Global Bioethics

ISSN: 1128-7462 (Print) 1591-7398 (Online) Journal homepage: http://www.tandfonline.com/loi/rgbe20

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To cite this article: Sunita Reddy & Tulsi Patel (2015): "There are many eggs in my body": medical markets and commodified bodies in India, Global Bioethics, DOI: 10.1080/11287462.2015.1112625

To link to this article: http://dx.doi.org/10.1080/11287462.2015.1112625

Published online: 17 Nov 2015.

Global Bioethics, 2015
http://dx.doi.org/10.1080/11287462.2015.1112625

Routledge
Taylor & Francis Group

RESEARCH ARTICLE

"There are many eggs in my body": medical markets and commodified bodies in India

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(*Received 3 September 2015; accepted 22 October 2015*)

With breakthroughs in science and reproductive technologies, "natural" birthing has undergone change due to the "assisted" use of conceptive technologies. Bodies and their parts have become commodities, to be sold and purchased in medical markets. In the literature, there have been numerous debates on commercialization and commodification, which have addressed the biopolitical and bioethical aspects of organ, egg and sperm donations, and gestational commercial surrogacy. This paper examines the everyday experiences of surrogates and egg donors, coerced and enticed into selling their reproductive services (for familial and socio-economic reasons), which become commodities for the larger medical markets of India's In Vitro Fertilization (IVF) industry. Based on a qualitative study of 4 IVF clinics and 28 surrogates in a state capital city of a southern state in India, this paper addresses the issue of commodification of women's bodies, where the women from lower socio-economic families are either lured or pushed to respond to the demands of reproductive markets. However, legal gestational commercial surrogacy in India, without clear laws and regulations to guide it, is a complex issue and raises many bioethical concerns. This paper limits itself to addressing the commodification of surrogates' bodies.

Keywords: surrogacy; egg donation; reproductive markets; commodification; India

Introduction

When reviewing the history of conception and "virgin births" in anthropological literature, Franklin (2002) indicates a long history of theorizing, from Roth's "ignorance of physiological paternity", which was then challenged by Malinowski's "generative power of the sexual act" (Malinowski, 2001), to Leach's questioning of the primitiveness and ignorance of the aborigines (Leach, 1966). Anthropological discourses on "birthing" are abundant. Discussions continue within the current context of advancements in biotechnologies, which have changed natural conception through the use of Assisted Reproductive Technologies (ARTs) or conceptive technologies. Strathern (1992) argued that existing models of nature and culture have been transformed by the explicit use of technology to achieve reproduction, with newly emerging forms of kinship and descent.

In the same way, anthropological understanding of the body; as an individual body, a social body, and a political body, an artifact of social and political control (Scheper-Hughes & Lock, 1987) provides an analytical framework for understanding gamete donations and surrogacy in

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India. Literature on various models of the body as a form of property, with individual ownership, either with full ownership or with no rights, exist in various contexts across all social groups. Women's bodies are sites for medical practices; especially childbirth. Under body politics, the concept of medicalization and power are ideas that must be based historically and culturally on an understanding of resistance, agency, and autonomy (Lock & Kaufert, 1998, p. 1).

This paper deals with a bioethical analysis of a growing reproductive industry; encompassing both gamete donations and surrogacy. It examines donors and clinicians' understanding of gamete donations, and fertile women's comprehension of their reproductive capacities and bodies from a social and cultural point of view, and the power of clinics to enforce body politics. Moreover, the paper looks at the everyday experiences of surrogates and egg donors, coerced and enticed into selling their reproductive services (for familial and socio-economic reasons), which become commodities in the larger medical markets of India's In Vitro Fertilization (IVF) industry. It also looks at cultural notions of the body and circumstances and procedures for surrogacy. The first part examines how IVF clinics screen and select surrogates and donors for reproductive services: egg and sperm donations. The second part investigates the desperation of Intended Surrogates (ISs), moving from one clinic to the next, undergoing various procedures like egg donation and surrogacy, and being repeatedly subjected to clinical trials in order to earn money.

Medical markets and commodified bodies

Globally, markets for reproductive services are well established and bioethical debates on such activities continue. While many countries have banned surrogacy, like Finland, France, Hungary, Iceland, Italy, and Japan, a few only allow altruistic surrogacy, like Australia, Canada, Belgium, and the Netherlands. Other countries, like India, Georgia, Greece, Israel, and the Russian Federation, have legalized surrogacy. Hence, bioethical debates on the commodification of bodies and reproductive services vary from country to country depending on their legal, ethical, and moral stances.

In consumer cultures, the body has become a fetishized commodity (Lupton, 2012). Body commodification should be understood in association with breakthroughs in biomedical technologies. Incursions on the body commodifies it either as a whole or in parts (Sharp, 2000). There is a marketability of human bodies. Bodies are for sale, whether whole or in parts, and are sold, bartered for or even stolen (Scheper-Hughes & Wacquant, 2002). The most notorious cases being the medical stealing of kidneys (Cohen, 2001). Medical markets have been exploiting the bodies of the poor and disenfranchized for want of corpses, either for dissection or for a range of valuable body parts for organ transplants. Cohen's term "bioavailability" to describe one's biological and physical availability to successfully remove and place organs into the bodies of others, is apt, determined by "economic need, political vulnerability and gendered moral demands of presentation" (Cohen, 2007, p. 85).

Medical research transforms socially expendable categories of persons into valued objects. Turner (1994) raised the dangers of the de-politicization of the body and the denial of sociality. In the book Reproductive Disruptions (2007), Inhorn describes the cultural anxieties over gametes and surrogacy and the perception of birth and bodies in contemporary society, which are regarded as a consumer commodity that must be groomed in order to achieve the maximum market value.

Reproduction gets redefined in the context of assisted reproduction as "natural phenomena" take second place to technological innovations. While discussing post modernism, Franklin (1995, p. 338) provided an outline of the extent of these cultural transformations, especially from anthropological literature, presenting beliefs about kinship, personhood, and human origins; the process of coming into being, or rather, conception. In all of these domains, reproduction is being redefined – socially, economically, politically, and culturally (Franklin, 1995).

Vora (2014) observed forms of sociality in ART clinics, which emerge by way of experiment, with modernity being seen to separate social relationships and reproductive bodies. Schicktanz (2007) uses the dialectical method for a critical identification and explanation of bioethical problems concerning the body and gives four different perspectives: bodily self-determination; respect for the bodily unavailability of the other; care for bodily individuality; and lastly, acknowledgement of bodily constituted communities. In the commodification of reproductive fluids and in discussions on the commodification of the body, questions arise regarding the fragmentation of body parts. Does it alter the construction of personhood or the social worth of human bodies? To what extent can it be considered victimization vs agential power of bodies?

In today's medical markets, body parts are donated for organ transplantation and profits are made from such donations. Similarly, when ovum/eggs,[1] sperms, and embryos are obtained at a low cost, profits are generated, as with marketable commodities. Can these then be regarded as "gifts" or "donations" as they are usually called? Mauss and Cunnison's (1954) representation of the symbolic exchange of cherished gifts and reciprocity can be sharply contrasted with the reality of surrogates, who are described as "angels" giving the "gift" of a child to childless couples. Gamete banks have become truly commercial banks, with commodities such as sperms, eggs, embryos, cord cells, and stem cells for sale. While in gestational surrogacy, both the mother's womb and the donor's eggs have become economically valuable. Commoditized male virility is an object of desire and the cultural relevance of semen has led to the commercial importance of sperm donations (Sharp, 2000).

Autonomy, ownership, and rights over body

In medical markets, the alienation of body parts and their transformation into commodities raises the question of ownership, property rights, and the violation of moral order. Lock (2001) discussed the social life of objects, including body parts, and multiple meanings given to the system of exchange. Debates on surrogates and their reproductive capacities cover issues from reproductive labor, referred to as "mother-worker" in India by Pande (2014), to the feminist construction of the body as property for sale in patriarchal capitalist societies where "renting of wombs" and "mother-machine" (Correa, 1985) metaphors are used. With reference to discourses on surrogacy rights, Ragone (1994) questioned the autonomy of surrogates in the US, where medical markets prey on the bodies of disenfranchized women in financial need, and are mystified by terms such as gift exchange. While clinical bioethics is largely concerned with a eurocentric tendency to favor universal "ethical" concerns rather than local "moral" ones (Kleinman, 1999, p. 70), in the Indian context both ethical and moral enquiries require a cross-cultural understanding of the issue through critical ethnography like that of Pande (2009) and Rudrappa (2012). The work of Team S.A.M.A. (2009) and Qadeer and John (2009) discusses the social and ethical dimensions of gestational surrogacy in the context of globalization and medical markets. Tanderup, Reddy, Patel, and Nielsen (2015a) analyze decision making in various medical procedures and reproductive autonomy, where women, especially surrogates, have little say regarding the number of embryos to be implanted, fetal reduction, and the number of children to be born: singleton, twins, or triplets, usually leaving such decisions to the doctors (Tanderup et al., 2015a).

Western discourses on "my body, my property" (Ginsberg & Rapp, 1995, p. 389) with the emphasis on property with a right to sell or alienate, need to be contextualized culturally. In India, the social identity of an individual takes precedence over the individual self (see Patel, 2004, for autonomy with regard to fertility). The body is seen as a shared rather than a private resource (Gupta & Richters, 2008, p. 247). There is a need for local understanding of the body and its place within the family, societal relations and local cosmologies when dealing with cosmopolitan biomedicine. Unlike the Indian shared body concept, Purdy (1996) stressed personal

experience, religious commitment, and emotional responses from the feminist bioethics point of view and clarified conflicts of interest in human reproduction. In the case of egg donations, a lot depends on the ethical and medical standards of the clinics. In India, cases of deaths due to hyperstimulation during the egg donation procedure have been reported in the media.[2]

Surrogacy: self-determination or colonization of bodies?

Gupta (2006) questioned whether the relationship between infertile women, who need egg donors or surrogacy services, and the women who provide surrogacy service for financial needs can be seen as a mutually beneficial relationship or mutual solidarity. Opinions are divided on this issue (see Rosalind, 1995; Markens, 2012). Some regard this form of surrogacy as a woman's right to self-determination concerning her body and an act of empowerment. Liberal feminists view the right to enter into a contract for surrogacy to be part of women's freedom. Therefore, while some consider it a woman's right to sell her procreative services, others consider the process as exploitative since it reinforces a woman's adherence to gendered norms. Radical feminists regard surrogacy as the ultimate form of medicalization, commodification, and the technological colonization of the female body (Sharp, 2000). However, Spar (2005) examined the political economy of commercial surrogacy and pointed out that the difference in income between Intended Parents (IPs) and surrogates is "evidence of the desperation caused by inequality" (Spar, 2005, p. 302). The provision of services for financial gain is becoming even more alarming with the expansion of cross border surrogacy and reproductive tourism, which thrives in certain developing nations. However, our paper goes beyond the binary of choice and commodification, and highlights the complexities of various procedures at different stages of the life cycle and in the different familial situations and political economic contexts of IVF markets, where the donors and surrogates play a crucial role.

Methods

Qualitative research was carried out in 2012 in four fertility clinics in the state capital city of a southern state of India. Key informants, such as fertility specialists, embryologists, counselors, agents,[3] coordinators, legal experts, and public health experts, were interviewed. Twenty eight interviews with surrogates were conducted, together with four focus group discussions mostly in the clinical setting and also in the surrogate hostels. Interviews with the clinic owners, counselors, embryologists, and the doctors were carried out in the clinics and two group discussions with doctors were also carried out. In compliance with ethical guidelines, the authors informed all the respondents of the objectives of the study and acquired their verbal consent to take part in it and to record the interviews. The names of the clinics are not revealed and the names of the respondents are pseudonyms. The Institutional Ethics Review Board (IERB) in Jawaharlal Nehru University was just being reconstituted in 2011 and, because it was not yet fully functional, was unable to review this study for ethical clearance.

In India, commercial gestational surrogacy is legal, although the draft ART (Regulation) bill of 2010 is still waiting to be passed by Parliament. There are only the guidelines of the Indian Council of Medical Research and the Ministry of Health and Family Welfare, or rather, Indian Government guidelines – the "National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India" (2005) – to follow, but these are merely guidelines and are not mandatory. These guidelines have little constitutional validity in terms of enforcement, and studies have shown clear violations of these guidelines (Team S.A.M.A., 2000; Tanderup, Reddy, Patel, & Nielsen, 2015b). Nevertheless, the guidelines are strikingly recalled by doctors and embryologists during interviews.

Results

Sites of study

Background details of the four clinics studied are given below, together with a comparative outline of the various procedures followed by each.

Clinic A is one of the oldest IVF clinics in the city, with guest rooms and hostels for its surrogate mothers. It has its own registered ART bank. It also has four sub-centers/satellite centers in other districts in the State. Clinic B is a private registered company founded in 2009. This clinic has networks and is in partnership with other agencies abroad, including sperm banks in Mumbai and other leading clinics in Hyderabad. Clinic C is part of a corporate hospital founded in 2009 by returned UK fertility specialists with 19 years of experience. They have an ART bank and a network with a cryobank in Aurangabad. Clinic D was registered as a company 17 years ago, and was founded by a doctor with 20 years' experience. It has links with an ART bank and has networks with other Life Lab for genetic analysis. Table 1 provides a comparison of the cost of various procedures in all 4 clinics.

Table 1. Cost (in Indian rupees[a]) of various procedures in the clinics.

Serial number	Procedures cost in Indian rupees	Clinic A cost	Clinic B cost	Clinic C cost	Clinic D cost
01	Consultation	400	500	400	400
02	IUI	6000	4000	4000	5000–7000
03	ICSI	175,000	105,000	105,000–165,000	50,000–100,000
04	IVF[a] (for each cycle)	150,000	85,000 plus medicines	105,000–165,000	100,000–120,000
05	GIFT	80,000	No Service	No Service	No Service
06	TESA/MESA	35,000	20,000–30,000	20,000	20,000
07	Sperm donation – per vial	8000	8000–12,000 sourced from Mumbai	2000	1000
08	Egg donation	20–50,000	30,000–40,000 through agents	20,000–30,000	20–30,000
09	Sperm Freezing	3000 for 6 months	5000 for 1 year	4000 per year	3500 for 6 months
10	Embryo Freezing	50,000 for 6 months	20,000 for 1 year	6000 per year	10,000 per year
11	Blastocyst culture	Included as part of IVF cost	Included as part of IVF cost	Included as part of IVF cost	Included as part of IVF cost
12	Embryo donor program	50,000	No service	Part of ART package	30,000
13	Assisted hatching	25,000	Part of ART package	10,000	10,000
14	Surrogacy[b]	Rs. 175,000–200,000 are paid to the surrogate.	Surrogate receives 200,000.	Surrogates are paid up separately 200,000.	Surrogates are paid via agents and receive up to 180,000–200,000.

Source: Data collected from four clinics during fieldwork in 2012.

[a]Rupee value in September 2012, was Rs. 55.55 for a US dollar.

[b]The surrogacy package varies from clinic to clinic, ranging from Rs. 800,000 to 1,000,000 (charged by the clinic for complete medical and in-patient care till delivery). It costs less where they only perform an embryo transplant, leaving the donor to cope on her own, with the help of the agent/agencies as was the case in two clinics.

All these clinics liaise with agents in order to get female egg donors and surrogates, and prefer using women of 21–35 years of age, in a good state of health with no previous complications and a history of normal parity. Each clinic has a counselor, who convinces surrogates of asexual conception that "their bodies are like *almirahs*, where they put in and take out clothes. Only in this case they put in the embryo and take out the baby". To prevent surrogates from getting emotionally attached to their newborns, the clinics do not show the newborns to the surrogate mothers and there is no possibility of breastfeeding. All clinics reported a 30–35% success rate for Intracytoplasmic Sperm Injection (ICSI) and IVF, and a 10–15% success rates for Intrauterine Insemination (IUI) treatments.

Factors motivating women to use their bodies as commodities

In this study, women revealed various motives for agreeing to egg donation and surrogacy. The primary motives were the meager earnings of their husbands, debts, and family responsibilities. Other reasons included domestic violence and alcoholism. In several cases, the single status of women either from broken families, deserted by their husbands, or widowed, separated, and divorced proved to be a motivator. In a few cases, husbands had migrated to different countries and had ceased supporting their families. In two cases, husbands had been cheated under false pretenses into thinking they were being taken to Dubai, losing large amounts of money, resulting in debts. To overcome this financial crisis and reattempt going abroad again, the women were persuaded into surrogacy.

As a result of poor financial conditions, women either came into contact with agents or their friends and neighbors, who introduced them to surrogacy. Agents shared their strategies in recruiting the surrogates from rural areas. During self-help group[4] meetings attended by local residents, agents have a pretty good idea of the financial needs of women and attempt to recruit them for surrogacy.

One of the agents attested: "It is only the poor who come, some do not have husbands. In some cases, where husbands beat them, they come without telling them, give birth and then return." Another agent stated: "They are really needy, poor and helpless. Many women want to commit suicide because of financial burdens. In the last 3 years at least three to four hundred women have approached me." Thus women coming forward in such large numbers and seeking to become surrogates demonstrates the desperate conditions in which they live and their strong desire to resolve the family's financial crises.

Women who opted for surrogacy felt that "it was a good opportunity to take care of their family's needs". Some felt that there was no feasible alternate to earning money, except as a daily wage earner, as almost all were either illiterate or had completed only primary education, with the exception of one graduate. They had no skills and were not engaged in any kind of work outside the home. They had married early, between 15–20 years, and having given birth to one or two children before the age of 22–25 years, were considered fertile, healthy, and ideal as potential surrogates and egg donors.

These women considered the possibility of becoming egg donors or surrogates to be the only way of getting "good money" in a short time. Around Rs. 180,000 to 2 lakh rupees was a huge amount of money for them, besides the rest and cherished food. However, the truth is that not all succeed in completing the process and getting the entire sum. Those who are not successful have to leave beforehand and only receive part of the sum. Surrogates, especially those who are single, deserted, or separated, who have to raise their own children and share the family responsibilities, found it more attractive. Hence, single, widowed, or divorced women were more vulnerable and likely to sell their reproductive services for the betterment of their children and their families, and for maintaining societal relations.

Commodification of gametes

With scientific technological advances and commercialized organ transplantation, organs like the eyes, liver, skin, and even the heart can be donated only once before dying, since none of these organs are regenerative, but in ARTs, body fluids and tissues are regenerative. Thus, the sale of sperm, eggs, and surrogacy services can be repeated and purchased again and again. On several websites like "Surrogacy India,[5]" donors provide their contact information for egg and sperm donations but mostly do not give their profile or pictures in order to maintain secrecy, since these services are looked down on socially and often stigmatized, whereas in US websites like Surrogacy America,[6] many donors' advertisements are posted on the site with complete details, pictures, and profiles with positive aspects of their personality.

Generally, it is the gamete banks, clinics (although technically, according to ICMR guidelines, clinics cannot advertise for donors, even though they do), and surrogacy service providers who advertise the need for sperm, eggs, and surrogates. As with any other product, efforts are focused on getting the best quality. Banks and clinics attempt to screen and select the best gametes, embryos, and surrogates (from a limited pool) to successfully bring about the final product – a "precious baby". The clinics, too, attempt to build labs with the most sophisticated and updated technology so as to get the best results. One embryologist said, "to set up a lab with imported latest equipment costs approximately Rs.70–80 lakhs". However, he continued, "nothing can be done with highly sophisticated equipment alone, unless one has trained embryologists". The following section looks at sperm donations, screening, selection, and distribution.

Sperm donations

The ART bill states that any man between the ages of 21–45 years can donate sperm up to two and three times per week and that this sperm should not be given to more than 75 women (Ministry of Health & Family Welfare, 2010, p. 20). Therefore, hypothetically 75 children born will have the same biological father, and since each donor's identity is confidential, the possibility exists for progenies of the same father to form conjugal bonds – even though one doctor said it was highly unlikely in such a huge population as India. According to Dr A, one man can donate up to 10 times. Yet there was no common understanding of how many times a man could donate or how many women could be impregnated with a single man's sperms. When discussing the sperm banks in Aurangabad and Mumbai, one embryologist was concerned that, "coming from a single region, most children were likely to be born with Maharashtrian[7] features". He suggested "setting up regional sperm banks, where each region in India had a local supply of sperm". Another felt that "the idea of having a centralized bank, as proposed by the bill, would not be practical".

Clinics collect information on the height, build, blood group, and eye color of the donors and each donor is given a number. This information is gathered for the purpose of matching biological parents, particularly the "husband".[8] Sometimes, however, after two or three cycles, if the IPs do not become pregnant, they get desperate. At which point they no longer bother with matching them, wanting only positive results at any cost. An embryologist from Clinic B said, "they did not have a bank and got consignments of eggs and sperms from Mumbai when they required them. Their embryologist chooses the sperm and the egg based on the medical history of the donors and other characteristics. It generally takes a day for the consignments to arrive."

Egg donations

According to the ART bill, a surrogate can give a maximum of five births, including her own children, and can donate eggs six times between the ages of 21–35 years. An embryologist mentioned

that altruistic[9] egg donations have so far not happened in India. This is thought to be so because egg donors have to undergo invasive procedures. These procedures can also lead to health risks such as Ovarian Hyper Stimulation Syndrome (OHSS), which in some cases, though rarely, can be fatal. He knew of college girls in Mumbai who earned their pocket money via egg donations, contrary to ICMR guidelines, which states that they should be married and have their own biological child. They earned 20–25 thousand rupees per donation. The media also brought to light, as mentioned earlier, the case of Sushma Pandey, a 17-year-old who died in a Mumbai IVF clinic in 2010[10]. This girl was not married, and was below 18 years of age. In another case, 21-year-old Yuma Sherpa died in a Delhi IVF clinic following an egg donation[11]. In both the cases, the risks of OHSS were played-down and the clinics got off scot-free. Though the cases were listed under medical negligence, justice was not enforced, as no one took up the cases of these poor women.

There is no clear consensus among IVF clinics regarding the number of times a donor can donate, or the time period that should elapse between interventions. According to Dr V, up to 6 cycles are allowed for egg donors, with a time gap of 3–4 months. Dr V felt, "it is not ideal to donate or receive eggs after 30 years of age, because the quality may not be good. Egg donors should be less than 30 and have a history of delivering children of normal height and weight and with reasonable nutrition levels. Color and beauty are secondary requirements."

Comparing egg and sperm donations, Dr V reported, "egg donations are not a very simple process like sperm donations. The procedure is not painful but it is labor intensive when compared to sperm donations, unless women are committed they cannot go through the whole process. Donors have to go through the entire procedure: sedation, collection and injections for at least two weeks." Egg donations require an invasive technique, and also labor intensive procedures, yet the financial incentives entice poor women to sell their reproductive capacities.

Perceptions and experiences of egg donors

Surrogates had various perceptions about their capacities to donate eggs. Ramya, who had undergone egg donations, reported, "I think there are many eggs in my body; they extract about ten every time they do the process. I was told that I could go as long as I can, depending on my health condition. There should be a gap of 3 months in between the egg donations. I went after 5 months. Doctors say that we should not do it frequently as it may affect our health in the long term; in spite of this, some mothers go every month to donate eggs."

However, we could not verify if this was true, but the doctors did say that there was no way of establishing whether a woman had an interval of three months' rest before returning to donate eggs.

One surrogate said that she did not want to be a surrogate again in the future, and it was only because of financial pressures that she had done so. Now she had chosen a different way to earn well – egg donation. She said that it was difficult to keep surrogacy a secret, and therefore, she had taken up egg donations instead. She wants to continue to be an egg donor as long as her health permits. By doing so, she can also manage her other work and no one will know that she donates eggs. She works with two clinics for egg donations. Previously, at a bigger hospital, she had donated eggs twice. Now she is undergoing the same process at another well-known clinic. Her case clearly shows how repeated egg donations are driven by the need to earn money, facilitated by the secrecy surrounding the industry, since women prefer egg donation to surrogacy – a long term commitment, which is difficult to conceal.

Another donor reported that she had donated eggs last September and stated, "How I am going through the process of becoming an egg donor. I am going to Dr X. They told me they will give me Rs. 20,000. I am not sure why they are giving me more since Dr Y and Dr Z give only

Rs.15,000. In the bigger hospitals, they give Rs. 25,000. If we go directly, without agents, we may get up to 30,000 rupees. But the agents take commission and give donors 20–23,000 rupees." This shows that donors are well aware of the going rates on the ART market and try to contact clinics directly to save on the extra commission of 5000 rupees going to the agents.

The responses of the egg donors showed that they were completely unaware of the risk of OHSS and repeatedly undergo egg donations. Moreover, switching from one clinic to the next makes it difficult to track how frequently they are donating. They consider it an easy way to earn the money they desperately need. Clinics, on the other hand, play-down the risk, as there is a huge demand of eggs, sperm, and surrogates in the growing reproductive markets of India.

The family's acceptance of donors' eggs and sperm

Dr K reported that these days people are open to accepting sperm and egg donations. Even though people ask for donors from their own caste, clinics do not encourage it and, in most cases, there is no choice. However, the acceptance of a donor's sperm or eggs is still shrouded in secrecy, in some cases people even ask the doctors not to reveal the donation to their partner. However, doctors reported that they are particular about revealing all the processes and getting the consent of both partners.

With regard to matching IPs, Dr V stated, "ideally they should be closely matching the recipient and donor but this cannot be done for all couples. Egg donors are not widespread in the country. Sometimes they need to compromise. Some IPs demand that donors are educated, fair in color, and with good looks. All this depends on availability. The people who come for egg donations are from lower strata of society, sometimes they ask their own hospital staff from lower ranks, and their friends too, to donate eggs/sperms."

A surrogate said that she had not been chosen as an egg donor because her complexion was too dark. Dr C from Clinic A said, "Sometimes the Commissioning parents come with strange requests. She referred to a gay couple, who wanted an egg donor with a good jaw line."

According to one of the counselors, ICMR guidelines state that donors and surrogates should not be relatives or known friends. It is always better to maintain confidentiality. Otherwise, with the importance given to "Vamsham" (lineage) in the Indian culture, there could be a lot of legal complications in future.

Screening and selection of surrogates

Clinics look for eligible women with healthy wombs who are married, with children, without health complications, and of appropriate age, height, and weight. Surrogates should also not smoke or drink and have healthy lifestyles. They must have successfully carried at least one child. Once a surrogate has been selected, she must undergo a full medical check-up. This includes a careful examination of her medical and family history, a thorough physical examination, a psychological evaluation, and blood tests for HIV, Hepatitis B, and C, and other sexually transmitted diseases. Also cervical cultures are carried out for microorganisms such as Chlamydia and Ureaplasma, together with an evaluation of the uterus via hysteroscopy, and blood tests for Prolactin and Thyroid-stimulating hormone. Stimulation of the ovary, the retrieval of eggs, insemination, and embryo transfer are all part of the usual course of action for surrogacy, yet the surrogates are unaware of all of the medical procedures. In some cases, where surrogates were too skinny and less than the prescribed weight, agents fed them beforehand to increase their weight and then took them to the clinics for screening.

Once screening has been completed, the embryo is transferred to the surrogate's womb. If the implantation is successful, the surrogate's pregnancy is confirmed. If not, she is sent back and asked to return after a few months. However, it has been observed that once they fail in surrogacy,

the ISs tend to go soon after to another clinic and donate eggs instead. These procedures are repeated from one clinic to the next, without adequate intervals. In the process, they treat their own bodies as commodities, moving from one clinic to the next donating eggs and attempting to become surrogates.

Repeating procedures: egg donations, surrogacy, and clinical trials

In six cases, the ISs had also undergone clinical trials locally, called a "medicine test", subsequently becoming egg donors and finally surrogates. In some cases after surrogacy, they again wanted to donate eggs and then repeat surrogacy. Many of these women understood the risks involved in each of the procedures. Yet they still continued to repeat the procedures. Amala was misguided into thinking that she could donate her eggs every month, though in the end she never went. One of the ISs considered going for clinical trials to be a better wage earner than working for a company where the salary was approximately Rs. 6000 rupees per month, since she could earn the same amount in 2–3 days from clinical trials. Almost making it a regular livelihood, even though they were aware of deaths caused by clinical trials in their vicinity, making surrogacy seem less risky.

Revathi had been a surrogate once but did not want to become one again because she had experienced problems and many side effects. Now she is an egg donor. She said, "I am preparing myself for egg donation. I need to take a good rest, eat good food and fruit. Then the eggs will grow sooner, healthier and bigger. Now I earn money through egg donations. I get accepted easily because of my fair complexion."

Ramya said that she had been advised to eat lots of dry fruit and apples, avoid citrus fruit, chicken and mutton, and to abstain from sex, when she had complained of stomachache while attempting to become an egg donor. Nine cases of women who went for repeated procedures clearly show how ISs commoditize their reproductive capacities.

Lalitha and her husband previously worked in a chemical company before going for the medicine test. They have undergone clinical tests for the past 4 years. He said, "we know that it is risky, but we do it because we need the money to overcome financial problems. For clinical trials the pay is high for women compared to men. For example, a man gets Rs. 8000, whereas a woman gets Rs.12, 000. I don't know why, but women are paid more." He continued, "my wife has stopped going for these tests since her health was not cooperating. Now she is trying for surrogacy instead. I also refer women for surrogacy, they give me Rs. 400 for each surrogate". Thus, the husband was working as an agent and his wife was helping him.

Payments and exploitation

With commodification comes pricing, costs, and bargains. In the ART business, the cost is borne by the IPs. With all the uncertainty and high failure rates, ART is an expensive proposition for them, however, motivated by the desire for their own biological child, they opt for various procedures and surrogacy. The costs borne by the IPs cover all those involved in the process of producing a baby. The largest share goes to the clinics, where the procedures take place, followed by the surrogates and agents, as shown in Table 1 above.

In spite of the fact that the ART bill states that payments should be negotiated between the IPs and the surrogates, in most of the cases, the surrogates, agents, and IPs have no say in the price. It is the clinics that decide the city's market rates. Egg donation procedures take only 9 days. The total price for egg donation is Rs. 25,000, on top of which donors have to pay Rs. 5000 as commission to the agents. The price for surrogacy is not fixed; it varies from one hospital to another, and ranges from Rs. 180,000 to 225,000. Surrogates are paid in installments. In three hospitals,

payments are made in cash. Other hospitals pay by cheque. If surrogates comply with all procedures and restrictions sometimes they also receive additional gift money from CPs. Srilakshmi, a surrogate, stated, "as per the agreement, they paid me Rs. 225,000 – and they gave me an extra 30,000. I received Rs. 50,000 after confirmation of the successful embryo transplant and after six months I received another 50,000. They paid me Rs. 155,000 after delivery. I listened to them and took my medicine at the right time so they gave me an extra Rs. 30,000 (gift money)." Two mothers complained of the non-payment of some balance outstanding. One surrogate complained that she had expected twice the amount promised, as she had delivered twins.

Exploitation of surrogates regarding pay is obvious. Dr A stated that the main reason surrogates come forward is because of financial hardship. According to her, there should be clear guidelines concerning the range of payments and these should be made known to the ISs. She felt that the amount should be increased since they are paid less considering the process they undergo. She said the agents benefit more, and even though they are important actors in the whole process, the surrogates are not getting their due share. Similarly, one of the counselors also stated that they should be paid more for all the pain they go through. He was not satisfied with the agents, who he considered to be "brokers" and exploitative.

To avoid paying commission to the agents, Clinic B paid surrogates directly by cheque. Most of the surrogates complained about the agents who took commission from them and also the clinics, and felt that the agents earned much more than they did without going through the pain.

One surrogate was very candid about the exploitation by the agents, "when agents handle surrogate mothers, they take at least half the amount (she named two agents). They act like consultants. The surrogate may not know the exact amount paid by the commissioning parents. Agents also deduct shelter, food, and travel expenses to hospital from the surrogate's share."

Another surrogate stated that some agents are more commercially minded than others and less concerned about the surrogate or donor's health. Agents receive Rs. 3000–5000 for each surrogate introduced, however, some talk directly to parents and fix rates for egg donations, in the region of Rs. 50,000–60,000. They then pay Rs. 20,000–25,000 to the donors and keep the rest. She thought that the government should make regulations to establish how much money should be paid. Moreover, that agents should be more sensitive to the mother's/donor's health and not concerned only about commerce.

The money surrogates receive is often not enough and they require more. All the surrogates who took part in this study felt that their remuneration should be increased, particularly because they had invested a long period of time in the project and undergone all sorts of stress while managing their own families. Further justification they gave for an increase was that CPs are charged exorbitant rates. However, one doctor saw things differently, "the women who come here for surrogacy do so purely for money; it is a business deal, for them there are no emotions and strings attached. No one comes to serve."

CPs' treatment of surrogates as commodities

One of the main concerns of the surrogates interviewed was the lack of dignity in their work and respect by others, especially the CPs. They were not happy with the attitude of the couples for whom they provided their services. As one surrogate mentioned, "She had to commit one year of her life. Not all commissioning parents are sensitive to the needs of the surrogate mothers. Some of them just view her as a commodity (service giver) just doing the task that she is paid for. When this kind of attitude develops no relationship is built. They pay the money and then come to take the baby. They do not care about the mother who has been through so much over the last year."

The protocol in IVF clinics in Hyderabad is that IPs never meet surrogates, except when foreign IPs are involved, in which case they meet once at the embassy to get their signatures. The policy of the clinics is to minimize bonding. In most cases, surrogates are not allowed to meet IPs and after delivery the surrogates are not shown their newborns and are not allowed to breast feed because they are told that this will lead to bonding and relinquishing their child will be more difficult (Reddy et al. in the Cassidy & El. Tom, 2015).

Conclusion

With India's billion plus population, poverty, and desperate living conditions, women are enticed and coerced into selling their bodies, either whole or in parts. The reproductive industry makes it legitimate for them to sell their reproductive services under the pretext of a "gift", shrouded in secrecy, due to fear of social stigma. Empirical evidence shows the marketability of gametes and wombs, and agents and IVF clinics have come together to respond to the growing demand of infertile couples to have their own biological progeny.

Women's bodies have become consumer commodities for the huge reproductive industry, where the agents, and women themselves, prepare and groom their bodies to increase their market value, not knowing the risks involved (Tanderup et al., 2015b) and the long term impacts on their bodies.

Contrary to Mauss' symbolic exchange of cherished gifs (1954), IVF clinics are situated in the capitalist world, where medical markets buy and sell reproductive services from the poor for the better off, where healthy and fertile bodies with active sperms and eggs become commodities, mystified by the language of gift exchange. The whole phenomenon is quite complex, where the demand of desperate couples wanting children makes the reproductive markets thrive. Cohen's (2007) concept of bioavailability determines the economic criteria of the donors and surrogates, further determined by the economic interests of the clinics, as intermediaries, and the fertility industry, on the global level, all promoting the commodification of women's bodies in the medical markets.

The fertile bodies of women are fragmented, or rather invaded, by invasive techniques to produce children for infertile couples, at a cost. In this study, women admitted selling their reproductive services and considered their bodies to be both productive and socially worthy, clinics market them and convince them through counseling that they are performing a noble job. The factors in this case that influence reproductive autonomy are strongly influenced by poverty and the belief system that devalues such autonomy (Purdy, 1996). In the process, poor women's bodies are victimized, as they undergo repeated invasive procedures, often facing failures, lured by money to keep experimenting with their bodies, moving from one clinic to the next for egg donations, surrogacy, and even to participate in clinical trials. From a biopolitical and bioethical point of view, as part of Neoliberalism, reproductive markets in India are thriving in the absence of any laws or regulations. Furthermore, enculturation with traditional Indian values constructs "mothers" as sacrificial entities; living and dying for their children and family, thus providing the perfect context for women to take the plunge into the deep dark sea of medical markets.

Notes

1. Eggs here refer to Ovum/oocytes, for keeping it in common parlance, the term 'egg' is used throughout.
2. http://www.livemint.com/Opinion/jaLf5RYkFQKSPhGZhrt42M/Minority-report–Death-in-the-birth-industry.html, accessed on 24 July 2015.

3. Agents are individuals who facilitate the process of surrogacy between the surrogate mothers and the clinics. In some literature they are called as brokers. They are well versed with the medical systems, or women who were earlier surrogates turned to be agents. Now bigger more professional agencies have come up which facilitate surrogacy end-to-end service.
4. Self Help Groups (SHG) is a village-based financial intermediary committee usually composed of 10–20 local women or men, linked to the banks for micro-credit program.
5. www.surrogacyindia.com.
6. www.surrogacyamerica.com.
7. Colloquial perception of sharing similar physical features, seen as typical of a particular state, Maharashtra is a western state in India.
8. Interesting point made by the embryologist, to match 'father' it can be interpreted either giving importance of patrilineal, and also confers the non-infidelity. In IVF all these goes out of the window.
9. Altruistic egg donor or altruistic surrogacy refers to those who are willing to come forward for providing services free of cost.
10. http://indianexpress.com/article/cities/mumbai/illegal-egg-donation-chargesheet-filed-against-director-doctors-of-bandra-fertility-clinic/ accessed on 24 July 2015.
11. http://www.livemint.com/Opinion/jaLf5RYkFQKSPhGZhrt42M/Minority-report–Death-in-the-birth-industry.html accessed on 24 July 2015.

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