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Whose Womb Is It, Anyway?

An Examination of the International Gestational Surrogacy Market

When Karl Marx wrote, "a commodity is, in the first place, an object outside us, a thing that by its properties satisfies human wants of some sort or another," (Marx 303) it seems near impossible that he could have imagined the commodification of humans themselves, let alone human organs, as separate from the people they sustain.

Nancy Scheper-Hughes describes this relatively new phenomenon of biological exchange as "strange markets and occult economies" (197), and it would be fair to refer to the transnational market in gestational surrogacy as such. An increased demand for infertility services has spurred biotechnological advancement in this area in the Global North and an informal and unregulated transnational industry trading in "wombs for rent" (Arora) has developed, with the global capital located in India (Schanbacher).

The current manifestation of capitalism has led us to a point in history where even human reproduction – some would say human life itself - has become a commodity to be bought by those with economic means, while the invisible labor, figurative and literal, is provided for by the poorest amongst us.

This paper examines the commercialization of pregnancy, the development of the international market for gestational surrogacy, and how these exploit Indian women by dehumanizing them and commodifying their wombs.

Part One: "Free-Market Medicine"[1]

. There are historical and religious texts documenting (mostly female) infertility and customary laws to overcome childlessness are prevalent across cultures, dating back hundreds of years (Schanbacher 202). Because the concept of reproduction is laden with more than simple biological meaning, the 'problem' of infertility has always transcended the individual to be located within a societal context. There are historical and religious texts documenting (mostly female) infertility and customary laws to overcome childlessness are prevalent across cultures, dating back hundreds of years (Schanbacher 202). In modern society, the phenomenon of infertility has shifted from a societal concern to a medical one. Anthropologists have suggested that this shift has been related to both medical innovation and biotechnological advances, as well as to broader changes in how society views womanhood and family. In the Global North, growing secularism, as well as increased autonomy and freedom of choice experienced by modern women, in large part due to the Feminist Movement, have advanced views of womanhood beyond simply wives and mothers. "Later marriages and a growing tendency for middle and upper-middle class women to want children later in their reproductive lives," as well as "the separation of intercourse from reproduction through new birth control methods such

[1] Scheper-Hughes, Nancy. "Rotten trade: millennial capitalism, human values and global justice in organs trafficking ." Journal of Human Rights 2.2 (2003): 213. Print.

as oral contraceptive pills" (Blatt 12) have largely made reproduction a choice, rather than an obligation of womanhood. Parenthood has also increasingly become decoupled from womanhood, as the growing acceptance of homosexuality and the international push for recognition of homosexual marriage have redefined the modern family.

Thus in the last thirty years, 'parenting as a choice', particularly for the wealthy, has resulted in an increase in the demand for fertility services in the Global North, despite no corresponding increase in the prevalence of infertility (Kuohung and Hornstein).

It is in response to this new 'demand' that biomedical research began to focus on infertility as a medical concern. Previous solutions to infertility, such as adoption, fell out of vogue as technological advancements meant that at least one parent could be genetically related to the child, as in 'traditional' surrogacy (in which the surrogate provides the ovum and is impregnated with sperm from the father-to-be, without having to engage in coitus) (Blatt 12). By the late 1980s, "the development of gestational surrogacy through IVF technology offered a possible genetic relationship for the intended mother," allowing women who had previously been deemed 'barren' to become biological mothers (Blatt 12-13).

"In 1987, the first gestational surrogate child was born in America. In 1989, the first gestational surrogate child produced from a frozen embryo was born in America… Two years later, in 1991, the first frozen embryo was shipped from England and implanted into an American surrogate's womb," (Blatt 13) and with that, the international gestational surrogacy market was born.

Further fueling demand for biological parenthood using gestational surrogacy was the 1987 legal case of 'Baby M'. In this case centered on 'traditional' surrogacy, Mary Beth Whitehead, a married mother of two, was hired as a surrogate for the Sterns, a wealthy couple from New Jersey. Upon giving birth, Whitehead changed her mind, deciding to keep the baby, who was a product of her ovum and Mr Stern's sperm. The New Jersey Supreme Court ultimately decided for the Sterns, upholding the initial contract. Wanting to avoid the emotional insecurity caused by such a situation, the preference amongst heterosexual couples (who were the predominant 'customers') and homosexual male couples (who began opting to use a donated ovum genetically unrelated to the surrogate that they hired) shifted heavily toward gestational surrogacy, from 5 percent to 50 percent by 1994 (Blatt 13-18) and up to 95 percent by 2009 (Schanbacher 203).

The case of 'Baby M' also changed the medical language of parenthood, narrowing the meaning to 'genetic relation' whilst characterizing the gestational surrogate as simply a biological "vessel through which another couple's child is born" (Blatt 21 quoting Ragone 1994). Rachel Blatt expands, noting that "this notion of surrogate-as-empty-vessel… has served to effectively quell the social and emotional uncertainties produced by surrogacy technologies in America, by emphasizing the biological distance of the third party carrier from the 'traditional' family" (Blatt 21). Nancy Scheper-Hughes would argue that this distancing was intentional on behalf of the biomedical and biotechnological industries looking to make a profit, contending that "free-market medicine requires a divisible body with detachable and demystified organs seen as ordinary and 'plain things', simple material for medical consumption" (213).

The collective cognitive dissociation of pregnancy and parenthood in the Global North and the preference of contemporary medical ethics to resolve the conflict between the principles of beneficence (moral duty for the medical act to benefit the patient) and non-maleficence ('first do no harm') in favor of neoliberal consumer-orientated principles have been the driving forces in the commercialization of gestational surrogacy (Scheper-Hughes 206; Schanbacher 210). In addition, laws across the Global North regarding commercial gestational surrogacy remain non-uniform, with varying degrees of limited access from illegality to heavy regulation (Schanbacher 203), standing in stark contrast to countries like India where gestational surrogacy is both legal and generally unregulated (Blatt 25). Moreover, would-be-parents are priced out of surrogacy in the Global North as "the cost of gestational surrogacy in the United States (is) 'between $59,000 and $80,000'," (Schanbacher 203 quoting Smerdon 2009) while "the value of an Indian woman's womb (is) roughly $7,000" (Arora). These factors have driven the 'market shift' to preference "outsourced surrogacy" (Arora) over the 'domestic market' which has proved prohibitively expensive and overly-regulated for most commissioning couples compared to that of less developed countries.

Thus, couching surrogacy in the neoclassical economic language of supply and demand, market and exchange has made acceptable "(t)he commodification of Indian surrogates into 'breeder machines'" (Schanbacher 209) which can be evidenced by the attitudes of would-be parents toward these women. Kristine Schanbacher retells a story in which a couple remarks, "(t)he eggs and sperm are ours. It's basically our child… (w)e are renting somebody's womb and we are paying her for that" (Schanbacher 209). This disconnect between the Indian woman's humanity and her womb dehumanizes the surrogate into a machine housing a coveted biological commodity – the uterus.

The cumulative effect of free-market medicine has been the commercialization of fertility, making a coveted commodity out of the healthy, tested womb and an industry out of pregnancy. Consequently, a "$500 million-a-year industry" (Schanbacher 204) in gestational surrogacy has been created - a new "modern route of capital" with labor flowing from South to North, from poorer to more affluent bodies" (Scheper-Hughes 199-200) and "from poorer to richer countries" (Harvey 22). Blatt puts it another way, writing, "(T)he transnational surrogacy industry…originated in the West, became routinized, and then proliferated into the developing world, where its growth was fueled by the body parts of the desperately poor and socially marginalized people" (Blatt 44).

Part Two: "Communities of Half-women"[2]

It is impossible to speak of this trade in human organs without acknowledging, as Blatt does above, the asymmetrical relationship between the would-be parents and the surrogate, a microcosm of the transnational inequality that exists in economic relations between the North and South. In general, there is a class differencial between couples and their surrogates – most commissioning couples are upper or upper-middle class and are more educated than the surrogates that they hire, regardless of geography. However, "(c)ompared to the relationships between actors in the U.S. surrogacy industry, the relationships involved in India's growing commercial surrogacy market demonstrate far

[2] Scheper-Hughes, Nancy. "Rotten trade: millennial capitalism, human values and global justice in organs trafficking ." Journal of Human Rights 2.2 (2003): 223. Print. Full Quote: "*And they certainly lie behind the fears of organ theft, and the deep anger expressed in Eastern European villages today toward the medical 'vultures' and 'mafia dogs' who have turned them into 'communities of half-men and -women'".*

greater discrepancies in terms of class, wealth, education and informed consent" (Blatt 28), prompting writers such as Ishika Arora to ask, "Is this exploitation?" (Arora).

An American woman interviewed about her choice regarding Indian surrogacy responded that her reasons were both economic and legal: ""(T)he legal issues in the United States are complicated… the (American) surrogate mother still has legal rights to that child until they sign over their parental rights at the time of delivery." India's surrogacy laws, she said, were much more attractive to wealthy, intended parents" (Blatt 24). The (perhaps unintentional) implication in making such a calculation is that the lack of legal protection or state regulation for surrogates in India is an attractive factor. This 'customer' preference for an asymmetrical legal relationship in which the surrogate is the disempowered party is exploited in the contracts the Indian surrogates are asked to sign, which "serve as a record of the sale between the two parties" and "deprive the surrogate mother of having any rights to the child after delivery… viewing them essentially as emotionless biological vessels" (Arora).

Compared to the U.S., the unambiguous legality of gestational surrogacy in India has allowed for the fast growth of Assisted Reproductive Technology (ART) clinics there which are largely unregulated and not heavily taxed, allowing them to decrease the cost of surrogacy (Arora). In ensuring that the 'market price' for renting an Indian uterus is up to ten times less than that of a woman in the Global North, "(t)his tells Indian women that in numbers they are worth less in comparison to their foreign counterparts" (Arora). In addition, these clinics provide world class health care for Indian women pregnant with implanted embryos, despite not granting access to similar health care when the same women are pregnant with Indian babies, thus there is an implied message to non-

surrogate gravid Indian women that "their children are inferior to the foreign babies they (carry) in their womb" (Arora).

Indian surrogates are often exploited by the medical community, as medical ethics are abandoned by the attending doctors. Motivated by their financial stake in a successful outcome, medical professionals often prioritize the 'life of the child" (putting the medical needs of the fetus over those of the mother) when complications arise in the surrogate pregnancy, as opposed to the worldwide professional norm of "life of the mother". The surrogate is, thus, treated as merely a receptacle with less medical rights or legal protections than the unborn fetus.

Ironically, although the main defense of proponents of the industry is the financial benefit to the marginalized women of India ("a $7000 surrogate fee that could transform the lives of lower class Indian women" (Arora)), financial insecurity is written into the contracts: There is no guarantee of financial remuneration in surrogacy until the end of the pregnancy – contracts stipulate that payment is only available if a surrogate pregnancy is taken to term and a healthy, live baby is born - a 'pay on production' clause (Schanbacher 211).

And while ultimately, Indian women are signing the contracts, signifying their consent and implying that the trade is worth it, the exchange is predicated upon the surrogate "acting under economic compulsion" (Schanbacher 214), compromising the legitimacy of the autonomy of that decision. Blatt wonders, "are Indian surrogate mothers a muted group, subject to bodily exploitations without knowing it, objecting to it, or resisting it?" (Blatt 50).

Conclusion: "Special Status Goods"

By applying the neoliberal concepts of market forces to the human body, we have created an ethical quandary in which we have to balance the desire for children by some women, over the exploitation of others. "Surrogate motherhood, since it generates a by-product that is desirable to wealthy customers, is subject to a host of forms of objectification and commodification" (Blatt 27). Despite this, there are some that would argue that the commercialization of organ trade, whether a good or a bad enterprise, exists, and what is left is to create industry regulating policy that is sensitive to the changing social realities of the global economy, including the transnational inequalities that can be easily exploited (Blatt 45). Anthropologist Nancy Scheper-Hughes disagrees, writing, "(f)or most bioethicists the 'slippery slope'… begins with the emergence of an unregulated market in tissue and organ sales. But for the anthropologist the ethical slippery slope occurred the first time one ailing human looked at another living human and realized that inside that other living body was something that could prolong his or her life" (Scheper-Hughes 219). While she is writing specifically about the trade in kidneys, this concept aptly applies to the international gestational surrogacy trade. Permitting the commodification of pregnancy is unwise because it replaces the social meaning of parenting and the biological norms of gestating children with the economic norms usually associated with the process of production (Schanbacher 209). I am persuaded by Debra Satz who said, "some goods seem to have a special status which requires that they be shielded from the market if their social meaning or role is to be preserved"[3].

[3] Quote by Debra Satz, 2005 in Schanbacher, Kristine. "India's Gestational Surrogacy Market: An Exploitation of Poor, Uneducated Women." Hasting's Women's Law Journal 25.2 (2014): 209. Print.

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