Women at Risk in the Unregulated Surrogacy 'Industry'

Evidence from a Study of Commercial Surrogates in Kolkata

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In recent times India has become a haven for commercial surrogacy, a controversial assisted reproductive technology. Acute poverty means that there are always women ready to rent their wombs. But lack of laws and regulations means there is no transparency in the business of surrogacy and the surrogate mothers are prone to exploitation. The Assisted Reproductive Technology Bill 2013 aims to mend matters. This exploratory study conducted in Kolkata brings to light challenges that any legislation dealing with surrogacy must address. It shows how poor women who rent their wombs for money—ignoring social stigma, health hazards, fear and mental stress—are vulnerable to exploitation.

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In a continuous effort to regulate commercial surrogacy and protect the rights of the players involved in this method of assisted reproduction in India, modifications were made to the Assisted Reproductive Technology (Regulation) (ART) Bill in 2013. This is the third draft of the bill, after the versions drafted in 2008 and 2010 were revised.

Media reports talk of efforts to regulate and legalise commercial surrogacy to minimise the exploitation of poor women. In a meeting, held in March 2014, to review and discuss the draft ART Bill of 2013 (which at present is a part of the cabinet notes and thus not available in the public domain) the Ministry of Home Affairs (MHA) suggested restricting surrogacy to "infertile Indian married couples" only. MHA also suggested that non-resident Indians (NRIs), persons of Indian origin (PIOs) and overseas citizens of India (OCIs) be eligible for surrogacy in India. It did not want to extend eligibility to foreigners unless they were married to Indian citizens (Malhotra 2014). The main aim of this proposal, as reported by a correspondent of the *Hindu* (Malhotra 2014), is preventing poor Indian women from taking the risk of surrogacy under the lure of financial benefit.

After the Foreigner Regional Registration Office (FRRO) identified three surrogacy clinics of Mumbai violating visa norms related to couples seeking surrogacy, Maharashtra Medical Council (MMC) formulated guidelines for the state. The draft guidelines have been submitted for scrutiny. According to media reports, a watchdog committee of six members has been appointed. It comprises two MMC members, two representatives from ART centres, one representative from ART bank and another from a non-governmental organisation (NGO) (Shelar 2014).

More recently, a member of Parliament has introduced a bill in the Lok Sabha to regulate surrogacy. The Bill, No 61 of 2014, named "The Surrogacy (Regulation) Bill, 2014" deals with surrogacy arrangements alone and not ART as such. It allows commercial surrogacy arrangements for couples from abroad, if they have an appointed guardian in India.

In 2005, the National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India framed by the Indian Council of Medical Research (ICMR) argued against legal bar for the use of ART by a single or an unmarried woman. The 228th report on "Need for Legislation to Regulate Assisted Reproductive Technology Clinics as well as Rights and

Obligations of Parties to a Surrogacy" submitted by the Law Commission of India in 2009, also states that since judiciary in India has recognised the reproductive right of the humans as a basic right and accorded it constitutional protection, surrogacy which allows an infertile couple to exercise that right should have constitutional protection. The report brings surrogacy into the ambit of reproductive rights and calls for legalising it.

Home Ministry Gets Tough

After several debates MHA, in 2013, gave a stringent instruction prohibiting gay couples and single foreigners from commissioning an Indian surrogate mother to bear their child. Only those foreign "men and women" who have been married for a period of two years will be granted visas to visit the country to have a child through a surrogate mother (Rajadhyaksha 2013). Meanwhile, the health ministry felt that single parents including foreigners should be allowed surrogacy (Thakkar 2014).

In addition to this, MHA gave another legal guideline which made tourist visa out of bounds for foreign nationals intending to visit India to commission surrogacy; they will require medical visa. They will also require a letter from their country's embassy or from their foreign ministry stating clearly that their country recognises surrogacy and the child/children born to the Indian surrogate mother will be permitted entry as a biological child/children of the couple commissioning the surrogacy. The couple will also have to give an undertaking that they will take care of the child born through surrogacy; the medical procedures for such surrogacy will take place in ART clinics recognised by ICMR. The couple will require an exit permission from the Foreigners Registration Office (FRO) before leaving the country's shores with the newborn. This permission will be given after authenticating the ART clinic certificate concerning the custody of the child/children. The couple must also have fulfilled their obligations and commitments to the surrogate mother, stipulated in the contract. The law also directs the FRRO/FRO to retain the birth certificate of the newborn and keep photocopies of the visa and passport of the foreign parents[1] (BOI 2014).

Exploitation

The question, however, is will the guidelines restrict exploitation of surrogate mothers?

India, a socially conservative society, has provided surrogacy arrangements to couples from both within the country and abroad since 2002. Britain is reported to be the single major source of clients for India's booming commercial surrogacy business (TOI 2012). Low medical costs, advanced medical infrastructure and skilled medical workforce, lax laws and poverty—which has fostered numerous labourers ready to rent wombs for a low compensation—have combined to make India the surrogacy capital of the world (*Guardian* 2009; Fontanella-Khan 2010). The world of commercial surrogacy flourishing without any legal framework along with all its stake holders, that is, surrogate mothers, commissioning parents, doctors and agents is awaiting the new regulations.

To explore the implications of existing surrogacy arrangements in India on poor women, a study was conducted in Kolkata city. It adopted a qualitative method. Individual case studies were conducted on nine women (S1–S9) who were in various stages of pregnancies after having agreed to rent their wombs, two biological parents or commissioning couples (C1 and C2), three agents/brokers (A1–A3) and husbands of the surrogate mothers (H1–H9). The focus of the study was to highlight the vulnerabilities of poor women who are willing to be surrogate mothers for the sake of money.

Important Players

Surrogate Mothers: The surrogate mothers interviewed were 22–35 years (we use S to refer to them). Most were married and stayed with husbands; three of them were separated. Six of the women had two children, one had three children and two had a child each. Some had primary education—one had progressed to the sixth grade—others were illiterates. Of the nine women, two were housemaids, one worked as an agent for infertility clinics and one was a beggar, while the others were unemployed (Table 1). Their occupational status shows that at best they could count on uncertain and irregular income.

Table 1: Profile of Surrogate Women Interviewed

Surrogate Women	Age	Marital Status	Occupation	Education	Number of Children
S1	27	Married	Beggar	Illiterate	2
S2	28	Married	Housewife	Illiterate	2
S3	25	Separated	Housewife	Class 4	1
S4	35	Separated	Housemaid	Class 6	1
S5	28	Married	Agent for infertility clinic	Class 5	2
S6	25	Married	Housewife	Illiterate	3
S7	22	Married	Housewife	Illiterate	2
S8	25	Married	Housemaid	Class 5	2
S9	26	Separated	Housewife	Illiterate	2

Source: All tables are on the basis of case studies conducted by the authors in Kolkata.

The age of the husbands of these women ranged from 25 to 50. All of them were illiterates. Five of the nine were unemployed, while others were involved in agriculture and factory work; one was a rickshaw puller (Table 2).

Table 2: Profile of Husbands of the Surrogate Women

Husbands of Surrogate Women	Husband's Age	Husband's Occupation	Husband's Education
H1	29	Unemployed	Illiterate
H2	40	Rickshaw puller	Illiterate
H3	29	Unemployed	Illiterate
H4	50	Factory worker	Illiterate
H5	36	Unemployed	Illiterate
H6	31	Agricultural worker	Illiterate
H7	25	Agricultural worker	Illiterate
H8	30	Unemployed	Illiterate
H9	31	Unemployed	Illiterate

The profile of the surrogate women and their husbands indicates their poor financial situation. All of them talked about their extremely difficult, poverty-ridden lives and the dire need for money which had left them with no choice but to rent their wombs. They needed money for their daughter's wedding, to build a proper house, to repay loans, to send their children to school and to economically support their family. For an average remuneration of Rs 2 lakh—the lowest was Rs 1.5 lakh

and highest Rs 2.5 lakh—they had agreed to rent their wombs. Their major sources of information about commercial surrogacy were agents working for the infertility clinics—women who had once been surrogates—and doctors and other acquaintances (Table 3).

Table 3: Reason to be a Surrogate, Source of Information and Remuneration

Surrogate Women	Heard about Surrogacy from Whom?	Reason to Be a Surrogate	Remuneration Received (Rs in lakh)
S1	Relative	Money	2
S2	Another Surrogate	Money	2.5
S3	Agent	Money	2
S4	Landlady	Money	2
S5	Doctor	Money	1.4
S6	Cousin who was a surrogate	Money	2
S7	Agent	Money	2
S8	Agent	Money	2 I
S9	Agent	Money	2

All the women showed a sense of desperation which led them to bear someone else's baby, ignoring embarrassment, discomfort, health hazards and social stigma.

> I am hardly able to feed my children properly even once a day. It's a shame for a mother. But I have to do this (S7).
> People might be criticising me now, but if my children do not have food to eat, will these people come and feed them every day? I cannot pay heed to what they say. If I do, I will see my children die of hunger. I being a mother cannot let that happen (S8).
> I am doing it only because God has left me with no other choice (S1).
> I am doing this not for me, but for my children and family. God is with me (S6).

All these women had no problem with their husbands. They said that their husbands were very supportive of their decision—though some had initial reservations.

> My husband did not want me to do this. He feared that my life would be at risk. But after many discussions, he agreed. He realised money was important for us and this was an opportunity. He is a good man. He does not drink nor does he have any bad habit. He said he will support me as long as I do not get involved in any bad work (S8).
> My husband has always been with me and has accompanied me every time I had to visit the clinic (S1, she had visited the clinic almost seven to eight times since her treatment began).

Family members, especially mothers, had a strong influence on the decision of the women who were seperated or divorced. S3, whose husband had left her six years ago, was financially dependent on her mother and wanted to earn and contribute to the family. Her mother, the family's decision-maker, carried out negotiations pertaining to her surrogacy.

> My mother wants me to have a normal delivery since I will not be able to do all the heavy household work soon after a caesarean operation. But the doctor is not agreeing. She will request him again (S8).

She had another serious problem.

> My mother does not want me to stay with her once my pregnancy is visible. I will move to a place arranged by the commissioning parents.

Commissioning Couples: Couples (we refer to them as C), who had hired surrogate mothers for their baby, belonged to a higher age group. In C1's case, the wife was 52 years old, while her husband was around 57 years; in C2's case, the wife was 45 years old and the husband 50 years old. Both the couples had been married for over 20 years and failed to have a child of their own.

In C1's case, the wife had conceived three years after her marriage, but experienced spontaneous abortion. In the following years, she realised she was not being able to conceive. She started treatment only to discover that she had a carcinogenic tumour in her uterus and wrong treatment had led to vaginal infection; she had to get her uterus removed. Her desperation for a child left her with no other choice but to go for surrogacy.

> I do not want to adopt a child. My husband wants a baby having his own blood and that is only possible through surrogacy (Wife, C1).

The first couple was not apprehensive about having a child at a relatively old age and planned out all that it would go in taking care of the new member. They reported that everyone close to them knew their decision to commission a surrogate mother. They had their family's support and in fact a family member suggested that they go for surrogacy.

The couple C2 were from Kolkata but their families were based in Mumbai. They had tried to have their own baby for a long time and underwent all possible treatments. They even approached *tantriks* and astrologers. The wife conceived several times, but on each occasion her pregnancy failed.

> At first I thought it was due to my carelessness and took the matter on a light note. After five years of our marriage, we realised something was wrong. It was then that we decided to seek medical help. Unfortunately we were late; we should have visited the doctor much earlier (Wife, C2).

Surrogacy was the only option left to them. The uncertain procedure and the difficulty of getting a "good" surrogate mother made them reluctant to begin with. But they finally agreed and gained confidence after detailed discussions with doctors and information from newspapers and magazines. However, they did not tell their family members. Their families knew that they were seeking treatment for infertility and since the couple was already staying away from their families, they did not feel the need to explan matters.

> We have decided to tell them that we had the baby through IVF. We will only let them know once we have the child. I do not think it will be a big problem (Wife, C2).

The Agents: The women agents (refered to as A) are involved with different clinics and work as brokers bringing women willing to donate eggs or willing to be surrogate mothers. They have a good network and the doctors rely on them to a great extent for the supply of egg donors and surrogate mothers.

A1, who was 22 years old, was married to a man of 26 years for almost six years and had two children. The elder son was five years and the younger only a year old. She had studied till Class 4 and was the only member in her family who had been to a school. Her husband worked as a mason on a contract basis. She had once been to a clinic with her sister-in-law for donating egg and decided to be an agent for surrogate women after that.

A2 was 38 years old and her husband was 44. They had been married for 22 years. She had education till Class 3 while her

husband, a carpenter by profession, had studied till Class 8. They had one daughter who was in Class 9. Two years back she had visited a clinic to sell her eggs, but could not since they were not of good quality. It was then on a doctor's suggestion she started working as an agent for that clinic.

A3 was the eldest of the three agents. She was 50 years old, married to a man of 56 years and had three children. All her children were engaged in higher studies, while she had education till Class 8 and her husband had completed Class 10. He runs a small jewellery shop and she helps the people in her area to open bank accounts and with other minor bank-related works. Three years back she came across a woman who approached her to be an agent and referred her to a doctor. After that she started working as an agent for two clinics. Her husband knew of her work, but her children did not.

Findings

The interviews of the surrogate mothers revealed many aspects of this business. It showed the immense resolve and determination of the women; it also showed their financial desperation. Social stigma and criticism was secondary to their need to sustain their life. However, under the veil of the enormous mental strength, lingered fear and apprehension.

> I am quite worried about going to Ranchi (for embryo transfer). I am illiterate and have never been out of Kolkata. What if I miss the station? What if anything happens there? What if I am sold there? The doctors have asked me not to take my husband there in order to prevent any sexual intimacy after the transfer. But I cannot do it without him; he is my support (S1).
>
> I fear I have to stay away from my family and children for the pregnancy period. Who is going to take care of them? I was not aware of this when I agreed to be a surrogate! (S2).
>
> My husband has not been living with me for six years. What will the neighbours think when they suddenly see me pregnant? The party (the intending parents) is not agreeing to arrange for my stay. But they have to, at least from the fifth month onwards. As far as my son is concerned I will tell him that the baby died in the womb. He is only four years, so convincing him will not be a problem (S3).
>
> Once I give birth they will take the baby away. What is going to happen to my breast milk then? Are there no means by which I can stop the secretion of milk? (S7).

As far as the foetus growing in the surrogate mother's womb was concerned, all the women displayed immense mental strength and were clear about their preference for money over the child.

> I need money, not another child. I cannot be weak and sentimental now (S8).
>
> I do not want to see the child nor do I want to know whether it is a boy or a girl. Doing so might make me emotionally attached and that will not help me in any way. I already have one daughter and I know what it is to be a mother. I am only concerned with the money now (S4).

However, only one of the women expressed some weakness for the child.

> The baby is going to stay in my womb for so many days, and I will be the one helping the baby grow up and yet I will not be allowed to see him/her even for once? How can I live without even having a glimpse of the baby? (S1).

The relationship between the surrogate mothers and the commissioning couple was reported to be good. The women who had rented the wombs found the commissioning couple caring and were happy to be hired by them; they even referred to the wives as *didi* (elder sister).

> They are extremely good. They enquire about my health regularly, always make an effort to know what food I like, what my children like. Every time they visit me they bring gifts and take us out to restaurants. Didi (the intending mother) treats me like her younger sister. Though I am doing this for money the couple needs to be good too. I am happy to have been hired by them. I did not like the couple I met before, even though they were ready to pay more. I am renting my womb, but I am also giving them a child (S5).

The couples who hire surrogate mothers are generally responsible for the latter's place of stay, especially after about the fifth month of pregnancy. They also need to take care of all the medical expenses and transport costs of the women renting wombs. Most of them took good care of the hired mothers and enquired about their health and other necessities regularly. S9, who was living in a room, rented by her commissioning couple, reported that they had hired a personal maid to care for her.

> I do not know how they (commissioning couple) will behave after the child is born. But the only thing that matters to me is that they are very good to me now. I am happy. I trust them and they trust me. They know that I will not let any harm to their child. I just pray to God that the remaining few months pass without any trouble (S9).

Though a few of the surrogate mothers referred their situation as a "punishment" and had no hesitation in saying that they will never rent out their wombs again, most expressed joy in fulfilling their "fateful" duty. Through a journey of physical pain, mental stress, social stigma and unknown fear, these women had decided to gift a child to the childless couple and were happy about it.

> When they keep on thanking me and tell me how happy I have made them, I truly feel that I am doing something good and that makes me feel very satisfied (S7).
>
> When I see the happiness of the couple, I forget everything. Let God bless the baby and the couple (S5).

The agents or brokers who brought these women to the clinics were important links between clinics/doctors, the surrogate women and the hiring couples. These women, who were mostly approached by the doctors to work for them, were well-connected with people who could help them contact prospective surrogate mothers. Unlike the surrogate mothers who were shy and docile, these women were bold, confident and wilful.

> Every one I bring to the clinic, trusts me. Not just the woman, her family members too depend on me. If anything untoward happens to her, that would be my responsibility. Their family will come and question me and not the doctors. So I need to be very careful. Money is not everything. I might be getting few thousand less but I have to see that the people involved are trustworthy (A3).
>
> I have brought quite a number of women who wanted to be a surrogate, but not all can be one. Many get rejected and many refuse after few days (A2).
>
> If a woman shows no interest in renting her womb after I explain the surrogacy procedure to her, I have to let it go. After all it is a sensitive issue. Again, if someone agrees, the woman needs to take the permission

of her husband. These women often ask me to go and talk to their husbands or their family members personally. Often there is absolute rejection from their side too (A1).

The agents portrayed themselves as having complete knowledge about the whole matter and were taking up deals and discussions with the doctors and commissioning couples on behalf of the women renting their wombs.

Money Matters

The most important factor in surrogacy is the money, which attracts poor women to lend their wombs. They are paid in instalments. As discussed earlier, the surrogate mothers in Kolkata were paid Rs 1.5 lakh–Rs 2.5 lakh. When they are recruited, the surrogate mothers are paid Rs 3,000–Rs 4,000. The commissioning couple also pay the costs of medicines, scans, injections and other medical expenses. The woman renting her womb then goes through an embryo transfer. If this transfer results in a successful pregnancy, she is paid a sum of Rs 30,000–Rs 35,000. After delivering the baby and handing her/him over to the biological parent, the surrogate mother receives the rest of the contracted amount. Besides this, the biological parents also bear the expenses of transport, food and at times, even living costs.

According to the doctors, paying the surrogates in instalments pre-empts any breach of agreement by the surrogate mothers. Some clinic staff gave examples of women contracted for surrogate motherhood not coming back for treatment after receiving the initial payment. There were also stories of women aborting the child. To check such practices, some clinics had started taking away the identity card, the voter identity card, of the women wanting to be surrogates; they kept the card till the baby was delivered and handed over to the biological parents.

The surrogate agents were paid in the range of Rs 15,000–Rs 20,000 per case. They received payments from the clinics because the latter had got them business.

I do not ask any reward from the surrogate women. But, if she feels happy with my service and support she might feel like giving something in cash or kind; likewise with the commissioning couples (A3).

Conclusions

Though surrogacy is often associated with altruism, women who rent their wombs are the most vulnerable and their dismal socio-economic condition makes them even more susceptible to exploitation. Mostly uneducated, they lack knowledge about the intricacies of surrogacy. Quite obviously they will find it difficult to comprehend the particulars of the medical procedure, the details of the treatment their body will have to go through, and most importantly, the side effects of the pregnancy. In most cases, counselling only mentions that she is going to become pregnant with someone else's baby, it talks about keeping the baby safe and tells her to hand the baby over to the biological parents—but it does not talk about the health hazards. It is only later that she realises the difficulties of artificial pregnancy and the subsequent health hazards.

The business is replete with hierarchies of gender, race, caste, class, religion, ethnicity and nationality: at the apex, well-off couples from abroad and rich Indian clinic owners; in the middle, medical personnel and surrogate brokers; and at the bottom, poor women serving as rentable wombs (Sama 2010). When a person from the lower strata of the society is in a posh clinic, surrounded by the well-to-do doctors and the rich couples, she is likely to become more psychologically aware of her societal position and her ability to negotiate, question or even discuss issues becomes highly compromised. When the commissioning couples are foreigners, there is a tendency of the women renting wombs getting swayed by their presence. She does feel a little close with the agent. However, the agents too are not educated enough to understand the process and their incomplete knowledge makes the situation worse. Thus the surrogate women are at the mercy of other players in the system.

Most ART clinics do not provide reliable information about the low rates of success, probability of multiple pregnancies and high probabilities of foetal abnormalities; instead they promote false and unethical claims to lure clients (Qadeer and John 2009). The Centre for Social Research (CSR 2013), in a study of 100 surrogate mothers from Delhi and Mumbai, found that a large percentage of such women do not get to interact with the commissioning couple, especially during the early stage of the treatment. When the couples are foreigners, they are usually informed after the first trimester when they visit India to sign the agreement. The study concludes that the doctors/agencies/clinics stand as barriers between the surrogate mothers and the commissioning parents. There are many reasons for this, one of which is the fear that the financial returns of these brokers might be hit if the two major parties in the surrogacy arrangement establish direct contact. So the surrogate mothers are forced to take statements made by the clinics at face value.

In October 2014, the owner of a clinic in Bengaluru was arrested on charges of running a surrogacy racket and human trafficking (*Deccan Herald* 2014). A *Bangalore Mirror* (2014) report noted that for Rs 3.5 lakh, the clinic had handed over a girl child born to a surrogate mother to a couple in seven months' time, only to discover later that DNA of the child did not match that of the father. Doctors use the social context and ideology of motherhood to exploit the gestational mothers in taking care of the baby during the pregnancy and after birth (Saravanan 2010). This scenario is going to prevail until there is transparency in the surrogacy "business"—whether foreigners are allowed or not allowed to commission surrogate mothers.

In the United Kingdom, Australia, Brazil, New Zealand, Israel and Holland where only altruistic surrogacy is allowed, close relatives of the commissioning couple come forward to offer their wombs. Such a gesture is motived by compassion, sympathy and a pure desire to help a childless couple. Since money does not play a major role here, there is little chance of exploitation. In India, however, commerce drives the surrogacy business. It is a service only rich couples can afford, and for women who rent their wombs, it is a way to resolve economic problems.

The reproductive and overall health of the surrogate women should be as important as the primary aim of surrogacy, delivering a healthy baby to the commissioning couple. But the well-being and health of the surrogate mother is rarely

addressed in the surrogacy arrangement and most often the attention is focused on the health of the foetus.

Besides the health of the surrogate mother before and during pregnancy, there are possibilities of many minor and major post-pregnancy health problems like post-partum infections, pain in perineal area, haemorrhoid, constipation, post-partum depression, urinary and faecal incontinence and breast engorgement which may even lead to breast infection. For example, usually between second and fifth day after delivery, the secretion of breast milk increases and breasts become hard. Breast engorgement can happen if the lactating women miss several nursings and not enough milk is expressed. The situation worsens with insufficient breastfeeding and/or blocked ducts, which might cause mild to extreme pain, and even infection. For a surrogate mother, who does not get a chance to breastfeed, this is often a problem. Several questions arise. Who should be taking the responsibility of her health after the completion of the procedure? Is she cared for at all after the procedure is completed? Who should bear the cost of all her post-partum treatment? What if she acquires some acute health complications while undergoing treatment and after, what if the complications cost her life? What if the surrogate mother is not paid her promised money? Not providing proper information or even recruited as surrogate without any proper contract or forced to abide by the decisions of other parties may lead to grim consequences. Who do these women or her family members approach for justice in such situations? Is there anyone who clarifies their doubts, assuages their fears and gives them emotional support?

The guidelines do not talk about the safety of the child when the future parents are from another country and commission the process through intermediary agencies and local guardians. They do not stipulate follow-ups and also do not require a local guardian to monitor the surrogate mother during pregnancy (Qadeer and John 2009). An Australian couple abandoning one of the twins born to an Indian surrogate mother created headlines recently. Reports say the couple already had one child and wanted another of a different gender (Kumar 2014). A person claiming to be a friend took over the unwanted baby while the Australian embassy suspected money had changed hands.[2] In July 2014, a couple from Australia left one of the twin boys born to a Thai surrogate mother, because he was suffering from Down's syndrome. Later it emerged that the father of the baby was a convicted child sex abuser (Kohlbacher 2014; Tillet 2014). Such known and many more unknown cases raise great concerns on the rights and protection of the child born to a surrogate.

Surrogacy is a medical innovation to serve needy couples who are unable to give birth. But in reality, is it only those few couples who are desperate for a child and yet unable to complete their family avail this arrangement. Or are there others who have chosen this arrangement as a way of escaping pregnancy? There have been cases where couples, who already have a child of their own and are capable of having another one but do not want to go through the process of pregnancy and labour, have commissioned surrogate mothers. This, indeed, is a major exploitation which requires to be regulated.

Will restricting the foreigners from hiring Indian surrogate women take care of the exploitative aspects of surrogacy? Banning foreign commissioning couples from commercial surrogacy in India will surely reduce the surrogacy market to a great extent. It will make matters difficult for clinics and hospitals, agents and even surrogate women and other agencies, who were making quick money in a short period. The demand for commercial surrogacy in India will be highly reduced. However, concerns of health, economic, legal and ethical exploitation of the vulnerable women will remain.

When the surrogate mothers are the main subject of concern in formulating and revising the guidelines, a little thought needs to be given to their point of view. The requirement of a transparent procedure is important. A clear set of rules and regulations mentioning rights and duties of the commissioning parents and surrogate mothers and the other actors is necessary. The guidelines should also mention the probable complicated situations and the responsibilities and actions of the actors in such situations. A background screening and proper counselling should be mandatory for all the surrogate mothers and the commissioning couples before recruitment, during the treatment, during pregnancy and also after the baby is delivered. The surrogate mothers should feel free to approach the counsellors without any hesitance.

Many women said that they were not informed well about the procedure while being recruited. The surrogate mothers should be made to understand the details of every step of the procedures along with the difficulties of the treatment, the side effects and the health complications that may arise. A woman should be recruited only after she decides to give her consent after getting extensive information on the arrangement. The guildelines should make it mandatory to explain all terms and conditions in the contract to the surrogate mother and her husband in their vernacular. The surrogacy contract should have all the names of all the people participating in the procedure, including the infertility physician, the psychiatrist or the counsellor, the legal member, the governmental authority, the agent and also the name of the clinic where the treatment is taking place along with the surrogate mother, her husband and the commissioning couples. It is also imperative to provide a copy of the contract to the woman renting her womb. This is going to make all the participants accountable in case there is any complication. Such transparency will also minimise the abuse of commercial surrogacy.

There should be ways to assure that the clinics and hospitals are abiding by the rules prescribed in the ART Bill and legal actions should be taken against violators. Though the term compulsory insurance is mentioned in the draft, it is not known to the surrogate women and they do not realise the importance of the same. As a result, most clinics find a way of escaping from this financial burden. The insurance of the surrogate mothers should be compulsory which every clinic needs to ensure. Rules should not only look after the rights of the surrogate mother, but also the child born as a result of surrogacy. Maximum care needs to be taken so that no child born through surrogacy remains unwanted. In addition, there should be strict action against the commissioning couples who forsake their surrogate child

because of gender, disease or any other reason. There should be a governing body to monitor the proper working of the system. The body should mainly serve the surrogate mothers by giving them information, educating them about their body, and making them realise their rights and duties.

Commercial surrogacy has brought child-bearing into the domain of the market in an unprecedented manner, challenging the ideological constructs of the family and the very basis of kinship (Sama 2012). Surrogacy is certainly a boon of medical innovation that is capable of giving the gift of life, but a shift from the humanitarian values to that of business and moneymaking is a matter of grave concern. In a country like India, even after laws and regulations, there are chances of poor women being exploited. Vested commercial interest, lack of laws and regulations, and increasing demand from within India and abroad, make commercial surrogacy a booming business, and at the same time, a "major threat" to poor and illiterate women. The need of the hour is not to ban commercial surrogacy as such, but have appropriate legislation and stricter implementation of laws.

NOTES

1 Immigration Visa Foreigners Registration and Tracking, Surrogacy, Bureau of Immigration, MHA, Government of India, 2014, available at: http://boi.gov.in/content/surrogacy

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