic guard and had a surrogacy to repay the loan her husband obtained for his sister's dowry, and he also had losses in his business. She repeated surrogacies to save money for her daughter's education. Gayatri's (61) household was "poor", and she became a "house owner" after the second surrogacy.
- **Radha (19)** was "poor" and had a surrogacy to release the land her in-laws had kept on lease. She repeated a surrogacy to pay back the loan her in-laws had taken for her marriage. She now bought a house but said, "My life is over. I have become weak after two surrogacies, but I sacrificed my life for the sake of my children."
- **Bairavi (26)** was "poor" and remained "poor" post-surrogacy. She had a surrogacy to repay a loan taken by her husband for buying an auto-rickshaw and repaid it successfully.
- **Gomati's (37)** household were "land owners" but decided on r surrogacy to repay family debts.
- **Padma's (38)** household owned a house but had family debts, so she went for surrogacy to pay off the debts. She was not in the labour force before surrogacy but began working as an old age carer post-surrogacy for want of a consistent income flow.

INCOME LEVEL AND EMPLOYMENT STATUS PRE- AND POST-SURROGACY

Most surrogate mothers had an overall reduced work capacity after surrogacy. The surrogate mothers employed mainly worked in labour-intensive jobs such as agricultural labourers, care workers, cooks, caterers, domestic helpers, cleaners or nurses in hospitals, traffic guards, and brick factory workers. The land/house-owning women moved out of the labour force as their monetary situation improved. The "very poor" and "poor women" who moved into paid labour post-surrogacy did so because their financial condition had deteriorated post-surrogacy. Some "very poor" and "poor" women who were not employed in the paid labour force had to seek post-surrogacy employment even if their health didn't permit it because their monetary status had worsened. Some women (4 of 45) became involved in the body market (egg donation or surrogacy agent) post-surrogacy. Nargisa (6), Yameena (10), Saaba (11), Gracy (12), and Neelam (27) remained at home before surrogacy, but since their financial situation worsened, they started working, despite deteriorated health. Some were at home before and stayed out of the paid workforce post-surrogacy despite a worsened financial condition due to health factors.

ALCOHOLISM

Only severe cases of alcoholism were shared by the surrogate mothers. Madhuri (1) had three surrogacies because her husband was a drunkard, and the family had no sustainable income. Her family situation improved from "very poor" to "poor." After three surrogacies, she could not buy a property, and her household remained "poor." Since she has started working in an N.G.O., the family has some subsistent income. Shruti (36) owned a house in rural Gujarat but had no sustainable income since her husband was an alcoholic. With the surrogacy money, she bought an auto-rickshaw, and they sustained an income. Madeeha (28) had a drunkard husband, and she bought a house with the surrogacy money and earned a living with a tailoring machine.

Similarly, Rabeena (29) was able to buy a sewing machine and a house and has been able to earn a living post-surrogacy. Madeeha and Rabeena purchased a lower-price apartment in a Muslim-dominated locality in Ahmedabad. These four women whose husbands were alcoholics have enhanced their life post-surrogacy.

However, Mercy's (5) husband started drinking after she went to the surrogate home. He eventually died, and she lost her previous job. She's unable to work because her health deteriorated after one surrogacy. She dipped into abject poverty post-surrogacy. Sriya (7), 44 years of age, was "very poor' before surrogacy and remained "very poor" post-surrogacy. Her drunkard husband persuaded her to become involved in surrogacy. He died 15 days before the interview. Mariam (20 years of age) was poor and became "very poor" post-surrogacy. Her husband was a drunkard, had been ill for some time, and died a few days after the interview. Padma's (38 years of age) husband is an alcoholic. She paid all debts, repaired the house with the surrogacy money, and worked as an elderly carer for a sustained income.

Both Sriya and Mariam are living in abject poverty with no sustainable income. According to Sriya (7), men start drinking after the birth of a child, especially a boy child. "The men think, now where will the wife go, then they start drinking?" Her capacity to work had reduced after surrogacy and the caesarean operation. Yet, she works as a housemaid since her son remained sick. She wanted to buy a house with the surrogacy money (Rs 3 lakhs), but the money was insufficient. Four of the nine women managed to enhance their life that was ruined due to their husband's alcoholism. However, the other five women faced extreme financial crises despite surrogacy.

EFFECTS ON SURROGATE MOTHER'S PHYSICAL HEALTH POST-SURROGACY

Surrogate mothers described the physical effect of surrogacy as an inability to work like before, physical pain, adverse effects of hormones and medicine, increased morbidity and near-death situations. All women said their physical capacity to work had considerably reduced post-surrogacy due to the excessive medication, hormone treatment and unwanted medical interventions such as foetal reduction and caesareans. Most women described the entire surrogacy process as very painful, exploitative, and intrusive to their bodies. It is the "very poor" women who have experienced severe physical effects of surrogacy (36%) as compared to the "poor" (21%) and "land/house owners" (20%) (Table 4). Many surrogate mothers said they continued experiencing pain due to the hormone injections. Others confided they had experienced extreme pain and bodily intrusion during the surrogacy pregnancy compared to their regular pregnancy. They described the embryo transfer period as intrusive, painful, harsh, and dreadful. Some of them were tied down during the procedure. "Over-medicalisation" with hormone injections, medicines, and invasive technologies such as ultrasounds, in-utero sex-selective abortions, and cervical cerclage caused several health problems for the surrogate mothers.

Table 4: Physical (Health) Effects Post-Surrogacy by Income Levels Before Surrogacy

Effect	Physical Effect			
Income levels	**No Effect**	**Effects**	**Serious Effects**	**Total**
Very Poor	4 (36.4)	3 (27.3)	4 (36.4)	11
Poor	3 (15.8)	12 (63.2)	4 (21.1)	19
Land/house owners	6 (40.0)	6 (40.0)	3 (20.0)	15
Total	13 (28.9)	21 (46.7)	11 (24.4)	45

Gracy (12) described the surrogacy process as:

> Endless saga of medicines and injections. It is extremely risky with serious impact on the surrogate mother's physical health. All the medicines, medical interventions and injections are unbearable. My body exists only on the outside; from inside my body has become hollow. I can't work as I used to work before the surrogacy. I face so many physical problems now.

Most surrogate mothers experienced several other health problems. Gracy (12) developed thyroid-related problems post-surrogacy. Banu-3 developed high blood pressure. Mercy had meralgia paresthetica (tingling and burning pain) and numbness of the upper lateral thigh area, and numbness of her hand and legs post caesarean section. Kamini-40 developed high blood pressure and thyroid disorders. Ujwala-14, Nargisa-6 and Yameena-10 also developed high blood pressure during the surrogacy pregnancy, which remained afterwards. Sunita-18 and Kamini developed diabetes. Sarala-13 and Sunita-18 discussed other surrogate mothers who developed cancer and HIV post-surrogacy.

Ujwala was carrying three foetuses, two girls and one boy. She experienced severe bleeding after sex-selective foetal reduction of the girl foetus and ended up in the Intensive Care Unit. This procedure is known to carry the risk of a complete miscarriage, which is what happened. This was her second surrogacy, and she had conceived after four unsuccessful attempts. She received hardly any payment and felt exploited and betrayed. As a result of multiple surrogacies and a near-death surrogacy experience, Ujwala has lost her earlier capacity to work and remains at home.

Raksha (45) developed haemorrhages after delivery, and her uterus had to be removed. More than the pain during the pregnancy, she spoke about this near-death experience. Manjula (9) developed a fistula in her delivery post-surrogacy. Moreover, she slipped into abject poverty post-surrogacy, with very little support from the clinic or the other surrogate mothers. Some surrogate mothers said their financial situation became so disastrous that their physical pain seemed trivial. Surrogate mothers in this study faced various forms of obstetric complications, specifically attributed only to their surrogacy pregnancies, as found in previous studies (Woo et al., 2017).

Sarala witnessed a near-death experience with a surrogate mother whose uterus had to be removed during her delivery. Sarala mentioned that she was petrified during

her delivery. Gracy (12) had witnessed the death of a surrogate mother in the clinic while she was in the surrogate hostel and became very depressed.

> Sangeeta's image stayed in front of my mind all the while. Whenever I opened my room door, I saw her bed, and I could imagine Sangeeta sleeping on her bed and talking to me. I remember that always, even now.

Gracy was petrified that she would die, too. Furthermore, sex-selective in-utero abortions were performed on her. Again, one girl's foetus had been aborted, and she was very unhappy and uncomfortable with this procedure but had no say in the matter because she had signed a contract that said she would not question any medical procedures performed on her. She was heartbroken, couldn't eat properly, and her health deteriorated in the surrogate home.

EMOTIONAL EFFECTS OF SURROGACY BY INCOME LEVELS

Almost all women experienced emotional deterioration post-surrogacy. But it was the "very poor" women who were severely affected by surrogacy as compared to the "poor" and "Land/House owners." The reasons given by the surrogate mothers for their emotional deterioration were yearning for the child(ren), adverse health effects, staying away from their family at the surrogate hostels, financial reversal, having near-death experiences, or witnessing other women's near-death experiences.

BONDING WITH AND YEARNING FOR THE SURROGACY CHILD

All the surrogate mothers, except one, said that they felt an attachment to the babies, which was as much as they felt for their children. Almost all, except one, said that the attachment they formed with the surrogacy baby was like they experienced with their own child. Gracy didn't want to think or speak about the baby because surrogacy badly affected her son psychologically. Her son saw the baby and felt she had given away his brother because his mother could not care for him. He keeps asking her about this baby.

All the surrogate mothers expressed the helplessness of having no rights over their children. The common expressions were:

> What can we do? What rights do we have? What is the point of bonding (with the children)? I wonder how would they (the children) be looking now? What would they be doing now?

Some children were abruptly separated from their surrogate mothers after an extended time of bonding together. Some surrogate mothers were never able to see the faces of the babies; others saw them but were kept apart. Some surrogate mothers could only see the children through a glass wall but were not permitted to go near the children, touch, or hold them. Their duty was confined to providing breastmilk using pumps. All these surrogate mothers are experiencing the pangs of separation. Schurr and Militz (2018) note that the commodification of women's body space continues through the attachment that surrogate mothers feel for the child and their desire to be a part of their lives, regardless of whether it is commercial or altruistic surrogacy.

None of the surrogate mothers could maintain contact with the children except for one. All the surrogate mothers said they would want to know about the well-being of the babies. Some surrogate mothers argued that it is the right of the child to learn about their birth mothers. Other surrogate mothers questioned why their name was

not on the child's birth certificate since they were the birth mothers. One surrogate mother's child asked, "why the children were not allowed contact when my mother is their birth mother?" Overall, 95% of the surrogate mothers felt sad, nervous or depressed post-surrogacy often or very often.

Table 5: Emotional Effects Post-Surrogacy by Income Levels Before Surrogacy

Effect	Emotional Effects			
Income levels	**No Effect**	**Effects**	**Severe Effects**	**Total**
Very Poor	1 (9.1)	6 (54.5)	4 (36.4)	11
Poor	0 (0.0)	13 (68.4)	6 (31.6)	19
Land/house owners	1 (6.7)	10 (66.7)	4 (26.7)	15
Total	2 (4.4)	29 (64.4)	14 (31.1)	45

All the surrogate mothers reported being depressed when they left their families and children behind to stay in a surrogate hostel for almost a year. Ujwala's son was four years old when she moved into the surrogate home.

> I was very upset. I felt I should run away from there. Then, when my husband and son came and met me every Sunday, it became somewhat better.

Gracy, Ujwala and Razia experienced sex-selective foetal reduction. Gracy witnessed the death of a surrogate mother. Sarala witnessed a near-death situation. Many surrogate mothers had left their children behind at home to be looked after by someone else. Saadia and Gracy were breastfeeding their babies when they left their home for the surrogate hostel. They were given medicines to dry up their breast milk and then endured the trauma of being physically separated from their infants by being forced to move into the surrogate hostel.

A single mother, Kamala (age 21), had left her children with her brother and his wife. They harassed the children, who were angry with her for leaving them alone. Some women like Shruti (36) had to take their children out of school for one year to live with her at the surrogate hostel, as her alcoholic husband could not be trusted with the responsibility of child care. The fallout of enforced absence from home during surrogacy gave rise to deep feelings of guilt, sadness, and extremely adverse situations at home. Maria's husband started drinking and became an alcoholic, and her daughter eloped with a boy while she was at the surrogate hostel. She says she feels guilty about being unable to care for her family when her work requires her to remain out of home for months. Nitya's (2) husband fell in love with another woman while she was in the surrogate home. Similarly, Banu's (3) husband began having affairs since she left home for her first surrogacy. Some surrogate mothers became detached from their husbands and family after staying away for a long time.

DISCUSSION

Most intended parents were from developed countries and non-resident Indians living abroad. Hence, the transnational surrogacy market is characterised by post-colonialism and neo-colonisation of women's bodies. The lower educational attainment of surrogate mothers hampers their ability to understand the contract and make informed choices within surrogacy. Lower educational attainment adds to women's vulnerabilities in India as it reduces their employment opportunities.

The poverty level of the respondents indicates that most women who entered surrogacy contracts in the sample were "poor" or "very poor." Surrogate mothers of poor households had to complete at least two surrogacies to buy a property. Only the women from poor households who had repeated surrogacy twice could escape poverty. In contrast, those who did one surrogacy remained poor or even slipped deeper into poverty. Despite this, most "poor" or "very poor" surrogate mothers stopped at one surrogacy and did not repeat the process. Most surrogate mothers from very poor households remained very poor after the surrogacy. The assumption that surrogacy generates income for very poor surrogate mothers in India is not borne out in this sample.

Half of the poor households could buy property after surrogacy, but most had to repeat surrogacy to do so. However, some poor became very poor after surrogacy. Some property owners had to sell their property after surrogacy due to indebtedness. Overall, 62% households benefitted financially after surrogacy, but they were mostly the property owners (93%), followed by the poor (52%) and a few of the very poor (36%)

Surrogate mothers from poor households experiencing indebtedness could not clear their loans with surrogacy; the few with debts who repeated surrogacy could do so. Women had to repeat surrogacy because of their alcoholic husbands. The financial situation of alcoholism and indebtedness adversely affected the surrogate mother, the number of surrogacies she was involved in, and the monetary outcome of the surrogacy. Only two surrogate mothers, both of poor households and alcoholic husbands, could sustain their household after surrogacy; Madeeha (28) purchased a property and a sewing machine, and Shruti (36) bought an auto-rickshaw.

Physical effects on the women not only included diseases such as diabetes, paraesthesias, hypertension, cancer, blood pressure, thyroid, and H.I.V. but surrogate mothers also revealed the painful process of surrogacy, the effect of the hormone medications, the pain of the injections that remained years after the surrogacy, and the overall lack of capacity to work like before. Overall, the physical effects of surrogacy on the women's bodies were multiple. These physical effects were more severe among the very poor surrogate mothers.

All the surrogate mothers reported emotional effects post-surrogacy, and their family members also experienced emotional effects. Separation from their children caused severe emotional consequences. Some surrogate mothers had breastfed the babies; others had not informed their extended families about the surrogacy and suffered silently. One had not told her son about the surrogacy arrangement since he was too young to understand, and he kept asking about the child who was given away.

CONCLUSION

The poorest remained in abject poverty, while the "not so poor" households became richer post-surrogacy. The "very poor" benefitted financially only if they repeated surrogacy. The "very poor" suffered near-death experiences and serious health problems. Several women went into surrogacy or had to repeat surrogacy to repay household loans. The loans taken by "poor" and "very poor" households had increased post-surrogacy. The number of surrogacies was higher among the "poor."

Two women with alcoholic spouses benefitted from the surrogacy money. A few of the poorest surrogate mothers benefitted financially only after repeating surrogacy two or three times. All mothers were affected emotionally after surrogacy. Alcoholism and indebtedness occurred mainly among the poor and "poorest," which caused havoc in the households, driving women into surrogacy. Emotionally, all surrogate mothers were affected; however, the "very poor" were affected the most. Women missed their family and children at the surrogate hostel, experienced/witnessed frightful death or near-death incidents, and experienced unpleasant and risky medical intrusions such as in-utero sex-selective abortions. Women's household finances often worsened household, and they suffered more depression and prolonged periods of sadness. The "poorest" and "poor" women were adversely affected by surrogacy. They had financial declines, and their physical and emotional health suffered.

The fear that feminists (Corea, 1985; Dworkin, 1983) had that commercial surrogacy would move to poorer countries became true with the evident global inequalities in the pattern of the surrogacy markets. Dworkin (1983) imagined that poor women would be held in brothel-like situations under strict rules and surveillance, which was evident in my study's findings. Several surrogate mothers, Gracy, Ujwala, Razia, Madeeha, Shruti, Kamala, Maria, Nithya, Banu and many others, were subject to objectification inside the surrogate homes and their families were adversely affected in numerous ways. A few of the negative consequences were: children were ignored and mistreated by relatives; the death of husbands due to lack of care; husbands having affairs; children witnessed the physical and emotional trauma suffered by the baby and their mother when they were separated; increase in debts among the poor and very poor families; and slipping deeper into poverty and health issues.

Women were exploited because they could not read the surrogacy contract written in English, and they lacked alternative earning opportunities. During the pregnancies, they were forced into in-utero sex-selective abortions and subjected to medical interventions without their wishes. Rudrappa (2015), Rozee (2019) and Pande (2014) claim that poor families found surrogacy as an opportunity to improve their monetary situation, which is not the whole truth. Many women from very poor households just remained very poor post-surrogacy, and those who could come out of poverty had to repeat surrogacies and face its adverse effect on their health. The adverse health effects that Woo et al. found in their study were also evident in my research, with women facing multiple health problems and an inability to work like before. The poorest of the poor women bore the greatest brunt of the health effects post-surrogacy. Surrogacy cannot be considered just another form of labour, as Pande (2010) suggested, given its adverse effects on women's health and emotional state. Hochschild (2015), Karandikar (2014), and SAMA (2012) in their studies observed emotional turmoil among surrogate mothers, and my study corroborates the same findings.

Table 6: Socio-Economic Conditions of the Surrogate Mothers and the Surrogacy Characteristics

Sl. No	Name	Age in 2019	Edu	S.M.'s Earlier occ.	S.M.'s Present occ.	Husband's occ.	Reason for surrogacy	Year(s) of surrogacy	No. of surrogacies	No. of children born	Money in lakhs	Before Surrogacy	Post-Surrogacy	Reason fulfilled post-surrogacy	Financial Effects	Physical Effects	Emotional Effects
1	Madhuri	35	7	at home	Surrogate agent, egg donation, works in N.G.O.	Sack-making factory	No subsistence	2013, 2017, 2018	3	6	3.5, 3.5, 3.5	V Poor	Poor	agent, no subsistence	improved	no	yes
2	Nitya	35	0	building labourer	Garland maker	separated, remarried, drives auto-rickshaw	low income	2010, 2012	2	3	3.5, 3.5	V Poor	L/HO	built a house, husband runs auto shop	improved	yes	yes
3	Banu	32	8	at home	Garland maker	drives auto-rickshaw	husband in debt	2008, 2016	2	3	3, 4	V Poor	L/HO	built a house, rents a shop, husband runs auto shop but still in debt.	improved	yes	yes
4	Kinjal	33	9	at home	Garland maker	drives auto-rickshaw	low income	2014, 2017	2	4	3, 4	V Poor	Poor	husband runs an auto shop	improved	no	no
5	Mercy	45	5	nanny, cook in church	at home	passed away	low income	2009	1	2	2.4	V Poor	V Poor	no subsistence	worsened	yes	Yes serious
6	Nargisa	30	5	at home	housemaid	vegetable vendor	low income	2010	1	2	4	V Poor	V Poor	bought house, but sold it and slipped back into poverty	worsened	yes serious	Yes
7	Sriya	32	8	informal sector	housemaid	drunkard, passed away just 13 days ago	low income	2013	1	1	3	V Poor	V Poor	could not build a house, husband died, drunkard, she works as housemaid	worsened	no	Yes

8	Neelima	40	8	tailoring	at home	labourer	low income	2009, 2012	2	2	2.5, 4	V Poor	V Poor	could not build house, married her daughter, disabled son	worsened	no	yes
9	Manjula	34	5	at home	at home	Electrician	low income	2010	1	1	3.5	V Poor	V Poor	very poor, health issues	worsened	yes serious	yes serious
10	Yameena	26	12	at home	housemaid	vegetable market	low income	2013	1	1	4	V Poor	V Poor	bought a bike, works as house-maid	worsened	yes serious	yes
11	Saaba	26	0	at home	labourer	labourer, goat keeper	low income	2015	1	1	7	V Poor	V Poor	built house but sold it, slipped into poverty	worsened	yes serious	yes serious
12	Gracy	40	10	at home	caretaker, cook	bangle ven-dor	low income	2012	1	2	4	Poor	V Poor	could not build house	worsened	yes	yes serious
13	Sarala	40	12	nurse	surrogacy agent, guard at drug trial centre	gardener	low income	2009	1	2	3.5	Poor	Poor	agent, in body market, no sus-tenance	improved, N.S.	yes	yes
14	Ujwala	39	10	house-maid	at home	factory worker	low income	2009, 2011	1	2	4.3, 50k	Poor	Poor	could not build a house	same	yes serious	yes serious
15	Deepti	35	6	caterer	at home	tempo driver	low income	2014, 2016	1	1	3.75	Poor	Poor	incomplete house	same	yes	yes
16	Gayatri	36	10	security guard	now caterer	caterer	Loss in business, debt.	2009, 2012	2	4	3.5, 3	Poor	L/HO	built house, scooter, runs a catering group	improved	yes	yes
17	Kalika	40	10	at home	cook, went to Saudi	mill worker, separated	low income	2007, 2010	2	3	unknown	Poor	L/HO	in body market, built a house	enhanced	yes serious	yes serious
18	Sunita	44	7	at home	at home	Works in a shop	low income	2010	1	1	3	Poor	L/HO	built a house	enhanced	yes serious	yes serious

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19	Radha	27	4	labourer	housemaid	works in a shop	low income	2012, 2016	2	3	6, 4.5	Poor	L/HO	released agri land from lease, built house, works as house-maid	enhanced	yes	yes
20	Mariam	42	7	cleaner in hospi-tal	cleaner in hospital	died in acci-dent, drunk-ard, painter	low income	2010	1	1	5	Poor	V Poor	works as cleaner, money went in hus-band's accident, he died	worsened	yes serious	yes serious
21	Kamala	35	9	cleaner in hospi-tal, agent body market	cleaner in hospital, agent body market	works in hospital	low income	2008, 2010	2	3	2.5, 3.5	Poor	L/HO	agent, disabled child built a house, job as cleaner	enhanced	yes	yes
22	Bhavya	38	6	Informal sector	works in mall	labourer	low income	2011, 2014	2	2	3.5, 3	Poor	L/HO	built a house, works in a mall	enhanced	no	yes
23	Parul	38	5	tailoring teaching	tailoring	driving teacher	low income	2011	1	1	3.8	Poor	Poor	saadhan, bought sewing machine	improved	yes	yes
24	Sneha	34	10	at home	at home	diamond worker	low income	2011	1	1	4	Poor	Poor	could not build, husband works, subsistence	same	yes	yes serious
25	Savita	34	10	at home	at home	works in car showroom	additional money	2012	1	2	5	Poor	L/HO	bought house, husband going to Dubai,	enhanced	no	yes
26	Bhairavi	42	6	at home	at home	auto-rick-shaw driver	in debt	2014	1	1	5	Poor	poor	could not build a house, husband works as la-bourer	improved	no	yes
27	Neelam	40	6	at home	labourer	labourer	low income	2010	1	1	3.21	Poor	V Poor	did not build a house, work as labourer	worsened	yes	yes

28	Madeeha	33	0	at home	rented house, tailoring	drunkard husband	low income	2017	1	2	4.3	Poor	L/HO	in body market, drunkard, bought a house and sewing machine	improved	yes	yes
29	Saara	35	0	at home	at home, egg donation	labourer, drives auto rickshaw, fruit vendor	low income	2017	1	1	4	Poor	L/HO	in body market, bought a house	improved	yes	yes
30	Razia	30	0	at home	at home, egg donation	labourer	low income	2018	1	1	4	Poor	L/HO	in body market, bought a house	improved	yes	yes
31	Vedha	32	8	factory worker	at home	drives auto-rickshaw	additional money	2011, 2015	2	2	3.5, 6	L/HO	L/HO	released agr land from lease, built house	enhanced	no	no
32	Parul	36	0	at home	at home	agri. lab.	low income	2013, 2015	2	3	4.75, 3.8	L/HO	L/HO	built a house	improved	no	yes serious
33	Charu	40	0	at home	tailoring	priest	low income	2016	1	2	4	L/HO	L/HO	house destroyed, rebuilt	same	no	es
34	Kaavya	33	8	at home	at home	security guard	low income	2013 2014	2	3	4.5, 4.5	L/HO	L/HO	kutcha house, rebuilt it. Husband works	improved	yes serious	yes serious
35	Dimpy	34	4	own agri field	own agri field	agri field, buffaloes	to buy an extra piece of land, buffaloes	2010, 2014	2	2	4, 4.5	L/HO	L/HO	bought land, two buffaloes	enhanced	no	yes
36	Shruti	32	12	at home	oversees auto-rickshaw	drunkard, at home	drunkard husband	2015	1	1	4.8	L/HO	L/HO	auto rickshaw	improved	no	yes
37	Gomati	40	4	agri lab	at home	Tempo driver, cow rearing	debts	2014	1	1	5.25	L/HO	L/HO	tempo, two cows	enhanced	yes	yes
38	Padma	45	12	nurse	tailoring, nurse	driving teacher	drunkard husband	2012	1	2	4	L/HO	L/HO	paid debt, works as old age carer	enhanced	yes	yes

39	Shraddha	34	9	labourer	at home	labourer	low income	2009, 2010	2	3	2.4, 3	L/HO	L/HO	house was destroyed in flood, rebuilt, works as a labourer	enhanced	yes	yes serious
40	Kamini	35	12	Informal sector	caretaker	drunkard, at home	low income	2015	1	2	5	L/HO	L/HO	built a house	enhanced	yes serious	yes serious
41	Seechal	33	5	works at household brick kiln	leased land	brick kiln owner	additional money	2014	1	1	6	L/HO	L/HO	built a house, works in brick kiln	enhanced	no	yes
42	Deepna	40	5	agri lab	agri lab	labourer	low income	2009, 2012	2	2	3, 4	L/HO	L/HO	agri. Lab., had a land, built better house on it	enhanced	yes	yes
43	Manjula	35	12	agri. lab.	agri. lab.	agri. lab.	additional money	2012, 2014	2	3	4, 3	L/HO	L/HO	built a large house in the village	enhanced	yes	yes
44	Megha	33	10	at home	at home	agriculture	additional money	2016	1	2	7	L/HO	L/HO	has saved money for education	enhanced	yes	yes
45	Raksha	44	0	at home	at home	at home	low income	2009	1	1	3	L/HO	Poor	slipped into poverty, no sustenance, son works as labourer	worsened	yes serious	yes

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AUTHOR BIOGRAPHY

Sheela Suryanarayanan (Saravanan), PhD, has worked on gender issues since 1998 and specialises in surrogacy, sex-selective abortions, and prenatal screening. Her book on surrogacy is titled *A Transnational Feminist View of Surrogacy Biomarkets in India*, published by Springer Nature, Singapore.

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