

More Than a Womb: Recognizing and Protecting 'Gestational Motherhood' in India's Commercial Surrogacy Industry

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Abstract

The advancements in reproductive medicine over the past thirty years have redefined what constitutes parenthood, and more specifically motherhood. These improvements have fostered a global market around reproductive labor, most notably that of commercial surrogacy. Considering a case study of commercial surrogacy in Kolkata, India, this paper presents research on the question of how reproductive technology is redefining motherhood, and more specifically how commercial surrogacy has given rise to the experience of 'gestational motherhood.'

Although there are numerous issues surrounding exploitation of surrogate mothers in India, this research will focus solely on the need to recognize and protect gestational motherhood and the emotional labor it involves. Rather than examining surrogate-client relations, this paper gives voice to Indian service-side actors to better understand their rationales and concerns related to reproductive labor. Moreover, this discussion employs a constructive approach, aiming to utilize service-side actors' perspectives to inform policy approaches that can support vulnerable surrogate mothers and safeguard their emotional labor.

Keywords: gender, reproductive labor, fertility medicine/technology, surrogacy, gestational motherhood, emotional labor

Introduction

Fertility technology has advanced significantly over the past three decades, expanding the boundaries around achieving parenthood. Since its advent in the 1980s, In Vitro Fertilization (IVF) has become a common solution for those struggling with conception. In IVF an egg is fertilized with sperm in a laboratory, and the resulting embryo is implanted in the biological or surrogate mother's

womb for gestation. IVF has engendered a global commercial surrogacy industry, where women in certain countries can essentially lease their womb to those struggling to conceive. Although these gestational surrogate mothers do not share genetic material with the fetus, they provide prenatal nurture required to give it life.

Through a case study of a fertility clinic in Kolkata, West Bengal, India, this paper explores the changing definition of motherhood as it is shaped by gestational

surrogacy. Fertility clinics across India provide surrogacy services to Indian citizens (“Surrogacy Regulation Bill,” 2017; Nair, 2015). Most often, impoverished women serve as gestational surrogates for wealthier clients in exchange for monetary compensation. Although multiple studies have illustrated surrogates’ ‘gestational motherhood’ and attachment to the fetus, Indian clinics and clients remain legally unaccountable when it comes to addressing emotional afflictions of reproductive labor; as such, surrogates are not afforded adequate socioemotional support for their labor. Surrogates are bound to a financial contract, which reduces their emotional labor to a transactional exchange.

This research highlights the growing need to understand how advancements in reproductive medicine are redefining motherhood. Centered on narratives of surrogate mothers, recruiters, and clinicians, the analysis argues to recognize surrogates’ gestational motherhood. Moreover, by suggesting approaches to protective policies for surrogates, this research begins to address the issue of contested or ‘lost’ motherhood in reproductive labor.

Why India?

Focusing on India allows insight into a country that struggles with its position in the commercial surrogacy industry, which it legalized in 2002. Once poised as the global leader in providing surrogacy services to couples worldwide, in October 2015 India limited surrogacy services to heterosexual, married Indian couples; the currently pending Assisted Reproductive Technology (ART) Bill proposes to curtail services further, prohibiting monetary compensation for

surrogates in addition to restricting who can provide and receive surrogacy services (“Surrogacy Regulation Bill,” 2017; Nair, 2015). Several politicians and scholars have criticized this proposed bill because it compromises surrogates’ agency to partake in wage labor and endangers their wellbeing without binding the exchange to a legal contract. Sharmila Rudrappa, a leading researcher on India’s surrogacy industry, critiques this bill, stating “This new bill will lead to far deeper exploitation of indigent women who are now expected to labor for free.” Her article emphasizes problematic emotional labor, wherein women are expected to labor selflessly rather than as wage workers. Rudrappa’s perspective highlights the importance of re-centering women’s agency in their labor, calling on India to better regulate the commercial surrogacy industry rather than ban women’s choice to perform reproductive labor (Rudrappa, 2016). Although India’s surrogacy laws are yet to be finalized, the industry is estimated to be worth US\$2 billion with thousands of clinics operating nationwide (“India Unveils Plans,” 2016; DasGupta et al., 2014, p.ix-x). Noting India’s developing surrogacy legislation, this paper presents insights from service-side actors that can inform protective policy for gestational mothers.

Additionally, considering female sexuality and motherhood customs, India represents a traditionally bound society that has fostered a thriving non-traditional reproductive industry. India’s successful surrogacy industry is largely due to the abundance of willing surrogate mothers, as the country is home to one-third of the world’s poor, with 21.2% of its population living below the US\$1.90-a-day poverty line (“Poverty & equity,”

2017). The majority of surrogates come from these impoverished communities, and the average income of US\$2,000-7,000 per surrogacy can be a life-changing catalyst for their upward mobility. In the clinic studied, surrogates made a base rate of US\$4,000 – earning approximately nine years of their daily wage in nine months. This financial allure is persuasive for poor women, rendering surrogates easily exploitable. However, unlike other research, this paper will not claim that commodifying one's womb is inherently exploitative, nor argue for India to ban commercial surrogacy. Rather, recognizing the reality that surrogacy is a viable opportunity for many impoverished Indian women, this paper argues to better empower and safeguard surrogate mothers.

Theoretical Framework

This paper builds underexplored scholarship that re-centers the surrogate and foremost recognizes the need to protect her wellbeing and agency to perform empowered reproductive labor. Accordingly, the theoretical framework grounds core issues regarding gestational surrogacy, and informs interventions that safeguard reproductive labor choices.

Non-Motherhood

Gestational surrogacy has transformed conventional reproduction, allowing women to achieve motherhood without needing to engage in intercourse or pregnancy. Today, rather than having two biological parents, a child can have up to five people involved its birth – egg and sperm donors, surrogate mother, and intended parents. Thus, as Amrita Pande (2011) discusses, motherhood is today

achievable through technology, where pregnancy is no longer a necessary component of motherhood and likewise biological connection does not entail parenthood (Pande, 2011, p.618-619). The rise of reproductive medical technology leads us to question what constitutes being a 'legitimate' mother, and whether legitimacy can be derived solely through gestational nurture.

Considering medical reproductive technology, Helena Ragone (2000) argues that motherhood is rooted in a series of social and cultural processes. Ragone discusses the centrality of the contract in creating biological motherhood and terminating social motherhood. She draws on the verdict from a California gestational surrogacy custody case that states, "She who intended to bring about the birth of a child that she intended to raise as her own – is the natural mother" (Ragone, 2000, p.60- 64). This verdict attaches the meaning of motherhood to child rearing and the intention to give it life. Here, it is neither the biological material nor gestation that create a mother, but rather the intention to become a mother to a particular child. Similar to Pande, Ragone illustrates the contested definitions of motherhood – that neither gestation nor biology are necessary or sufficient conditions to beget legitimate motherhood.

Class and Unequal Motherhood

Being that fertility treatments require substantial capital; one can question the ethicality of being able to purchase genetic motherhood through a process that delegitimizes the poorer gestational mother. Due to financial desperation, the Indian surrogate is easy to manipulate, as she prioritizes income

even though the process devalues her wellbeing. The vast socioeconomic difference between surrogate and client illuminates the class inequality that underpins India's commercial surrogacy industry. Along these lines, Rudrappa's (2015) *Discounted Life: The Price of Global Surrogacy in India* illustrates that although clients may be well-intentioned, the surrogacy exchange rests on a power imbalance in which the surrogate is neglected based on her socioeconomically subordinate position. Rudrappa notes:

Surrogacy agencies and infertility doctors are far more solicitous, attentive, caring, and alert towards client parents' physical and emotional needs than those of the surrogate mothers. The latter's mother-work in their own families, their rights to bodily integrity, to refuse or accept medical interventions, and their feelings about pregnancy and choice in childbirth are more or less disregarded. (Rudrappa, 2015, p.40)

Rudrappa describes the inadequate medical and emotional attention provided to impoverished surrogate mothers compared to wealthier clients. Surrogates' neglected medical experience also resonates in this paper, begging the need to better legitimize and protect gestational motherhood.

Ragone (2000), on the other hand, depicts class as a challenging but necessary tool gestational surrogates can use to emotionally distance themselves from the fetus (p.65-71). The surrogate is able to utilize the stark socioeconomic difference to rationally comprehend her lack of relation to the fetus. Interestingly, many global surrogacy programs look for

surrogates who do not racially represent clients, in order to deemphasize gestational bonding (Ragone, 2000, p.68, 71). Following Ragone's argument, the socioeconomic gap between clients and surrogates deemphasizes surrogate motherhood, while enhancing biological motherhood legitimacy. However, although a surrogate may recognize the biological detachment between herself and the fetus, she may still feel emotional attachment from the maternal gestational experience.

Women's Altruistic Labor

In *Circles of Care*, Emily K. Abel and Margaret K. Nelson (1990) analyze the trials and perils of care-work. Care-work or 'emotional labor' embodies an intense altruism that is the love for labor (Abel and Nelson, 1990, p.4). Abel and Nelson argue that the devaluation of women's work rests on a dichotomy between emotion and reason, where care-giving, being altruistic, is seen as unskilled work and is therefore underpaid. Being a surrogate represents care-work, as altruism and affection are important expectations of women's reproductive labor while they gestate a fetus (Abel and Nelson, 1990, p.13, 21). The surrogate is expected to act as a caring mother during pregnancy, but is denied recognition of motherhood to any extent. Clinicians entrust the surrogate with the maternal duty to nurture the fetus, but consistently reinforce her non-mother status. The emotional energy she commits to her care-work is immense, and immensely under-recognized as legitimate labor (Abel and Nelson, 1990, p.13).

Policy has largely ignored the needs of caregivers, focusing instead on the demands of recipients. Stereotypical

conceptions of gendered labor define care-work as a woman's inherent domestic responsibility, and thus see little need to adequately recognize such labor in the patriarchal labor economy (Abel and Nelson, 1990, p. 26, 35-36). This resonates in Rene Almeling's (2007) work on egg donors. Almeling portrays how clinic staff dissuade donors from negotiating higher compensation and advise women to construct donor profiles resembling altruistic values of wanting to help build families, reinforcing the 'nurturing mother' ideal (Almeling, 2007, p.329-331). Similarly, Pande (2011) stresses that the Indian surrogate is socialized to reinforce her role as a dutiful mother, rather than an empowered wage-earner, thus de-legitimizing her emotional labor (Pande, 2011, p.622). Empowered breadwinning is skewed into maintaining expectations of (unrecognized) maternal responsibility, where a surrogate is limited to being grateful for a financial opportunity, rather than negotiate contractual terms in her interest.

Alienating Motherhood

In his philosophical labor theory, Karl Marx (1978) articulates the despair of worker alienation. As the worker continues to produce, she eventually exists solely as a commodified means of production for an external force, losing a sense of her very self:

"The worker becomes an even cheaper commodity the more commodities he creates. [...]. The alienation of the worker in his project means not only that his labor becomes an object, an external existence, but that it exists outside him, independently, as something alien to him [...]; it means that the

life which he has conferred on the object confronts him as something hostile and alien. [...] the worker's activity is not his spontaneous activity. It belongs to another; it is the loss of his self. (Marx, 1978, p.71-74)"

Donna Dickenson (2001) applies Marx's theory of worker alienation to surrogate mothers' emotional labor. With biotechnological developments "women are alienated from control over both the conditions of their labor – forced to accept the 'gift relationship' – and from any control over the profits resulting from it (Dickenson, 2001, p.213)." The surrogate provides a motherhood service, where she is valued solely as a womb, yet forgoes any recognition of legitimate motherhood. She is made to detach her womb from her personhood, as her reproductive ability is controlled for commercial production.

Noting issues of imposed altruism and alienation, reproductive labor discourses should re-center the surrogate's agency and wellbeing, legitimizing her meaningful maternal contributions. Accordingly, Catherine Waldby and Melinda Cooper (2008) stress that reproductive economies should be understood as clinical labor. They state, "The assumption of passivity seems to be a particular danger when analyzing women's bodily work," calling on markets to empower women laboring in the fertility industry as workers, not romanticized givers (Cooper and Waldby, 2008, p.66-67). Similarly, Dickenson (2017) problematizes the notion 'Vanishing Ladies,' where women are not considered active stakeholders in practices surrounding their reproductive labor, relegated to the sidelines while their

reproductive capacities become the object of debate (Dickenson, 2017, p.176, 178). These researchers illustrate the need to empower women's voices to safeguard their interests in the fertility industry.

Constructive Interventions

Although substantial literature addresses the hardship low-income surrogate mothers experience, there is little that informs interventions to protect willing gestational surrogates. This paper explores foundations for such interventions and urges further research into solutions that mitigate exploitation while supporting women's agency to partake in commercial reproductive labor.

In her dissertation on egg donation in the U.S.A.¹, Janette Catron (2014) discusses issues surrounding professionalism and ethicality:

Without any sort of regulation, there were no controls or standards for recruiting, screening, or educating donors. Since the internet provided access to a vast pool of potential egg donors, unscrupulous individuals could suddenly and with ease recruit women as donors, fail to educate them, and pay them vast sums of money [...]. (Catron, 2014, p.323)

Catron highlights the need to regulate the reproductive workers' recruitment and education process. She draws on SEEDS (Society for Ethics in Egg Donation and Surrogacy), which recommends developing standardized, professional systems that ensure women

are not coerced into reproductive labor and are adequately educated on the medical risks in order to provide informed consent (Catron, 2014, p.343, 345, 352). Applied to India, perhaps professionalizing the recruiter role and obligating staff to support and educate the surrogate would better safeguard reproductive labor.

Further, surrogate mothers require comprehensive health support. Research suggests that surrogates experience notable fear and trauma from feeling coerced to deny attachment to the fetus, managing stigma, being apprehensive about health issues post-surrogacy, and general pregnancy-related stressors (Eskandari et al., 2014, p.474-476). Interestingly, surrogates' emotional trauma is typically not related to separating with the child post-delivery, but rather coping with the complexity of gestating a fetus that they have no ownership over (Golombok, 2015, 130-135). Prior studies detail the need to provide surrogates with pre-pregnancy, pregnancy, and post-natal counseling support; however, they are yet to definitively establish the efficacy of such counseling, perhaps indicating that more longitudinal research is required to understand surrogates' mental health needs and inform industry best practices (Burrell and O'Conner, 2013, p. 116-119; Eskandari, 2014, p.476-478).

Methodology

The analysis below is based on in-depth interviews with surrogate mothers, recruiters, and clinicians at a prominent

¹ As of 2018, egg donation remains legally unregulated in the U.S.A.

fertility clinic in Kolkata. I conducted twenty semi-structured interviews in Bengali: seven with surrogates (women impregnated with clients' embryos), five with recruiters (women who connect surrogates with fertility clinics), and eight with clinicians (those who medically facilitate the surrogacy). Focusing on a single clinic allowed me to conduct a close examination within a tight-knit network; however, this also entails that procedural policies are unique to this particular clinic and Kolkata's social landscape. Nevertheless, the analysis of gestational motherhood and how to protect it can be applied more generally to India's commercial surrogacy industry.

Findings and Analysis

At Bright Futures², fertility treatment begins with a consultation to determine clients' needs. If surrogacy is chosen, the IVF Coordinators escalate the clients' requirements to recruiters who find a suitable surrogate mother, on average, in less than two weeks. After completing health screenings and contract agreements, the clinicians begin medical treatments to prepare the surrogate and client for the embryo transfer. Once the surrogate is pregnant, Bright Futures has completed its contractual responsibility. When the time comes an Obstetrician Gynecologist, not necessarily associated with the clinic, will perform a caesarian section³ to deliver the child. The clinic's recruiters often remain involved as a liaison and support system for the surrogate, and Bright Futures pays the surrogate upon delivery. As such, the clinic functions as a business with a well-

defined system for handling surrogacy requests and completing its main objective: to deliver babies for clients.

While the clinic is client-centric in providing surrogacy services, it is equally if not more important to address the needs of the surrogate, who is the bedrock of this industry. A major concern researchers and policymakers have pointed to is the emotional trauma – a sense of lost motherhood – a surrogate mother faces while carrying a fetus that is not hers (Eskandari et al., 2014, p.474-476). Not surprisingly, surrogates and clinicians are at odds when it comes to the legitimacy of gestational motherhood and emotional attachment between surrogate and fetus. However, recognizing gestational motherhood is crucial to developing protective policy that supports women throughout their experience as surrogates.

Denying the Basis of Surrogate Motherhood

The fertility clinicians and staff systematically deny gestational motherhood, even in its most basic form of emotional attachment to the fetus. They emphasize the financial aspect of the surrogate's role, claiming that she is only interested in the money. When questioned about the possible emotional trauma a surrogate might face, Ms. Ambika, an IVF Coordinator, was adamant in pointing out that the surrogate did not develop any attachment to the fetus:

No, no, no, no [...] (emotional attachment) doesn't happen. (The surrogate) already has two or three children of her own. She just wants

² All names are fictionalized to protect privacy

³ At this clinic, standard protocol required that all surrogates deliver through caesarian sections

this child to be ok, so she can give it to its parents and get her money. [...] There is no emotional stress. This is a business for her. (Ambika Interview, 2015)

Ambika's response represents that of almost all clinicians interviewed. According to clinicians, the surrogate only sees a financial transaction, where emotional attachment is not a factor worth consideration. This blatant denial of surrogate motherhood worked as a strategy to evade the burdensome concerns that perhaps gestational surrogacy did lead to deep emotional stresses. It seemed as though the clinicians' insistent dismissal of surrogate motherhood was a tool to avoid the very idea that it may be real.

Bright Futures also controls interactions between the surrogate and child to prevent potential for attachment. Among several strategies to decrease maternal affection, the surrogates are not allowed to deliver the babies naturally. This is partly due to the risks associated with natural births, and also because the surrogate mothers should not experience the afflictions of maternal labor. Chandrika, a recruiter who has also been a surrogate, states, "Our own children are made with our blood. Giving birth to them feels natural. These babies are not ours. [...] That's why they don't let us push them out (Chandrika Interview, 2015)." In addition, Bright Futures does not recruit surrogates who do not have biological children, fearing that the woman may become attached to her first pregnancy (Sayomita and Pushpita Interview, 2015). Furthermore, the surrogate is not permitted to see the child unless the client contacts her to do so.

Throughout the surrogacy process, even during initial recruitment, the recruiters and IVF Coordinators underscore to a surrogate that this is not her child. The clinic takes these precautions to emphasize detachment between surrogate and fetus. However, by instilling these preventative strategies, Bright Futures inadvertently illustrates the legitimate bonds of gestational motherhood as an unspoken concern. Even though clinicians do not admit that surrogates experience maternal affection, their efforts to prevent surrogate-fetus attachment reveal that they are wary of a sense of gestational motherhood.

Recruiters play a pivotal role as key intermediaries between surrogates, the clinic, and surrogates' communities. Chandrika has been a recruiter for ten years and has also served as a surrogate. Her account exemplifies the clinic's simultaneous denial and acknowledgment of surrogate motherhood. As a clinic representative, Chandrika emphasizes the lack of gestational motherhood; however, when discussing her personal experience with surrogacy, Chandrika portrays a very different image of maternal care:

There is no sadness or emotion attached to this baby. We think of it like we are doing a job and eight months later we will give this baby up, take our money, and we're done. I tell all the surrogates from the start that this is not their baby, they are simply responsible for giving birth to it. [...] We don't get to see the babies. But my client had shown me mine. My girl is now four years old.

She calls me aunty.⁴ I will never tell her that I carried her, but the clients still keep a relationship with me. (Chandrika Interview, 2015)

Recruiter Chandrika projects Bright Futures' narrative requiring her to deny gestational motherhood. However, when she reflects on her personal experience as a surrogate, her attitude shifts. She refers to the child as 'my girl,' and fondly recounts experiences with her clients. Chandrika continued to emphasize how fortunate she was to have clients that allowed her to maintain a relationship with 'her girl.' She discusses exchanging presents and feeling like she was a significant part of the girl's life. Although recruiter Chandrika asserts that there is no emotional bond between surrogate and child, the surrogate Chandrika is grateful to continue a relationship with 'her girl' and feel a sense of legitimized partial motherhood in being able to maintain these emotional ties.

The clinic purports a dual narrative of surrogate motherhood. On one hand Bright Futures' representatives are almost robotically trained to negate gestational motherhood, while on the other they implement mechanisms that seek to diminish surrogates' maternal bonds and may even sympathize with the surrogate's sense of motherhood. These competing notions illustrate that the emotional hardship a surrogate mother undergoes while navigating an intimate relationship with a fetus that is not biologically hers is significant and worth addressing.

The Medical Wall

Clinicians are very clear in underscoring that they only deal with the practical medical aspects of surrogacy fertility treatment. Clinicians also denied responsibility of having to counsel surrogates on medical procedures involved in their impregnation, instead directing surrogates to recruiters or IVF Coordinators. In effect, the clinicians willingly erect a 'medical wall' around their scope of responsibilities, restricting their availability to the surrogate on a personal level. This medical wall prevents surrogates from receiving adequate clinical support, highlighting a sense of socioemotional disengagement between the clinician and surrogate.

Dr. Marwa, Bright Futures' Principal Director, explains that a medical wall ensures there is no opportunity for a sympathetic or emotional involvement with the surrogate, as this could impede the standardization of the surrogacy contract:

I only have a medical relationship with the surrogates. [...] Most surrogates are interested in whether we can get them some more money, over and above the contract. They will put up stories about how they are in hard times, how their husbands owe money. But unfortunately, I have to be selfish and I put up a wall. My wall is absolutely medical. My questions are medical. My issues are medical. My assessments are medical. My judgment is medical. (Dr. Marwa Interview, 2015)

⁴ In India, children refer to adult women as 'aunty' out of respect. It does not indicate a familial bond.

The medical wall is a protective as well as a restrictive barrier. Clinicians use the wall to protect the boundaries of their job description, ensuring they fulfill their medical duties. However, in doing so, clinicians also intentionally restrict their job scope to avoid engaging in the emotional aspects of reproductive medicine, wherein lies the issue of neglecting gestational motherhood.

At Once A Mother and Non-Mother

Recruiters present the most eye-opening narratives on the complexity of gestational motherhood because they represent the clinic's position and also sympathize with surrogate mothers. As a mediator between clinic and surrogate, recruiters must find a language with which they can both complete their assignment of identifying reliable surrogates, as well as emotionally support the surrogates. As such, the recruiter completes a challenging job, where she must balance simultaneously denying and acknowledging surrogate motherhood.

When representing Bright Futures, the recruiters instruct the surrogate on how to nurture the fetus in her womb, while maintaining an emotional distance from it. They over-emphasize the financial transaction, reminding the surrogate that this compensation is her motivation and the exchange of the child is her professional responsibility. Recruiter Lakshmi represents a common approach for counseling surrogates:

This is how I explain to the women who want to be surrogates: 'imagine I am childless, but you are able to have babies [...]. All I am asking you to do is carry my baby for nine months. [...] Now, you have to think this baby is yours. In the

sense, you have to care for this baby like it is your own. However, you must never actually believe that this baby is yours, because it is mine. Think that you have taken surrogacy as a job, and you have to complete the job. Once you complete the job and give me my child, you will get the money. (Lakshmi Interview, 2015)

Lakshmi denies surrogates the basis of legitimate motherhood, which she reserves for the client who has initiated a financial transaction and who intends to raise the child; yet, she underscores the importance of the surrogate's maternal nurturing during pregnancy – perhaps allowing a parameter of prenatal, gestational motherhood based on the surrogate's intensive emotional labor. Additionally, like most recruiters, Lakshmi consistently reminds the surrogate that she has taken a financially compensated job, reaffirming her responsibility to the client and clinic.

However, when recruiters are not acting in official capacity, they are an immense support for the surrogate, as a confidante and guide through the medical process. Being from a similar socioeconomic background and often having worked as surrogates themselves, recruiters can sympathize with surrogates' challenge to reconcile gestational motherhood. Naina, a recruiter with six years' experience, had also attempted to be a surrogate once. Unfortunately, she suffered a concussion resulting in miscarriage, after which she decided not to re-attempt surrogacy. As a seasoned recruiter and surrogate, even for a short duration, Naina discusses the intense reality of carrying another's child:

Of course, the women are sad when they have to give the child up. Even though they know that this child is not theirs, it has lived in their womb for nine months. They can feel the baby move around, they know that it is living inside them. [...] The child is moving, kicking, feeling uncomfortable, and the surrogate mother, like a mother, feels all of this too. These nine months she has held the child in her womb, and after that when she is not allowed to see it after delivery this is extremely upsetting. [...] This sadness they usually discuss with us later. Many wish they could have seen the child, seen what it looks like. They feel very sad. They wish in some way they could have kept the child, even though they know it's not theirs. A lot of (surrogates) cry after the delivery. (Naina Interview, 2015)

As seen in Naina's account, although recruiters know the surrogate isn't the fetus' biological mother, they recognize the emotional hardship and loss (of motherhood) surrogates face. Recruiters' accounts illustrate that it is unrealistic to ask a woman to totally detach from a fetus in her womb, legitimizing the surrogate's sentiment of gestational motherhood. Despite biological difference, surrogates' crucial maternal contribution and emotional labor should be recognized.

Finding Motherhood as a Surrogate Mother

Surrogate mothers must learn to negotiate their place as a valuable gestational carrier, but not a long-term mothering figure. Aditi Das, currently pregnant with her second surrogacy fetus, struggles to navigate gestational

motherhood. Aditi considers her first surrogacy child to be an extension of her kin, and in remaining in contact with her clients she fulfills her duty as a partial and distant mother:

I asked (the client) for some money so that I could go to the temple and pray for the child that I carried and my children too. [...] This is a ritual that mothers do for their children. I know that this is not my child. I know (the embryo) was theirs, but still. The womb was mine, wasn't it? I carried her. Just like I love my children, I know that in some way that child is a part of me too. [...] I will never say that child is mine. I will never try to be like that to her. But I will show my love from above. I will do my part in my own way. (Aditi Interview, 2015)

Like so many others, Aditi feels a definite sense of love and motherhood. Aside from the financial transaction of being a 'rented womb,' most surrogates feel that they deserve the respect that comes with being a gestational mother. In efforts to mitigate their detachment and denied motherhood, surrogates describe various approaches to feeling acknowledged for their maternal contributions. Some, like Aditi, complete rituals for the child and 'show love from above,' while others simply want to maintain a relationship with their clients.

Surrogate mothers would not claim the child they delivered to be their own. They understand that their motherhood is restricted to the gestational experience. Still, the surrogate being involved in the child's life is left to the client's discretion. Thus, surrogates seek, often to no avail, to reconcile their maternal affections within a transaction that has repeatedly denied

them recognition of forming legitimate attachments. Although the financial transaction may seek to only compensate the woman for her womb, the surrogate mother desires recognition for her entire emotional being.

Protecting Surrogate Motherhood

Although there are several issues surrounding commercial surrogacy, this paper focused on recognizing gestational motherhood; the following discussion on protective policy will also center on approaches to support surrogate mothers in negotiating the boundaries of their motherhood. Most importantly, these recommendations give voice to surrogate mothers, recruiters, and clinicians, who are integral to the surrogacy process. Surrogacy as an exchange can be a mutually beneficial and empowering experience. A client receives the child they have longed for, and a surrogate can transform her life with a sizeable income. However, crucial to this exchange is the need to ensure that the industry has enforceable laws to protect vulnerable surrogate mothers.

Although these suggestions are based on a single fertility clinic, the overarching principles can be applied generally to national legislation. Indian parliament is currently considering the 2016 ART Bill, which seeks to eliminate monetary remuneration for surrogates ("Surrogacy Regulation Bill," 2017; Nair, 2015). The call to de-commercialize surrogacy is based on the notion that 'renting wombs' is inherently exploitative of women. However, many politicians, activists, surrogates, and clinicians throughout India, including some at Bright Futures, have argued otherwise,

calling for more regulations to safeguard the commercial industry rather than a ban ("India Unveils Plans," 2016; Rudrappa, 2016). Centralizing reproductive workers' agency in fertility discourses, this research agrees that protecting surrogates' interests can foster a safe, empowering, and sustainable industry.

Policy should recognize gestational motherhood to the extent that surrogate mothers do experience significant emotional attachment with the fetus and require support to overcome any emotional trauma. In order to legitimize and adequately address these challenges, protective policy should: (i) create a formal industry around surrogacy and professionalize all workers and (ii) establish comprehensive, longer-term health support for surrogate mothers.

Professionalizing the Industry and its Workers

Although Bright Futures functions well, there are gaps that put the surrogate at risk. In particular, the crucial position of the recruiter as an intermediary is largely underestimated. Recruiters are not only responsible for bringing surrogates to the clinic but are also the initial person who explains surrogacy to potential candidates. Although IVF Coordinators are trained to counsel women about the surrogacy process, recruiters typically fulfill this responsibility. Sharing the same socioeconomic background, recruiters also act as the surrogate's main support system for understanding their gestational motherhood.

Considering the recruiter's impact, they should be professionally trained on surrogacy medical procedures and counseling strategies – an intervention also presented in Catron's (2015)

discussion on regulating the U.S. egg donation industry. Recruiters need a more thorough understanding of the challenges and emotional trauma surrogates can face, and how best to address such issues. Clinics could require recruiters to attend accredited workshops to learn the technicalities of ART, complexities of gestational motherhood, and counseling techniques surrounding related trauma (Eskandari et al., 2014, p.474-478). Additionally, clinics should provide recruiters with a basic script to explain surrogacy to candidates, focusing on how the fetus is not related to the gestational carrier, and potential risks such as miscarriage or emotional trauma. Formalizing the recruiter's job would enhance her capability as an intermediary, empowering her with tools to assuage surrogates' challenges.

Even after professionalization it remains that recruiters are not medical experts. Thus, clinicians must take down their 'medical wall' and reinforce the information recruiters convey, ensuring accuracy in surrogates' understanding of the medical procedures and associated risks. The surrogate is eager to perform reproductive labor because of financial desperation and vulnerable due to lack of education. To best protect these women, clinicians and recruiters must work cooperatively to recognize and fully support the hardships of surrogates' emotional labor. Accordingly, ethical legislation should require clinics to provide emotional counseling throughout the surrogacy process, and ascertain that surrogates thoroughly understand the medical processes and risks, ensuring she is aware of what her consent entails.

A Healthy Surrogate, A Healthy Practice

Legitimizing a surrogate's gestational motherhood is integral to paving the way for mental health support that addresses the hardship of reproductive labor. Such counseling would help surrogates navigate emotional trauma and define the parameters of gestational motherhood (Eskandari et al., 2014, p.474-478). Accordingly, clinics and clients must be contractually required to provide the surrogate longer-term health support. Although the surrogate mother's role as a gestational carrier ends at delivery, her associated health concerns can persist after she has given birth (Burrell and O'Conner, 2013, p. 116-119).

Although there are some medical protections in place for the surrogate, these are not expansive or accessible enough. For instance, at Bright Futures clients purchase basic health insurance for surrogates, lasting a year post-delivery. However, the clinic does not monitor whether the surrogate accesses this insurance – indeed, none of the surrogates interviewed were aware of this entitlement. Clinicians also described maintaining a strictly medical relationship with surrogates. They absolved themselves of responsibility to provide non-procedural support, even if a surrogate was struggling emotionally as a result of the procedure. A further ethical concern was that Bright Futures, the central facilitator of the surrogacy, contractually disentangled itself after impregnating the surrogate. A fertility clinic must remain liable throughout the surrogacy process, which does not end at impregnation.

Currently, fertility practitioners are not required to support a surrogate

through pregnancy-related psychological or emotional issues. Clinicians adamantly emphasized that surrogates do not experience trauma; however, recruiters and surrogates painted a very different emotional aftermath. Echoing prior research, the surrogates interviewed also struggled with detachment and denied motherhood; even understanding the fetus was not theirs, the attachment from gestational motherhood was undeniable, yet unrecognized (Eskandari et al., 2014, p.474-476). Policy should require that clinics and clients provide surrogates regular group and/or individual counseling to cope with emotional trauma, during and in the year post-pregnancy (Burrell and O'Conner, 2013, p. 116-119).

By establishing a supportive surrogacy environment, the clinic will ground a sustainable practice while encouraging women to perform as surrogates. Moreover, providing counseling would enable surrogates to form a mutually supportive community. Recognizing and helping ameliorate surrogates' sense of 'lost motherhood' changes surrogacy from a plight that women conceal and endure alone to a legitimate sentiment that deserves care.

Conclusion

Although commercial surrogacy can empower impoverished women, as it stands the potential for exploiting surrogates impedes sustainability. While the industry becomes over-commercialized, surrogate mothers bear the brunt of lax regulations that do not consider their wellbeing. Accordingly, sustaining the surrogacy industry requires protective policies for surrogate mothers that recognizes their gestational

motherhood and legitimizes their emotional labor. As fertility technology redefines parenthood, it is crucial that each role in the surrogacy process be given due credit. For surrogates, this involves acknowledging and helping navigate gestational motherhood.

Commercial surrogacy in India has significant potential to transform the country's medical economy. Surrogate motherhood is one of few professions completely restricted to women. Similarly, being a recruiter is also a feminized position, as women can sympathize on matters of pregnancy and motherhood. Commercial surrogacy can position marginalized women as breadwinners for their families, perhaps providing greater gender empowerment in the workforce through a unique and revolutionizing approach. Since India's commercial surrogacy legislation is still underway, policymakers have an opportunity to mold the industry into one that is both ethical and economically successful. By informing policy that safeguards gestational motherhood rather than bans it, further research can strengthen reproductive workers' agency, prioritize their health, and promote a healthy, functional ART industry. Legislation that foremost protects surrogate mothers, as both the most vulnerable and crucial actors in the industry, will allow India to harness the benefits of reproductive medicine to mutually empower the surrogate, client, and nation. ■

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