

# THE CONSTRUCT OF AN INDIAN SURROGATE QUALIFYING FOR VULNERABILITY

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*“People say it is the conscious choice of the woman. Our stand is that it is a very wrong notion of the family as a whole to use the woman’s body to make money. Is she a child-producing factory?”*

- Anupriya Patel, Union Minister of State, Health and Family Welfare<sup>1</sup>

*“The press calls surrogates machines. If you have three children instead of two would your family call you a machine?”*

- Rashida Banoo, five-month pregnant surrogate<sup>2</sup>

*“In my village, one woman has nine boys and two girls but no one calls her a baby-making factory.”*

- Sera, seven-month pregnant surrogate<sup>3</sup>

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<sup>1</sup> Abantika Ghosh, *Surrogacy legislation: is woman a child producing factory*, INDIAN EXPRESS (Sep. 2, 2016) <http://indianexpress.com/article/india/india-news-india/surrogacy-ban-commercial-foreign-clients-woman-child-producing-machine-3008933/>.

<sup>2</sup> Nergish Sunavala, *Humans of Anand: “We’re not baby making machines”* THE TIMES OF INDIA (Sep. 8, 2016) <https://timesofindia.indiatimes.com/india/Humans-of-Anand-Were-not-baby-making-machines/articleshow/54197129.cms>.

<sup>3</sup> *Id.*

## A. INTRODUCTION: SURROGACY, VULNERABILITY AND THE LAW

Surrogacy is a practice in which a woman decides to act as a gestational mother for the offspring of another person. Surrogacy may be traditional, i.e., the gestational mother (the surrogate) is also the genetic mother of the offspring she carries, or it may be genetic, i.e., the intending mother or a donor provides the ovum for the procedure. Surrogacy is a widespread practice in India and a complex phenomenon and poses great many legal, ethical and political questions that are as yet unanswered.

In 2015, the Government of India made a radical shift in its stance on surrogacy, claiming that commercial surrogacy would no longer be legally permitted in the country. Surrogacy was to be, henceforth, only altruistic. This stance on surrogacy was diametrically opposite to the Indian Supreme Court's stance in 2008-2009 when during the case of *Baby Manji Yamada v. Union of India*,<sup>4</sup> it legally recognized and in effect legitimized the commerce of the surrogacy industry in India. This legitimacy in effect led to surrogacy becoming a multi-million dollar industry.<sup>5</sup> While the industry burgeoned and India came to be known as the cradle of the world<sup>6</sup>, ground research revealed that all concerned parties - identifiably surrogate mothers, commissioning parents and surrogate babies - were being potentially short-changed in the unregulated surrogacy industry.<sup>7</sup> Concerns were raised that surrogate mothers were being made to sell their motherhood - exploited under the control of a handful of medical experts.<sup>8</sup> The shift of the Government in 2015 towards a ban was ostensibly to end the exploitation of surrogate mothers.<sup>9</sup>

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<sup>4</sup> *Baby Manji Yamada v. Union of India and Anr.*, A.I.R. 2009 S.C. 84 [hereinafter the Baby Manji case].

<sup>5</sup> Sharmila Rudrappa, *Reproducing Dystopia: the Politics of Transnational Surrogacy in India 2002-2015*, 1 CRITICAL SOCIOLOGY 4 (2017).

<sup>6</sup> Aditya Ghosh, *Cradle of the World*, HINDUSTAN TIMES (Dec. 23, 2006), <https://www.hindustantimes.com/india/cradle-of-the-world/story-sPA9Q9b2r4MHRQ9R7dNJnK.html>.

<sup>7</sup> CENTRE FOR SOCIAL RESEARCH, REPORT OF THE NATIONAL CONFERENCE ON 'A POLICY DIALOGUE ON ISSUES AROUND SURROGACY IN INDIA' 3 (2014), <http://www.womenleadership.in/Csr/SurrogacyReport.pdf> [hereinafter the CSR Conference Report]. Recording the deliberations of a two day conference on 22<sup>nd</sup> and 23<sup>rd</sup> September 2014.

<sup>8</sup> Bhadra Sinha, *'It amounts to sale of motherhood': Surrogacy warrior who moved SC speaks up*, HINDUSTAN TIMES (Aug. 26, 2016), <https://www.hindustantimes.com/india-news/magazine-article-led-78-year-old-surrogacy-warrior-to-move-supreme-court/story-Yj6VytKEooOChZTVV3KDmK.html>.

<sup>9</sup> Editorial, *The New Surrogacy Bill will Stop Exploitation of Women*, HINDUSTAN TIMES (Aug. 25, 2016), <https://www.hindustantimes.com/editorials/the-new-surrogacy-bill-will-stop-exploitation-of-women-and-make-way-for-ethical-practices/story-zefLgh17Ijpfjg8T8zv1QM.html>.

Media reports consequently highlighted various surrogate mothers objecting to this shift in position, which suggested a conflict of interest between the government and the surrogates. In November 2015, a group of surrogate mothers moved the Supreme Court.<sup>10</sup> They said the changes by the Government of India were discriminatory and projected surrogacy in a very negative light.<sup>11</sup> However, their attempt to be heard was opposed by the Union of India itself in its counter affidavit dated 29 January 2016, which rejected the surrogates' contention that they had been rendered jobless by the government's changed stance. The basis of this rejection was the claim that surrogate mothers are not directly affected by the ban<sup>12</sup> – a problematic stance, given that the ban was enforced to end the exploitation of surrogates.

In the wake of this changed stance, there have been numerous debates about whether surrogacy is immoral,<sup>13</sup> exploitative and commodifying<sup>14</sup>. There have also been significant discussions led by social workers, women's rights activists, public intellectuals, and law and policy makers on how the industry is to be regulated, who is to be regulated, whose rights are to be protected, what can and cannot be permitted, and so on. In the throes of these raging debates, however, little is known about the 'surrogate mother'. Who is she? What are her needs, opinions and expectations? What options does she have? Does she identify her state as immoral? Does she consider herself exploited or commoditized, and if yes, then by what specifically? Where and how does she anticipate her own vulnerability in the face of potential exploitation? There is no doubt that the surrogate mother is vital for the success of the surrogacy arrangement and plays a pivotal role with the longest and toughest investment in the arrangement. Yet, it appears that draft after draft of any proposed

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<sup>10</sup>Bindu Shajan Perappadan, *A Setback for Surrogacy in India*, THE HINDU (Nov. 29, 2015), <http://www.thehindu.com/opinion/op-ed/a-setback-for-surrogacy-in-india/article7927730.ece>.

<sup>11</sup>Aradhna Wal, *Surrogate Mothers say Regulate Practice, Don't Ban it; Moves SC Opposing Restriction*, DNA (Nov. 30, 2015), <http://www.dnaindia.com/india/report-four-women-vocally-oppose-the-new-restrictive-banning-foreigners-from-availing-surrogacy-in-india-2150202>.

<sup>12</sup>Bhadra Sinha, *Women are not Legally Empowered to Become Surrogates: Centre to SC*, HINDUSTAN TIMES (Feb. 4, 2016), <http://www.hindustantimes.com/india/women-are-not-legally-empowered-to-become-surrogates-centre-to-sc/story-LWItwPR2MOYkqhQ0vzsvDN.html>.

<sup>13</sup>MARGARET ATWOOD, *THE HANDMAID'S TALE* (McClelland and Stewart 1985). Dystopian novel where some women are subordinated to the sole purpose of being a surrogate.

<sup>14</sup>Angie Godwin McEwen, *So You're Having Another Woman's Baby: Economics and Exploitation in Gestational Surrogacy*, 32 VAND. J. TRANSNAT'L L. 271, 273–78 (1999).

regulation on surrogacy has failed to involve her in the law-making process or make her central to it.

The Government's changing stance on surrogacy was supposedly to end exploitation, but we cannot really begin to understand what exploitation entails if we don't first have an adequate idea of who it is that is being exploited and where this exploitation comes from. The main aim of this paper is thus to develop an understanding of the construct of the surrogate and, concomitantly, understand how the possibilities of exploitation and its regulation are necessarily framed by interconnected legal, societal, medical and economic structures. In this regard, the question of the surrogate's vulnerability to potential exploitation forms one of the central aspects of this paper in its attempt to understand the construct of the surrogate in the Indian context. Another key element is understanding the relationship between the law, vulnerability and the possibility of exploitation before we ask how this relates more specifically to the issue of surrogacy. This understanding is highly relevant today as actions seeking to protect vulnerable individuals or groups may often appear paternalistic, and therefore are questioned by the very groups for whom protection is sought.<sup>15</sup> This appears to have also been the case in India, as surrogates themselves have opposed the steps of the Indian Government to presumably end the exploitation of surrogates.

### **A.1 Methodology**

In India, there exist very few systematic studies that have attempted to understand the demographic and socio-economic backgrounds of women acting as surrogates. At the time of writing this paper, only three research studies were available on women acting as surrogates. The first is an exploratory study by the Centre of Social Research (CSR) titled *Surrogate Motherhood – Ethical or Commercial* (2012), in which 100 surrogates from Anand, Surat and Jamnagar were interviewed (hereinafter referred to as the CSR ASJ Study). The second is a study conducted by Sama – Resource Group for Women and Health titled *Birthing A Market – A study on Commercial Surrogacy* (2012), which interviewed 12 surrogates in total, of whom 4 were interviewed in depth (hereinafter referred to as the Sama Study). The third is also by the CSR, *Surrogate Motherhood*

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<sup>15</sup> RUTH MACKLIN, *BIOETHICS, VULNERABILITY AND PROTECTION* (Blackwell Publishing Ltd. 2003), 473. Also available at <http://www.unige.ch/medecine/ieh2/files/8714/3472/9172/me-12-Macklin-vulnerability-and-protection.pdf>.

– *Ethical or Commercial* (2014), in which 100 surrogates from Delhi and Mumbai were interviewed (hereinafter referred to as the CSR DM Study). The studies by CSR were funded and recognized by the Ministry of Women and Child Development, Government of India.

Even in these studies, there is a dearth of analysis of the surrogates' strengths and vulnerabilities due to their demography and socio-economic background. Without this understanding as a starting point, the various attempts to put a law in place to regulate surrogacy might not be able to take into account the vulnerabilities experienced by the surrogate mother nor identify the potential for exploitation or discrimination in the various levels of interaction in the process.

The aim of this paper is to know the surrogates better with the help of their demographics, and begin to clarify ways for the legislation to take their vulnerabilities into account in a way that helps support their interests. By focusing on the interviews conducted and comparing the data collated in these studies, we identify and analyze the common, operational circumstances that define the demographic and socio-economic background of a woman wishing to act as a surrogate. Then through the development of a concept of vulnerability, we provide a deeper insight into how such a background may or may not make her vulnerable in the surrogate arrangement and how potential legislation can make provisions to address vulnerabilities, if any, and narrow the possibility of exploitation or discrimination.

In order to fulfil this aim, the argument of this paper proceeds as follows: 1] we analyse the concept of vulnerability as developed in existing studies and legitimize its use and value for the purpose of this paper; 2] we analyse the three available studies to identify who the surrogate is and what her circumstances are; 3] in a meta-analysis that draws from the two earlier sections, we conceptualise a vulnerability matrix specific to this context in relation to the law.



## B. THE CONCEPT OF VULNERABILITY

In an influential 2013 collection of essays on the subject, Mackenzie et al.<sup>16</sup> defined vulnerability as an ontological human condition. Our lives, they observed, are “conditioned by vulnerability”<sup>17</sup> since, to a large extent, we depend on others for our wellbeing, care and support. With this broad definition as their starting point, they began to theorise vulnerability “in connection with a range of other concepts, including harm, need, dependency, care, and exploitation”.<sup>18</sup> Drawing from theorists like Judith Butler<sup>19</sup> and Martha Nussbaum<sup>20</sup>, vulnerability is understood as something that is always relational and infrastructural. Where quality of life is defined by relationships and dependencies, vulnerability is not only an undeniable fact, but also a “socially induced condition”.<sup>21</sup> We are always already vulnerable, as Butler would have it, to certain “symbolic systems”<sup>22</sup> which fundamentally structure how we act and identify with others and ourselves. On this theoretical base, Mackenzie et al. developed a taxonomy of vulnerability that distinguishes between two kinds of vulnerabilities: inherent and situational. The former refers to those “sources of vulnerability that are intrinsic to the human condition. These vulnerabilities arise from our corporeality, our neediness, our dependence on others, and our affective and social natures”.<sup>23</sup> Situational vulnerability on the other hand refers to a context-specific vulnerability, “caused or exacerbated by the personal, social, political, economic, or environmental situations of individuals or social groups”.<sup>24</sup>

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<sup>16</sup> CATRIONA MACKENZIE, WENDY ROGERS & SUSAN DODDS, (Eds.) *VULNERABILITY: NEW ESSAYS IN ETHICS AND FEMINIST PHILOSOPHY* 3 (Oxford University Press 2014).

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> Judith Butler, *Precarious life, vulnerability, and the ethics of cohabitation*, 26(2) *THE JOURNAL OF SPECULATIVE PHILOSOPHY* 134-151 (2012). Symbolic systems encompass nearly all social relations – gender, race, class, caste, age, marital and educational status – which define, legitimise or delegitimise, and determine the contexts and possibilities of the ways in which we relate to one another.

<sup>20</sup> MARTHA C. NUSSBAUM, *FRONTIERS OF JUSTICE: DISABILITY, NATIONALITY, SPECIES MEMBERSHIP* (Belknap Press 2007).

<sup>21</sup> JENNIFER HOBBS, *Vulnerability In Resistance*, Eds. Judith Butler, Zeynep Gambetti & Leticia Sabsay, 19:4 *INTERNAT'L. FEMINIST J. POLITICS* 539-541 (2017).

<sup>22</sup> Butler, *supra* note 19.

<sup>23</sup> Mackenzie et.al, *supra* note 16 at 7.

<sup>24</sup> *Id.* at 8.

Another significant definition of vulnerability is offered by Chandrima B. Chatterjee in her work on vulnerability and health for CEHAT (The Centre for Enquiry into Health and Allied Themes).<sup>25</sup> Diverging from Butler and Mackenzie et al.'s dependency-based model, Chatterjee defines vulnerability specifically as the state of being exposed or susceptible to danger or abuse. She writes that vulnerability "comprises of weakness of physical or mental strength, defenselessness, unprotectedness, fragility and exposure to undesirable conditions/factors."<sup>26</sup>

For the purpose of this paper, this definition is a crucial refinement of those presented above. Although vulnerability may be an ever present condition of human life, being vulnerable isn't necessarily tantamount to being exploited. The link between vulnerability and exploitation is indeed the exposure to detrimental conditions. In the case of surrogacy, it could be argued that a careful identification of those detrimental conditions that render a surrogate negatively vulnerable could constructively inform regulatory interventions to prevent exploitation.

While Mackenzie et al.'s taxonomy (inherent and situational vulnerability) marks an important point of departure for this paper, there are nevertheless significant differences in the way the construction of vulnerability is deployed here. The vulnerability construct for surrogacy in this paper could be considered a situational one on the whole: A surrogacy arrangement marks a very context-specific vulnerability. Our own categorization of vulnerability involves a distinction between intrinsic, extrinsic and relational vulnerabilities that a surrogate mother could be subjected to. This will be defined and elaborated in Section C.

A further refinement and legitimation of our classification are possible by recourse to biomedical research on human subjects, in which the measurement of vulnerability of the subject has been largely guided by universal ethical principles formulated by the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. Historically, this concept vis-à-vis biomedical research on human subjects links with surrogacy intimately as the Indian Council of Medical Research's (ICMR)<sup>27</sup> first reference to surrogacy was in its Ethical Guidelines

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<sup>25</sup> CHANDRIMA CHATTERJEE & GUNJAN SHEORAN, VULNERABLE GROUPS IN INDIA, The Centre for Enquiry into Health and Allied Themes (CEHAT) 1998.

<sup>26</sup> *Id.* at 23

<sup>27</sup> The Indian Council of Medical Research [*hereinafter* ICMR] was set up as the Indian Research Fund Association in 1911, has evolved over the years in line with changing health research needs. Today, it is the apex body in India

for Biomedical Research on Human Participants, 2000.<sup>28</sup> In the year 2000, the practice of surrogacy was likened to biomedical research being conducted on the human subject, and we argue that the surrogate mother and her vulnerabilities should therefore be visibilised similarly.

In the Belmont Report in 1978,<sup>29</sup> vulnerability came to be understood in eight categories<sup>30</sup>, briefly defined here:

**(1) Cognitive or Communicative Vulnerability** concerns the capacity of a person to be able not only to consent but also understand, appreciate and reason through the consent documentation and/or explanations.

**(2) Institutional Vulnerability** includes individuals who are subject to a formal authority and whose consent may be coerced directly or indirectly.

**(3) Deferential Vulnerability** recognizes informal subordination to authority figures. These may arise in doctor/patient relationships or husband/wife relationships where one person feels obligated to follow the advice of the other.

**(4) Medical Vulnerability** includes individuals whose medical state may cloud their ability to make a decision regarding participation. As surrogates are not receiving medical treatment for any of their own ailments, such a category of vulnerability would not usually apply to the surrogate.

**(5) Economic Vulnerability** includes individuals whose economic situation may make them vulnerable to the prospect of free medical care and/or the payments issued for participating in the arrangement.

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for the formulation, coordination and promotion of biomedical research. It is one of the oldest medical research bodies in the world.

<sup>28</sup>ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH ON HUMAN PARTICIPANTS (ICMR, 2000), [http://whoindia.org/LinkFiles/HSD\\_Resources\\_Ethical\\_Guidelines\\_for\\_Biomedical\\_Research\\_on\\_Human\\_Subjects.pdf](http://whoindia.org/LinkFiles/HSD_Resources_Ethical_Guidelines_for_Biomedical_Research_on_Human_Subjects.pdf). [*Hereinafter* ICMR Research Guidelines 2000].

<sup>29</sup> THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH, The National Commission For The Protection Of Human Subjects Of Biomedical And Behavioral Research (1978) [*Hereinafter* Belmont Report].

<sup>30</sup> EIGHT CATEGORIES OF VULNERABILITY, Institutional Review Board for Social & Behavioral Sciences, University of Virginia, (modified from National Bioethics Advisory Committee, Ethical and Policy Issues in Research Involving Human Participants. Aug 2001.), [http://www.virginia.edu/vpr/irb/sbs/resources\\_guide\\_participants\\_vuln\\_eight.html](http://www.virginia.edu/vpr/irb/sbs/resources_guide_participants_vuln_eight.html).



**(6) Social Vulnerability** recognizes the vulnerability of participants who are at risk for discrimination on account of race, gender, ethnicity and age.

**(7) Legal Vulnerability** would concern the legal situation of an individual such as the ability or inability to provide proof that would allow a situation to be legalized, presence without legality, undeclared professional activity, etc. It would include participants who do not have the legal right to consent or who may be concerned that consenting could have legal repercussions for them.

**(8) Study Vulnerability** includes participants who are made vulnerable by the study's design. As this is specific to medical research studies, it is not immediately applicable to the surrogate in our general assessment of her vulnerabilities.

Section D will elaborate further on the connection between these types of vulnerabilities and the classification we develop. We now turn to the relation between vulnerability and the legal system of India.

### **B.1 Vulnerability in Indian Law**

The Constitution of India, adopted in November 1949, is prefaced by a preamble that is a solemn resolution of the people of India to secure Justice, Liberty and Equality for all its citizens, with an objective to promote fraternity.<sup>31</sup> In 2017, the President of India reiterated once again that this is not an abstract ideal and has to be made meaningful to the lives of ordinary people in every street, village and mohalla [neighbourhood] of India. "It has to somehow connect with their everyday existence and make it more comfortable," he said.<sup>32</sup> However, in the face of ever growing

<sup>31</sup> THE CONSTITUTION OF INDIA, *Also at* <https://indiankanoon.org/doc/237570/>. PREAMBLE - WE, THE PEOPLE OF INDIA, having solemnly resolved to constitute India into a SOVEREIGN, SOCIALIST, SECULAR, DEMOCRATIC, REPUBLIC and to secure to all its citizens: JUSTICE, social, economic and political; LIBERTY of thought, expression, belief, faith and worship; EQUALITY of status and of opportunity; and to promote among them all FRATERNITY assuring the dignity of the individual and the unity and integrity of the nation; IN OUR CONSTITUENT ASSEMBLY this twenty sixth day of November 1949, do HEREBY ADOPT, ENACT AND GIVE TO OURSELVES THIS CONSTITUTION.

<sup>32</sup> Asia News International, *Constitution Rests on Three Pillars – Liberty, Equality, Fraternity: President Kovind*, THE FREE PRESS JOURNAL (Nov. 27, 2017), <http://www.freepressjournal.in/india/constitution-rests-on-3-pillars-liberty-equality-fraternity-president-kovind/1177131>.

economic and developmental disparities,<sup>33</sup> how can the constitutional ideals of liberty and equality possibly be realized? This is where the country's legal structure is undeniably important. Law is what bridges the gap between the ideals of the constitution and reality by ensuring that every legislation in India mirrors these ideals or standards, converts them to rules<sup>34</sup> and reduces discrimination.

Reducing discrimination is a direct mandate of the Constitution of India which provides that the State shall not discriminate against any citizen on grounds of religion, race, caste, sex or place of birth.<sup>35</sup> The Constitution inherently recognizes structural discrimination, which refers to rules, norms, generally accepted approaches and behaviors in institutions and other social structures that constitute obstacles for subordinate groups to enjoying the equal rights and opportunities possessed by dominant groups.<sup>36</sup> Clause 4 of Article 15<sup>37</sup> was added in the first amendment to the Constitution in 1951 as a consequence of a Supreme Court judgment on equality to clarify that the State can make special provisions for the educational, economic, or social advancement of any backward class of citizens and not be challenged on grounds of being discriminatory. The Constitution in its original form recognized in Article 15(3) the inherent vulnerability of women and children, thus providing as an express exception that nothing in Article 15 shall prevent the State from making special provisions for women and children.

Specifically in the field of bioethics and human rights, India is a signatory of the 2005 UNESCO Universal Declaration on Bioethics and Human Rights.<sup>38</sup> Article 8 of the Declaration lays down a categorical respect for human vulnerability and personal integrity and states, "In applying and

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<sup>33</sup> Nisha Agrawal, *Inequality in India: What's the Real Story?*, WORLD ECONOMIC FORUM (Oct. 4, 2016) <https://www.weforum.org/agenda/2016/10/inequality-in-india-oxfam-explainer/>. Based on the new India Human Development Survey (IHDS), which provides data on income inequality for the first time, India scores a level of income equality lower than Russia, the United States, China and Brazil, and more egalitarian than only South Africa.

<sup>34</sup> Louis Kaplow, *Rules versus Standards: An Economic Analysis*, 42 Duke L.J. 557, 568 (1992) <http://nrs.harvard.edu/urn-3:HUL.InstRepos:10611784>.

<sup>35</sup> THE CONSTITUTION OF INDIA, *supra* note 31 at Article 15(1).

<sup>36</sup> See a consolidated reading of Articles 14, 15(3), 23, 39 and 42, THE CONSTITUTION OF INDIA, *supra* note 30.

<sup>37</sup> THE CONSTITUTION OF INDIA, *supra* note 31 at Article 15(4). Nothing in this article or in clause ( 2 ) of Article 29 shall prevent the State from making any special provision for the advancement of any socially and educationally backward classes of citizens or for the Scheduled Castes and the Scheduled Tribes.

<sup>38</sup> UNESCO UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS (Oct. 19 2005). *Also at* [http://portal.unesco.org/en/ev.php-URL\\_ID=31058&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html).

advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.”

Discrimination may be visible or invisible, and intentional or unintentional. In order to reduce discrimination, however, every legislation under the Constitution of India needs to first recognize discrimination, and acknowledge possibilities, and constantly strive to identify areas in which discrimination can take place. We would argue that an analysis of vulnerability becomes a necessary exercise preceding any legislation on surrogacy – to adhere to constitutional standards as well as universal commitments.

### **C. ANALYSIS OF RESEARCH STUDIES & THEIR RELATIONSHIP WITH VULNERABILITY**

The characteristics identified in the three empirical studies – one conducted by the CSR in Delhi and Mumbai;<sup>39</sup> another by it in Anand, Surat and Jamnager<sup>40</sup>; and one conducted by the Sama-Resource Group for Women and Health (Sama) in two Indian cities<sup>41</sup> – that define the socio-economic background of the surrogate have been classified as intrinsic, extrinsic or relational. Intrinsic signifies something that is part of essential nature or possibly biology. For example, a potential surrogate is necessarily female. Age is another intrinsic characteristic. Extrinsic characteristics are those which operate and affect from the outside. Characteristics such as education, previous employment, household income are all identified as extrinsic characteristics of a surrogate. Regarding relational characteristics, the term relational is borrowed from concepts and theories on interpersonal communication in the study of relationship development as

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<sup>39</sup>CENTRE FOR SOCIAL RESEARCH, SURROGATE MOTHERHOOD: ETHICAL OR COMMERCIAL (2012) <https://archive.nyu.edu/bitstream/2451/34217/2/Surrogacy-Motherhood-Ethical-or-Commercial-Delhi%26Mumbai.pdf>. [Hereinafter the CSR DM Study].

<sup>40</sup>CENTRE FOR SOCIAL RESEARCH, SURROGATE MOTHERHOOD: ETHICAL OR COMMERCIAL (2010) [https://drive.google.com/file/d/0B-f1XIdg1JC\\_Ui04RmlYUkNsTFE/edit](https://drive.google.com/file/d/0B-f1XIdg1JC_Ui04RmlYUkNsTFE/edit). [Hereinafter the CSR ASJ study].

<sup>41</sup> SAMA – RESOURCE GROUP FOR WOMEN AND HEALTH, BIRTHING A MARKET (2012), <http://www.samawomenshealth.in/birthing-market/>. [Hereinafter the Sama Study].

propounded by D.H. Solomon and Knobloch.<sup>42</sup> As the term suggests, characteristics that are indicative of relationships such as marital status and children are grouped under this heading for the purposes of this paper.

Each of these characteristics, as we discovered, plays a crucial role in the woman's choice to be a surrogate and at a systemic level in whether or not she is likely to be engaged as one. It is important to point out here that these characteristics can be distinguished analytically but in reality appear deeply interwoven in ways that pose particular problems at the legal level of legislation and policies.

In this section, we will first introduce the characteristics under each classification alongside the research data of the three studies being reviewed. We shall see what the position of the proposed regulation is in those terms. As India has yet to arrive at a final legal position on surrogacy, these positions are drawn from the ICMR's 2005 Guidelines<sup>43</sup> (which is loosely regulating the practice presently), the Assisted Reproductive Technology (Regulation) Bill, 2010<sup>44</sup> (which was proposed though not enacted, but is one of the most detailed drafts with forms and schedules that are currently being used by ART Clinics under ICMR guidance) and the Surrogacy (Regulation) Bill, 2016<sup>45</sup> which was the latest attempt<sup>46</sup> of the Union to prohibit commercial surrogacy but has yet not been passed by the Parliament of India and is still pending in the Lok Sabha (lower house).<sup>47</sup> We shall see how each characteristic is linked to vulnerability and where the opportunities lie for

<sup>42</sup> Denise Hunani Solomon & Leanne K Knobloch, *Relational Uncertainty and Relational Information Processing: Questions without Answers?*, 32 (3) COMMUNICATION RESEARCH, 349-388 (2005) <https://doi.org/10.1177/0093650205275384>.

<sup>43</sup> NATIONAL GUIDELINES FOR ACCREDITATION, SUPERVISION AND REGULATION OF ART CLINICS IN INDIA, ICMR and the National Academy of Medical Sciences, India (2005), [http://icmr.nic.in/art/art\\_clinics.htm](http://icmr.nic.in/art/art_clinics.htm). [Hereinafter ICMR's 2005 Guidelines].

<sup>44</sup> THE ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) BILL, 2010, Ministry of Health & Family Welfare, Government of India, Indian Council of Medical Research, New Delhi, <https://icmr.nic.in/guide/ART%20REGULATION%20Draft%20Bill1.pdf>. [Hereinafter the ART Bill 2010].

<sup>45</sup> THE SURROGACY (REGULATION) BILL, 2016 [http://www.prsindia.org/uploads/media/Surrogacy/Surrogacy%20\(Regulation\)%20Bill,%202016.pdf](http://www.prsindia.org/uploads/media/Surrogacy/Surrogacy%20(Regulation)%20Bill,%202016.pdf) [Hereinafter the 2016 Surrogacy Bill].

<sup>46</sup> Government of India, Cabinet, *Cabinet Approves Introduction of the Surrogacy (Regulation) Bill 2016* PRESS INFORMATION BUREAU (Aug. 24, 2016) <http://pib.nic.in/newsite/PrintRelease.aspx?relid=149186>.

<sup>47</sup> K. Deepalakshmi, *The Long List of Bills Pending in Parliament*, THE HINDU (Jul. 3, 2018) <https://www.thehindu.com/news/national/list-of-bills-pending-in-parliament/article24320759.ece>.

legislative intervention to reduce possible exploitation that may arise due to the vulnerability exposed.

### **C.1 Intrinsic characteristics**

#### **(i) The sex of a surrogate**

The sex of the surrogate is necessarily female. Therefore, none of the research studies has specifically identified this as a characteristic or analysed the links between sex and vulnerability.

Ruth Macklin wrote with disquiet,

Although it is surely a mistake to construe women in general as a class of human beings who are vulnerable, it remains sadly true that women in many parts of the world not only lack power and self-determination within the family and in the culture in which they reside, but they are also subjected to the grossest forms of physical harm and psychological degradation.<sup>48</sup>

In Indian society, women have a low status compared to men.<sup>49</sup> Chandrima Chatterjee described them as a vulnerable group:

They have little control on the resources and on important decisions related to their lives. In India, early marriage and childbearing affects women's health adversely. About 28 per cent of girls in India get married below the legal age and experience pregnancy (Reproductive And Child Health - District level Household Survey 2002-04, August 2006). These have serious repercussions on the health of women. Maternal mortality is very high in India. The average maternal mortality ratio at the national level is 540 deaths per 100,000 live births (National Family Health Survey-2, 2000)..... Women face violence and it has an impact on their health. During infancy and growing years a girl child faces different forms of violence like infanticide,

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<sup>48</sup> Macklin, *supra* note 15 at 480.

<sup>49</sup> Chatterjee, *supra* note 25 at 87.



neglect of nutritional needs, education and healthcare. As adults they face violence due to unwanted pregnancies, domestic violence, sexual abuse at the workplace and sexual violence including marital rape and honor killings...<sup>50</sup>

Visibilising this ground reality, sex is a factor that even the Constitution of India recognizes as a variable that attracts discrimination. As discussed above, the Constitution specifically makes provision for positive legislation in favor of women to counter structural discrimination.

A surrogate is intrinsically vulnerable due to her sex in a patriarchal system. A reasonable assumption from this is that she may be prone to subordination, whether imposed by her own family members or medical practitioners, making her more susceptible to exploitation in deferential or institutional relationships. She may be conditioned to serve and exhibit social vulnerability. She may be unable to articulate herself sufficiently or make herself heard, leading to communicative impairment. Her requests for information may be denied on account of them being not worthy of consideration.<sup>51</sup> Later in Section D, we shall see how sex as an intrinsic vulnerability links in with other forms of vulnerability identified in the Belmont categorization and therefore mandates legislative responses that are gender-sensitive and empowering.

## **(ii) The average age of a surrogate**

In the studies conducted by the CSR in three high-prevalence areas – Anand, Surat & Jamnagar – amongst a sample of 100 surrogate mothers (CSR ASJ Study),<sup>52</sup> it was found that the majority of the women who act as surrogates are between the ages of 26 and 35.<sup>53</sup> In the other study conducted by CSR in Delhi and Mumbai (CSR DM Study),<sup>54</sup> 66% of the 100 surrogates covered fell in the age group of 26-30 years.<sup>55</sup> In the Sama Study, all the surrogates at the time of the interview were in the age group of 21–38 years, with all except one below 35 years<sup>56</sup> at the time they acted as surrogates.

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<sup>50</sup> Chatterjee, *supra* note 25 at 87.

<sup>51</sup> The Sama Study, *supra* note 41 at 62.

<sup>52</sup> CSR ASJ Study, *supra* note 40.

<sup>53</sup> *Id.* at 30.

<sup>54</sup> CSR DM Study, *supra* note 39.

<sup>55</sup> *Id.* at 43.

<sup>56</sup> The Sama Study, *supra* note 41 at 33.

Although the minimum age for marriage for a woman or even the age of majority is 18 years, none of the women in the respondent groups was below 21 years. This might be explained by the provisions of the ART Bill 2010. In Section 34, the draft bill provides that a surrogate shall not be less than 21 years of age. This may have had an impact on actual practice even though the bill is only a draft and not the law.

In 2005, the ICMR published guidelines for the accreditation, supervision and regulation of ART clinics in India.<sup>57</sup> The guidelines did not give a minimum age, but stated that a surrogate mother should not be over 45 years of age.<sup>58</sup> Curiously, while allowing 45 years as the upper limit for a woman to act as a surrogate, the ICM's 2005 Guidelines describe in Section 3.5.12 that no more than three eggs or embryos shall be placed in a woman during one treatment cycle excepting under exceptional circumstances such as "elderly women" (described as those above 37 years of age). Since a surrogate would also be required to have eggs/embryos placed in her, the rationale was unclear for expanding that age group to 45 years of age when otherwise a woman is termed as elderly at 37 years.

From the studies it can be seen that none of the respondents was above 34 and that the preferred age for surrogate mothers was even lower - below 30 years of age.<sup>59</sup> This appears to be a preference driven by the clinics that select surrogates, possibly because the success rate of surrogate pregnancy is assumed to be higher at a lower age.<sup>60</sup> In the Sama Study, age-related responses from doctors pointed to a preference for involving younger women in surrogacy. According to one of the interviewed doctors,

If a surrogate goes in for her first arrangement at 25 years, then she can go for two or three arrangements till she is 30 years. The chances of getting pregnant are reduced after 30, and delivery is also perceived to be more complicated in older women, given higher incidences of high blood pressure, diabetes, thyroid, etc.<sup>61</sup>

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<sup>57</sup> ICMR's 2005 Guidelines, *supra* note 43.

<sup>58</sup> *Id.* at Clause 3.10.5

<sup>59</sup> CSR DM Study, *supra* note 39 at 44. "Hence, there is a preference for surrogate mothers below 30 years of age as the success rate of surrogate pregnancy is considered higher within lower age group."

<sup>60</sup> *Id.*

<sup>61</sup> The Sama Study, *supra* note 41 at 34.

With this logic underlying the selection process, there would be a drive for younger surrogates. Here it can be seen that there appears to be a fine and ever blurring boundary between capital interests (possible costs incurred if the surrogate pregnancy fails) and concern for the health of the surrogate mother. Such a conflation reveals an ethically troubling alliance between medical practitioners who isolate the woman's body from the socio-cultural/phenomenological realities and the socio-legal domain which seeks to regulate social subjects on a presupposition of an equally troubling moral code. Though the interviewed doctor posed the younger age preference for the surrogate herself – suggesting that she would be interested in going in for multiple arrangements before the age of 30 years, the actual considerations appear to be different. The same doctor went on to elucidate that exceptions to this general preference did exist if the surrogates were “34-35 years old but looked younger and were healthy.”<sup>62</sup> Here, looks appear to matter more even in terms of health.

The 2016 Surrogacy Bill specifies that a surrogate should be between the age of 25 to 35 years on the day of implantation.<sup>63</sup> The rationale for changes in age parameters, of the minimum age from the ART Bill 2010 (21 years) and of the maximum age from the ICMR's 2005 Guidelines (45 years) is unclear in the absence of explanatory literature.

On its own, age is not a characteristic that makes a surrogate vulnerable. In fact, old age (above 60 years) or young age (adolescence and childhood) are more likely to be vulnerable times. The age framework of 21 years to 45 years (consolidated from all proposed legislation) does not immediately suggest an opportunity for exploitation on account of age. However, as the discussion that has taken place shows us, younger surrogates are preferable. The ICMR has gone so far as to describe women aged 37 years as elderly. Age, here, seems to render women particularly prone to vulnerability and exploitation, especially if their reproductive value is the main determinant. The emphasis on younger age coupled with her sex increases intrinsic vulnerability, as a younger woman would be more likely to be dominated in a patriarchal society, she may still be economically dependent and may be under the control of her household. Moreover, early

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<sup>62</sup> *Id.*

<sup>63</sup> 2016 Surrogacy Bill, *supra* note 45 at Section 4(3)(b)(I).

childbearing or bearing multiple pregnancies in quick succession has been found to affect women's health adversely.<sup>64</sup>

Hence, age and sex are both recognized as twin vulnerabilities and may require particular consideration especially when they are linked to other forms of vulnerability identified in the Belmont categorization (discussed in Section D). A potential surrogate of a younger age may well require specific counselling, taking into account her reproductive history as well as her aspirations for her reproductive future.

## **C.2 Extrinsic Characteristics**

### **(i) Education**

Almost half of the surrogates in both CSR studies were educated to primary school level. In Mumbai, more than half had also completed the senior secondary level of education. In the Sama study, there was a wide range of formal education – 2 of the 12 women in the sample were graduates, 3 had studied until class 10 (the UK equivalent of GCSE's – or 'O' Levels), 3 had completed class 5, 3 had no formal education, and information was not available for 1.

Notably, none of the respondent groups in Mumbai, Delhi, Jalandhar, Surat or Jamnagar (5 of the 6 cities covered by the three studies) was illiterate. This flies in the face of the usual descriptor for a surrogate mother hailing from India.<sup>65</sup> In 2013, the media in Australia reported a case of a couple who had hired an “illiterate Indian woman” to be the surrogate mother of their twins and was ordered by a judge to return to India to prove she had not been exploited.<sup>66</sup> In that case, the surrogate was a Hindi-speaker. The judge noted that she had used a thumbprint to sign a contract

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<sup>64</sup> Zulufkar Ahmad Khanday, Mohammad Akram, *Health Status of Marginalized Groups in India*, 2(6) INT'L J. OF APPLIED SOCIOLOGY 60-70 at 61 (2012) DOI: 10.5923/j.ijas.20120206.02.

<sup>65</sup> Manas Jena, *Good that New Bill to Rein in Commercial Surrogacy*, DAILY PIONEER (Sep. 3, 2016), [http://www.dailypioneer.com/print.php?printFOR=storydetail&story\\_url\\_key=good-that-new-bill-to-rein-in-commercial-surrogacy&section\\_url\\_key=state-editions](http://www.dailypioneer.com/print.php?printFOR=storydetail&story_url_key=good-that-new-bill-to-rein-in-commercial-surrogacy&section_url_key=state-editions).

<sup>66</sup> Brenden Hills, *A couple who hired an illiterate Indian woman to be surrogate of their twins ordered to prove she wasn't exploited*, THE SUNDAY TELEGRAPH (June 30, 2013) <https://www.dailytelegraph.com.au/news/nsw/a-couple-who-hired-an-illiterate-indian-woman-to-be-surrogate-of-their-twins-ordered-to-prove-she-wasn8217t-exploited/news-story/084b3c0f22bf0cf990d766af309af718>.

written in English. The concern expressed was that the document did not establish whether the surrogate mother had signed it after it had been read and translated to her.

In India, literacy is not linked to knowledge of English (the usual language of drafted surrogacy contracts and medical paraphernalia). The Census of India describes the concept of literates and illiterates<sup>67</sup> as “a person aged seven and above who can read and write with understanding in any language as a literate.” There are 22 official languages in India, Hindi being the official language of the union and the regional languages being the official languages of the individual states. The Official Languages Act passed in 1963 gave English the status of a secondary official language, meaning that it could also be used for official use along with Hindi. However, a person is considered literate if they have an understanding of any language. Moreover, Census parameters state that a person need not receive any formal education or acquire any minimum qualification to be treated as literate.

Clearly, while literacy or the lack of it is a vulnerability that is ripe for exploitation, the prime concern is of functional literacy, i.e., were the respondents functionally literate enough to be able to understand the paperwork and documentation of their contract?

In the CSR DM Study,

[a] majority of surrogate mothers (80% of the respondents in Delhi and 96% in Mumbai) stated that surrogacy agreement between all the involved parties took place in the form of a written contract..... The nature of contract for most of the surrogate mothers is a bond paper on which the agreement would take place (70% of the respondents in Delhi and 72% in Mumbai). 14% of the respondents in Delhi and 10% in Mumbai said that the contract was signed on the paper prepared by the agents.<sup>68</sup>

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<sup>67</sup> CENSUS OF INDIA REPORT Chapter VI (2011), [http://www.censusindia.gov.in/2011-prov-results/paper2-vol2/data\\_files/AP/Chapter\\_VI.pdf](http://www.censusindia.gov.in/2011-prov-results/paper2-vol2/data_files/AP/Chapter_VI.pdf).

<sup>68</sup> CSR DM Report, *supra* note 39 at 60.



The researchers recorded their concerns that “Since the surrogate mothers are unable to read or write, she and her husband are told about the contract by the hospital/clinic authorities in a suitable language and easy terms, which the surrogate mother cannot verify by any means.”<sup>69</sup>

The study noted that out of the total number of respondents, 88% in Delhi and 76% in Mumbai stated that they were not aware of the clauses of the contract.<sup>70</sup> On this being cross-referenced, the report records that

[t]he agencies/hospital/clinic authorities responsible for giving the information to the surrogate mothers stated that the expecting surrogate mothers might not have remembered the clauses which were orally explained to them during counseling procedure as they are semi-literate and might have forgotten what had been told to them during the process of signing the agreement.<sup>71</sup>

A similar story emerged in the CSR ASJ Study. In the Sama Study, it was reported that gaining access to information and maintaining communication was a challenge even among surrogates with higher levels of education, as the transaction documentation was usually in English. This has serious implications for the giving and obtaining of informed consent. The ICMR’s 2005 Guidelines are silent on the educational qualifications or literacy of a qualifying surrogate. The proposed legislation of 2016 is also silent in this regard. This may be a considerable oversight that could compound the vulnerability of a potential surrogate.

As the Supreme Court of India has noted in *Samira Kohli v. Dr. Prabha Manchanda & Anr.*:<sup>72</sup>

In India, majority of citizens requiring medical care and treatment fall below the poverty line. Most of them are illiterate or semi-literate. They cannot comprehend medical terms, concepts, and treatment procedures.....They are a passive, ignorant and uninvolved in treatment procedures. The poor and needy face a hostile medical environment - inadequacy in the number of hospitals and beds, non-availability of adequate treatment facilities, utter

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<sup>69</sup> CSR DM Report, *supra* note 39 at 61.

<sup>70</sup> CSR DM Report, *supra* note 39 at 63.

<sup>71</sup> CSR DM Report, *supra* note 39 at 61.

<sup>72</sup> 1 (2008) CPJ 56 (SC). Also at <https://indiankanoon.org/doc/438423/>.

lack of qualitative treatment, corruption, callousness and apathy.....What choice do these poor patients have? Any treatment of whatever degree, is a boon or a favour, for them. The stark reality is that for a vast majority in the country, the concepts of informed consent or any form of consent, and choice in treatment, have no meaning or relevance.

Can this narrative form the rationale for arriving at the conclusion that informed consent is a mythical construct which cannot be achieved in Indian circumstances? Realistically, the nature and circumstances of surrogacy are far removed from that of patients as described by the Supreme Court. Surrogacy is a treatment entailing choice. It is not a necessity derived from the surrogate's disease but rather is an act on her part that benefits others. To participate in the surrogacy arrangement, a woman needs to undergo multiple medical procedures. Hence, it is crucial not to overlook informed consent as being irrelevant to cases of surrogacy.

In medicine, the principles of patient autonomy, informed consent, beneficence, non-maleficence and confidentiality guide clinical practice.<sup>73</sup> The surrogacy arrangement, to the extent expressed as clinical procedures, must necessarily conform to and uphold such principles. The ICMR Research Guidelines, 2000 describe the principle of informed consent as a cardinal principal in which the subject is kept continually informed of any and all developments that affect them and others. This ties in with the recognition of cognitive or communicative vulnerability in the Belmont classification discussed in Section D.

## **(ii) Previous Employment**

In both of the CSR Studies, a large majority was employed previously (61.7% in Anand, 91.4% in Surat, 100% in Jamnagar, 68% in Delhi and 80% in Mumbai). They were generally employed as housemaids or domestic help, factory workers, construction workers, in hotels and restaurants or beauty parlours, and even as nurses, midwives or casual workers assisting clinics and hospitals, with a range of earnings between 1000 to 3000 INR. While 3 of the surrogates in the Sama Study described themselves as housewives, of the remainder, 5 were involved in garment work, one was

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<sup>73</sup> Imrana Qadeer, *Social and Ethical Basis of Legislation on Surrogacy: Need for Debate*, 6(1) INDIAN JOURNAL OF MEDICAL ETHICS (2009) <http://ijme.in/articles/social-and-ethical-basis-of-legislation-on-surrogacy-need-for-debate/?galley=html>.

a peer educator with an NGO, one was a cook, and one worked in a government office serving tea and doing other such chores.

In both the CSR Studies, the surrogates usually had working husbands, though in some cases the woman was the sole breadwinner as the husband was without employment or an alcoholic. The spouses of the surrogates in the Sama study included a mason, drivers, cooks, supervisors in factories, workers in an export firm and in a garment factory, and a hotel manager. The kind of work was largely casual, irregular and seasonal, with no formal benefits or safety net. Only one of the surrogates was separated from her husband. One surrogate (for whom this was her second surrogate pregnancy) was engaged in garment stitching (piece work from home) and had earlier been engaged in papad rolling from home. Her husband, who used to do garment embroidery in a factory, had been unable to find work in Delhi due to the relocation required for the surrogacy.

Prior employment seemed to be the norm rather than the exception amongst the surrogates interviewed in the three studies. How prior employment of the surrogate (or rather the lack of it or the nature of it) suggests vulnerability is discussed below after taking into consideration another characteristic, household income.

### **(iii) Household income**

In the Sama study, the range of monthly household income of the surrogates interviewed in Punjab was 3000 to 15,000 INR, with most falling around the average of 6000. The range of household income of the surrogates from Delhi was 4500 – 12,000, with most averaging around the 7500 mark. Only one surrogate had the current surrogacy arrangement as her only source of income.

In India “below poverty line” (BPL) is an economic benchmark used by the Government of India to indicate economic disadvantage and to identify individuals and households in need of government assistance and aid. While an income-based poverty line pegs BPL families as those

with a household income that is less than 27,000 INR annually,<sup>74</sup> there are other parameters that may also classify a family as being BPL.<sup>75</sup>

On the whole, the respondents in the three studies under discussion fell in a range of INR 12,000 to 180,000 as an annual household income. Of these in the CSR DM Study, 50% of the respondents in Delhi and 68% in Mumbai earned more than 3000 per month and hence could not be classified as BPL or even at the edge.

However, as close to half the respondents could be at the edge of poverty or even BPL, prior employment and household income are characteristics that offer a deeper view on vulnerability that may be potentially exploited. The choices a potential surrogate is making for the aspirations she holds dear have to be understood in the Indian context as a structural reality with real actors and real consequences.<sup>76</sup>

A life below the poverty line would suggest that the potential surrogate has already been exposed to possible malnutrition, disease and various other rigors that may require specific evaluation and treatment to bring her to a healthy and safe level that would support a healthy pregnancy. Living below the poverty line or at the edge of it suggests that the option of surrogacy may not be a free choice but a compulsion. Put in context and read in relation to other circumstances, however, monetary needs could be interpreted differently, and ideally lawmakers must be less prone to depriving women of a potential source of income. Consider the case of bar dancers in India, for whom, after a ban was put on the practice, the Supreme Court of India retorted in support of their

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<sup>74</sup> Ministry of Electronics & Information Technology, Government of India, <http://digitalindia.gov.in/content/below-poverty-line-certificate>.

<sup>75</sup> In India Below Poverty Line is an economic benchmark used by the Government of India to indicate economic disadvantage and to identify individuals and households in need of government assistance and aid. While an income based poverty line pegs BPL families as those who qualify as beneficiaries as they have household income that is less than 27,000 INR annually, there are other parameters that may also classify a family as being below poverty line such as no land or minimal land holding, no house or dilapidated house, no sanitation latrine, family with an illiterate family member, no regular employed person in the family, no access to safe drinking water, a women headed household or presence of widows or divorcees, scheduled castes or scheduled tribes and mentally retarded or disabled members in the family.

<sup>76</sup> Amrita Pande, *Not an "Angel", not a "Whore": Surrogates as "Dirty" workers in India*, 16 (2) INDIAN JOURNAL OF GENDER STUDIES 141-173 (2009) <https://interseksionalitet.files.wordpress.com/2011/03/notanangel2.pdf>.

work and against the ban, “It is better to dance than beg on the streets.”<sup>77</sup> Consider also, that while the studies do indicate that affluent women were not acting as surrogates, this is not a viable or sufficient argument. Affluent women do not seek employment as domestic workers or construction workers either, and yet the argument does not extend to these lines of employment to suggest compulsion and hence prohibition of employment in such sectors.

In the Sama Study, the remuneration for surrogacy – the amount, the nature of payment (lump sum) and the time span over which the amount is received – emerged as the central reason for becoming a surrogate. The surrogates spoke of their everyday hardships and difficulties in making ends meet. One surrogate spoke of the tension of impoverishment and the moral qualms of bearing a child and giving it away,

It is money that gets you to do everything. One has compulsions at home. Everyone is sitting with a lot of tension at home. No one does it because they enjoy (shauk nahi hota) bearing someone else’s child. When there are compulsions, this is what god gets you to do. No woman bears a child and gives it away out of interest.

A few of the surrogates in the Sama Study also spoke of surrogacy as a familial expectation to salvage the family out of debt,

In our home, Munna’s father [her husband] doesn’t have that much work on his hands. And, as you know, if there is a death in the family, then there are expenses. So there was debt. We had to take loans for doing all the work [performing the last rites for the deceased] . . . The family was saying if it happens (it would be good), since there was no money.

From these anecdotes, the dearth of money certainly forms a narrative of compulsion. Compulsion suggests vulnerability. But does vulnerability translate into exploitation? Surrogates point out that those who are privileged will never face this choice. On the other hand, they are well aware that the money earned from surrogacy cannot easily be matched by the earnings from any other

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<sup>77</sup> Surabhi Malik, ‘*Better to Dance than to Beg*,’ says Supreme Court on Plea on Dance Bars, NDTV (Apr. 25, 2016) <https://www.ndtv.com/india-news/better-to-dance-than-to-beg-says-supreme-court-on-plea-against-dance-bars-1399142>.



available avenue of income generation. According to one surrogate attending a courtroom proceeding<sup>78</sup> concerning the prohibition of commercial surrogacy, “Meri sab takleef surrogacy ne khatam kar di (surrogacy put an end to all my troubles). Ek naukranī kitna kama legī (how much will a maid earn).”

Here income closely ties with employability. Prior employment of a surrogate or proof of prior employability of a surrogate suggests prospects and possibilities, i.e., the presence of choice. Someone who has never been employed or has no perceptible employment opportunity may be vulnerable to compulsion. But a person who is employable may choose to participate in a surrogate arrangement as a matter of choice. It is evident that the majority of the surrogates were already engaged in work, which was menial and poorly paid. Surrogates themselves speak of their current work negatively and in belittling terms. Surrogacy is actually the way out of impoverishment for them.

Consider the trajectory of one surrogate interviewed in the Sama Study. She went to school until Class 8, her husband owned a shop, and then due to medical debt, they had to sell the shop and migrate. She started working as a domestic worker and was told by the placement agency that she would work in a 2-room house. However, the house was much larger with 4 floors and 15 rooms where she was expected to clean bathrooms, wash clothes, clean utensils, and also take care of a child and attend to an older woman, all with no increase in salary. When she found herself unable to keep up physically, she discontinued the work after a fortnight. Her employers or the placement agency did not pay her.

How are such situations any less unjust or without choice? The Supreme Court of India has cautioned about Hobson’s choice<sup>79</sup> - acts which are involuntary in the sense that they are

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<sup>78</sup> In February 2015, a writ petition – 95 of 2015 – was filed and linked with civil appeal no. 8714 of 2010 (the ‘Jan Balaz’ case) which was being heard by the Supreme Court of India. This was a public interest litigation (PIL) by Advocate Jayshree Wad seeking a ban on commercial surrogacy (the Jayshree Wad PIL). In November 2015, a group of surrogate mothers moved the Supreme Court. Notice was issued on this writ petition (Pavan Agrawal v. Union of India W.O. (C) No. 841/2015). on 16 December 2015, which with its stay application was tagged to the Jayshree Wad PIL, which in turn was tagged to the main Jan Balaz case. One of the authors interviewed some of the surrogates who attended the courtroom proceedings.

<sup>79</sup> People’s Union for Democratic Rights v. Union of India AIR 1982 SC 1473. “A contract of service may appear on its face voluntary but it may, in reality, be involuntary, because while entering into the contract the employee by reason of his economically helpless condition, may have been faced with Hobson’s choice, either to starve or to submit to the exploitative terms dictated by the powerful employer.”

compelled by inevitable circumstances and not choice. But making a different choice may not be the same as a Hobson's choice.

The tension between impoverishment and economic exploitation is a very real one. At present, not one of the proposed regulations has identified or addressed the vulnerability created by the nature or lack of previous employment or limited household income. Both these characteristics influence the category of economic vulnerability in the Belmont classification, which is discussed in Section D.

### **C.3 Relational characteristics**

#### **(i) The surrogates' marital status**

In the CSR DM Study, none of the surrogates was single. Of the married majority, some of them were divorced, separated or abandoned. In both cities, 12% was divorced. In Mumbai, 14% had been previously abandoned by their husband, and 6% was separated, whereas in Delhi the percentages were 4% abandoned and 2% separated.<sup>80</sup> In the Sama study, all 12 of the surrogates were married, though 2 were separated but not divorced.<sup>81</sup> One reconciled with her husband for the duration of the surrogacy (despite having walked out of a violent relationship) as the clinic required his consent for the surrogacy arrangement. In the CSR ASJ Study, most of the surrogate mothers were married, and only 3.3% in Anand and 2.9% in Surat were single.<sup>82</sup> Respondents included widows, persons abandoned by their husbands with children to look after, and some who were undergoing midwife training while working as nurses in the same hospitals where the surrogacy procedures are carried out. Overall, more than 95% of the respondents were married and living with their husbands.

The ICMR's 2005 Guidelines do not specify that a surrogate needs to be married to act as a surrogate. Yet it appears from the respondent groups of the studies and particularly from the case documented in the Sama Study that married status of the surrogate and consent of the spouse are

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<sup>80</sup> The CSR DM Study, *supra* note 39 at 44-45.

<sup>81</sup> The Sama Study, *supra* note 41 at 35.

<sup>82</sup> The CSR DM Study. *supra* note 39 at 30.

important requirements for clinics selecting surrogates.<sup>83</sup> The Sama Study recorded the particular emphasis laid by doctors and agents (that seek surrogates for clinics) on marital status as a primary criterion for inclusion in surrogacy arrangements. Doctors also justified marital status as a necessary condition as per the draft ART Bill 2010.<sup>84</sup> Interestingly, the 2010 bill does not make marriage a pre-qualification for a woman acting as a surrogate. It does provide that if a potential surrogate is married, her spouse's consent will be required. The 2016 Surrogacy Bill makes marriage a pre-qualification for a woman to act as a surrogate. The rationale for this added pre-qualification is not immediately evident from the bill itself or any relevant explanatory literature.

The preference for married women is apparent in surrogacy arrangements, in which despite being described as deviants of the natural order,<sup>85</sup> the selection of married surrogates actually seeks to conform to patriarchal norms of marriage and reproduction. As the Sama Study documented, “surrogacy arrangements were undoubtedly directed by a hetero-patriarchal construct of marriage and child bearing that permits the latter only within the former.”<sup>86</sup> Whether this is advantageous to the woman is a point that needs to be considered.

In the Sama study, when faced with the concern of her baby bump showing in a few months, one of the surrogates dismissed it saying, “*No worries. My man is with me.*”<sup>87</sup> This is an example of a surrogate drawing power and security from being in a heterosexual marital relationship. So is marriage as a pre-requisite for potential surrogates an important shield against societal stigma that often hounds the unwed mother? It is possible.

There is, however, also evidence to the contrary. In the CSR DM study, the researchers noted that

[during] field investigation it was found that the fear of abandonment among married surrogate mothers also acts as a driving force to enter into surrogacy arrangements since their husbands found this arrangement as the easiest way to earn quick money

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<sup>83</sup> The Sama Study, *supra* note 41 at 34.

<sup>84</sup> The Sama Study, *supra* note 41 at 35.

<sup>85</sup> ELLY TEMAN, *BIRTHING A MOTHER: THE SURROGATE BODY AND THE PREGNANT SELF* (March 2010, 1<sup>st</sup> Ed., University of California Press). “Surrogacy threatens to stigmatise the surrogate as deviant of her natural, national, maternal duties.”

<sup>86</sup> The Sama Study, *supra* note 41 at 35.

<sup>87</sup> *Id.*

beyond their earning capability either to set up a business, repayment of a loan amount or simply to enjoy life at the cost of the health risk that their wives are subjected to unnecessarily.<sup>88</sup>

In the Sama Study, one surrogate spoke of a proactive role of her husband: she said that when approached by an agent, she had refused the offer of surrogacy, but then the agent approached her husband,

I said I won't do it. She (agent) said do it, someone will have a child in the house. They will be happy. I refused. Then my husband talked to her. She explained it to him. He talked to the madam [doctor], about a lakh or two. Then he said do it, someone will have a baby in their house.

On another note, some of the surrogates in both CSR studies reported resistance from their husbands, and to a much lesser extent from parents and in-laws. Most of them were from nuclear families where the family elders would not even be informed. In the Sama Study some of the husbands expressed strong reservations, stemming from the assumption that the surrogate would have to engage in sexual relations, leading to comparison with sex work. The absence of sexual intercourse was a key factor in persuading the surrogates and their husbands. One surrogate recounted that she impressed upon her husband that she viewed surrogacy as a means for a better future for her children,

I explained to my husband as well that whatever is in (our) fate will happen, so just give your signature and don't tell me so many things. He still said he can't give it. He was being so difficult. I said, "you will have to give it, for my sake (tumhe meri kasama)...The agent is saying that if the signature is not there, then it will not happen. You have an I-card, I don't." So he agreed.

Although marriage is not a stated requirement in the ART Bill 2010, if a surrogate is married, spousal consent is necessary before she can act as a surrogate under both the ART Bill 2010 and the ICMR's 2005 Guidelines. This raises the question of whether a woman is truly autonomous in

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<sup>88</sup> The CSR DM Study, *supra* note 39 at 45.

the decisions she needs to make, first to enter into the surrogacy arrangement and second to continue to participate in it and take decisions concerning her body. This also comes up against the notion of patient autonomy and sheds light on the fundamental legislative incongruity because the surrogates are not entitled to the same rights as patients.

Patient autonomy means that a mentally competent adult accessing a health service does not need the authorization of a third party.<sup>89</sup> In the context of a surrogate, autonomy would have two meanings – 1) patient autonomy, i.e., the surrogate's right to take autonomous decisions with regard to the medical treatments she shall undergo for the surrogate arrangement; and 2) reproductive autonomy, i.e., the surrogate's right to take free and informed decisions about her own fertility and sexuality. The right to make free and informed decisions about health care and medical treatment, including decisions about one's own fertility and sexuality, is enshrined in Articles 12 and 16 of the Convention on the Elimination of all Forms of Discrimination Against Women (1978).<sup>90</sup> India, as a signatory to the International Conference on Population and Development, 1994, has committed itself to ethical and professional standards in family planning services, including the right to personal reproductive autonomy and collective gender equality.<sup>91</sup> This understanding is reflected in the Medical Termination of Pregnancy Act, 1971<sup>92</sup> and the National Population Policy 2000,<sup>93</sup> which provides that in matters related to contraception, abortion and sterilization, third party consent or prior consent of the spouse is not necessary. It

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<sup>89</sup> WORLD HEALTH ORGANIZATION, DEPARTMENT OF REPRODUCTIVE HEALTH & RESEARCH, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS, Geneva WHO (2<sup>nd</sup> Edition 2012) [http://www.who.int/reproductivehealth/publications/unsafe\\_abortion/9789241548434/en/](http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/).

<sup>90</sup> UNITED NATIONS DIVISION FOR THE ADVANCEMENT OF WOMEN, CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (Dec. 18, 1979) <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>.

<sup>91</sup> UNITED NATIONS DEVELOPMENT PROGRAM, REPORT OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT Cairo, Egypt: UNDP (Sep. 1994) <http://www.un.org/popin/icpd2.htm>.

<sup>92</sup> The Medical Termination of Pregnancy Act, 1971, Act No. 34 of 1971, as amended by Act No. 64 of 2002 [*hereinafter* MTP Act 1971], and The Medical Termination of Pregnancy Rules, 2003, available from: <http://mohfw.nic.in/MTP.htm>. Also see Ministry of Health and Family Welfare, Government of India. *Guidelines for Medical Officers for Medical Termination of Pregnancy up to eight weeks using manual vacuum aspiration technique*, New Delhi, Government of India (2001). Though it is to be noted that the MTP Act 1971 removes the initial decision itself out of the hands of the women and places it in the hands of doctor(s) depending on the stage of pregnancy. Hence strictly speaking this is not a reproductive choice exercised by the woman herself.

<sup>93</sup> NATIONAL COMMISSION ON POPULATION, GOVERNMENT OF INDIA, NATIONAL POPULATION POLICY, 2000, <http://populationcommission.nic.in/npp.htm>. See also Ministry of Health and Family Welfare, Government of India, *Standards for Female and Male Sterilization*, New Delhi, Government of India (1999).



follows that if spousal consent or third party consent is unnecessary for preventing pregnancy or terminating pregnancy,<sup>94</sup> then it should also be unnecessary for becoming pregnant.

There is however a contrasting position taken by the Supreme Court of India in *Samar Ghosh v. Jaya Ghosh*<sup>95</sup> which held on reproductive autonomy that:

If a husband submits himself for an operation of sterilisation without medical reasons and without the consent or knowledge of his wife and similarly if the wife undergoes vasectomy (read tubectomy) or abortion without medical reason or without the consent or knowledge of her husband, such an act of the spouse may lead to mental cruelty.<sup>96</sup>

Mental cruelty is a ground for divorce under Hindu law in India. So while the decision itself does not require spousal consent to be carried out, the consequences of exercising autonomy may affect the status of marriage.

Would this possible threat to marriage raise enough grounds for rationalising spousal consent in cases of surrogacy where the conceptus has no genetic link with the spouse of the surrogate? Maybe not. At best, such a situation may be addressed by requiring that the act of acting as a surrogate be brought to the knowledge of the spouse beforehand by the surrogate if she is married, and the surrogate could give an undertaking in this regard. It would also mean that she has suitably assessed any risk to her marriage.

Reality is in stark contrast to this ideal. In the Sama Study, the field investigators noted that being married or more importantly receiving the surrogate's husband's consent along with the surrogate's consent was a condition adhered to quite strictly by doctors and agents.<sup>97</sup> The rationale

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<sup>94</sup> Cf. see *Samar Ghosh v. Jaya Ghosh*, *supra* note 94 where the same acts without the consent or knowledge of the husband may constitute mental cruelty.

<sup>95</sup> (2007) 4 SCC 511 Supreme Court of India [database on the Internet]. Also available at <http://judis.nic.in/supremecourt/chejudis.asp>.

<sup>96</sup> *Id.* at 520.

<sup>97</sup> Medical Council of India, *The Code of Medical Ethics* (approved by the Central Government under section 33 of Indian Medical Council Act, 1956) Clause 13, Chapter - Disciplinary Action. The Chapter enumerates a list of responsibilities, violation of which will be professional misconduct. Clause 13 of the said chapter places the following

for this requirement was described as important to pre-empt the possibility of any trouble (or liability) claimed by the surrogate, or to avoid future monetary contestations by the husband as well as ensure cooperation towards a positive outcome of the pregnancy and towards “easy” relinquishment. The husband’s affirmation was also identified as critical to avoid challenges to the practice of abstinence particularly in the early months of the pregnancy.

From a progression through the draft legislation on the issues which arrive at making it mandatory for a potential surrogate to be married and also to seek spousal consent, it appears that the notion of patient autonomy does not apply to surrogates. These provisions evidently exist not to protect the surrogate, but rather to ensure her compliance. They further highlight perceptions in society about the nature of the ownership a husband wields over his wife’s body. Counselling is considered insufficient to the extent that contractual liability is required on the husband’s part to cede his control. What paradigm shift might be necessary in such a case to turn the legal framework towards protecting the surrogate mother’s rights, and regulating surrogacy as work, rather than merely working within patriarchal norms to secure the woman’s body for financial gains? What kind of vulnerability does such an alliance bring to bear on women?

The presence or a negative state of marriage creates tension regarding the autonomy of a surrogate. In one example in the Sama Study, the requirement of spousal consent caused a woman to reconcile with a violent spouse. While the ICMR’s 2005 Guidelines did not make marriage a qualifier to act as a surrogate, the proposed 2016 Surrogacy bill does. The threat is that making marriage and, by the same coin, spousal consent a precedent condition for a potential surrogate, this would invisibilize the stress that it may cause to her personal autonomy. A spouse needs to be seen as an influence on the woman to act as a surrogate. From the studies conducted by CSR, the other influencing factors, which can be identified in order of influence, are agencies or representatives of clinics, the suggestions of family and friends, the experiences of other surrogate mothers, and also media coverage. The CSR data shows that the majority of the surrogates from Anand, Surat

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responsibility on a doctor: “In an operation which may result in sterility the consent of both husband and wife is needed.” This would cover every procedure in which the reproductive system is manipulated of either spouse. In effect, as doctors in India are trained, marriage carries with it the assumption of ceding of personal autonomy and loss of control over one’s body, particularly of one’s reproductive abilities. This is a troubling construct.

and Jamnagar reported having taken the surrogacy decision jointly with their husbands. In contrast, the researchers reported findings that the husband emotionally pressurized the wife to undergo surrogacy in order to buy a house or to set up a garage or to start a business. A possible interpretation is that while the surrogate and her husband have similar motivations, as wife and husband they have different aspirations on how the money would be utilised. In Mumbai, fewer surrogates were dependent on their husband and termed it their own decision. In Delhi, the “self decision” and “husband’s role” were almost equal influences on the decision for surrogacy.

The anecdotal evidence from the studies and the experiences noted above do appear to indicate that the mandatory qualification may bring with it a high degree of deferential vulnerability, which is another category of vulnerability identified in the Belmont Classification, elaborated upon in Section D below.

**(ii) The surrogates’ children**

The researchers in the CSR DM Study and also the CSR ASJ Study found that all the surrogates had children of their own, and the majority had two children.<sup>98</sup> They noted that this was a prerequisite for infertility physicians/clinics/hospitals engaged in the surrogacy business as it acted as a proof of fertility of the potential surrogate mothers.<sup>99</sup> In the Sama study, all the surrogates interviewed had children, and 5 of the surrogates had previously had children for surrogate arrangements.

Notably, the ICMR’s 2005 Guidelines had no requirement that a surrogate have children of her own. As per the draft ART Bill 2010, while no requirement of prior progeny was prescribed, it laid down that a surrogate could have a total number of five (5) children (successful live births), which includes her own children. The rationale for this specified number was unclear as no commentary on the development of the bill is publicly available. The proposed 2016 Surrogacy Bill mandates that a potential surrogate mother needs to have a child of her own to qualify for surrogacy.<sup>100</sup>

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<sup>98</sup> The CSR DM Study, *supra* note 39 at 50.

<sup>99</sup> The CSR DM Study, *supra* note 39 at 50.

<sup>100</sup> 2016 Surrogacy Regulation Bill, *supra* note 45 at Section 4(3)(b)(I).

Again, there is no available literature on the rationale for this additional requirement from previous guidelines and drafts.

According to one of the agents introduced in the study, completion of the surrogate's family and having the desired number of children prior to entering the surrogacy arrangement was something that agents took into account. One of them was quoted as saying, "Because, God forbid, a problem should arise in conceiving later, they would say that I got this done and that is why I can't have children now." Evidently, the surrogate's identity as a mother is primary. First as mother to her own progeny and then as mother for the commissioning parents. However, the surrogate's identity as a mother clashes with her identity as a worker. Amrita Pande in her seminal work "Not an angel Not a whore"<sup>101</sup> identifies, based on the findings of her interviews with surrogates in Anand, that the same narratives that serve to reinforce the surrogate's image as a dutiful and selfless woman in the service of her family also undermine her role and image as an independent wage worker. Pande illustrates with examples that recruitment tactics for surrogates often target women who are desperate for money to provide for their children, to get their daughters married on time, and so on. She identifies that "being a mother is not just a medical requirement for a woman to be recruited as a surrogate but also an insidious mechanism to control her" during the surrogacy arrangement.

The CSR DM study noted that amongst the surrogates, families with more than two children were more prevalent. It concluded, "That's why family maintenance and education of children became a compelling factor in the absence of other employment avenues for mothers to enter surrogacy arrangements."<sup>102</sup> It further noted the concern that, "Respondents, who had one-child family through C-section, were ignorant that after a delivery through surrogacy arrangement (in which most of the time the child is delivered through C-section) they will not be in a condition to have another child of their own if they wished to."<sup>103</sup>

There is a tension of sorts created here. The history of birthing a child would make a surrogate evidently able to birth a child in the future as assessed by the clinics. But having a child or children

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<sup>101</sup> Pande, *supra* note 76 at 169.

<sup>102</sup> CSR DM Report, *supra* note 39 at 49.

<sup>103</sup> CSR DM Report, *supra* note 39 at 50.

would also make a woman more vulnerable to coercion for acting as a surrogate for the future welfare of her own child. Having only one child of her own may create concerns about whether she can have further children of her own after the surrogacy process, which usually involves extensive hormonal treatment and surgical deliveries. But a requirement of having completed her family first before acting as a surrogate would add to the potential compulsion to act as a surrogate due to enhanced family needs and increased economic responsibility on her.

It is unclear if any requirement imposed on a surrogate to already have her own child/children would be empowering to her or would make her more vulnerable. In a published example, Anita acted as a surrogate because her son had a heart condition and needed an expensive operation.<sup>104</sup> Another case in point is one that the CSR DM Research team came across in Mumbai in which the surrogate mother had filed a case to fight for the custody of her child with the money she would get out of the surrogacy arrangement she had entered into. Another surrogate highlighted education for her children as a strong motivation –

Who will help us out? We have put our children in an English-medium school. The most important thing that came to my mind is that we have to educate our children. So it is just that. I have this dream, since I couldn't study and we are so miserable. My children should be able to go forward, with blessings from you too. With English, one can meet [good, decent people]. Whatever I couldn't get, my children should. That's why I came here. I have no troubles over my sustenance (khana-peena). I can work anywhere and get my food.

Take another example, of X, who has a seven-year-old biological son whom she hopes to send to a good school and away from the rigours of city life,

After this delivery and sending my child to hostel, I will work full-time. If my husband and I work, we will be able to ensure that my child becomes a doctor and

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<sup>104</sup> Sarmishta Subramanian, *Wombs for rent: Is paying the poor to have children wrong when both sides reap such benefits?*, MACLEAN'S (Jul. 2, 2007) <https://archive.macleans.ca/issue/20070702>.

escapes this life of struggle. After all, we have no pension or government security in our old age. Who knows if our children will take care of us?<sup>105</sup>

The presence of dependents can thus also be a motivator for a woman to become a surrogate, as much as it is an area of stress that also contributes to the narrative of desperation. It appears that a surrogate's own children can be an insidious influence. Legislation that mandates that to qualify as a surrogate she should have her own children is not necessarily reducing her vulnerability. It may only be expounding on patriarchal thought that a woman should first have served the reproductive interests of her own family before serving another's.

It is a matter of concern that the proposed 2016 Surrogacy Bill makes both marriage and children into requirements that a woman should have met before she can act as a surrogate. This does not demonstrate an adequate understanding of the nature of the stress such factors can cause to autonomous choice and how it exacerbates vulnerability. While it is not necessary for the law to make not being married or not having children as qualifications, the requirement of being married and having children certainly fails to see the huge compulsions these may pose on the surrogate.

## **D. THE VULNERABILITY MATRIX**

### ***D.1 Intrinsic, Extrinsic and Relational Vulnerabilities: A taxonomy for vulnerability in surrogacy***

From the above analyses, a taxonomy comprised of intrinsic, extrinsic and relational vulnerabilities can be effectively derived. It is defined as follows:

i) **Intrinsic Vulnerability:** For a nuanced understanding of intrinsic vulnerability, the primary determinants of a surrogate's susceptibility to vulnerability are her biological (intrinsic) characteristics, namely her sex and her age. In a surrogacy arrangement, being a woman renders the surrogate prone to certain gender-specific discriminations and exploitations, while her age places definitive restrictions on her economic autonomy.

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<sup>105</sup> Perappadan, *supra* note 10.



ii) Extrinsic vulnerability: Social factors such as income and education level potentially render a surrogate vulnerable in terms of the contract. A consideration of extrinsic vulnerability necessitates questioning on a normative ethical level the extent to which the contract (legal and written) ought to correspond to the surrogate's literacy level and whether her economic needs ought to be given primacy in the arrangement.

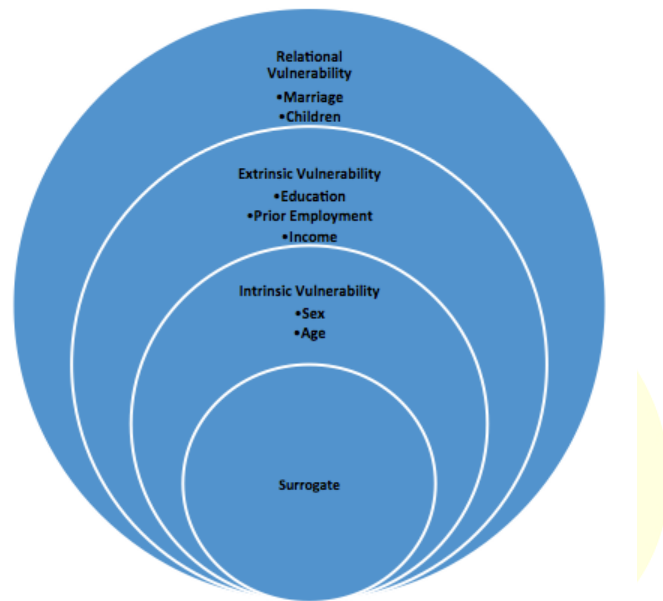
iii) Relational vulnerability: Relational vulnerability addresses questions regarding the surrogate's decision-making autonomy when entering into the arrangement by asking to what extent her relational attributes such as marital status and family structure shape or delimit her own choices. In understanding the surrogate's position as a relationally shaped embodiment, the notion of relational vulnerability necessitates a consideration of her continued well-being through the process.

The issue of surrogacy is interesting in that it destabilises the idea that the causes of danger, potential exploitation, discrimination or exclusion lie outside of yourself. It is certainly in the nexus of commercial interests and patriarchal mores that qualities like age and sex become determinants of vulnerability among surrogates, but we would like to note that intrinsic does not mean non-relational. This criterion has heuristic value in that it helps identify fixed and mobile, culturally defined and physically defined points of relation. Also, the mere existence of extrinsic vulnerabilities does not presume the existence of exploitation – only the possibility of it. While relational characteristics are identified as possible sources of vulnerability, it is recognised that the relational characteristics of marriage and children may at the same time be stressors and motivators – their identification as a possible source of vulnerability does not immediately cast either a positive or negative light on them. The idea of visualizing the vulnerability construct is to enable any legislation to take these various connotations and characteristics into account with all their separate complexities without lumping them all together.

A significant point of interest of such a differentiated identification is the relationship between vulnerabilities and the law, as specifically seen in the case of surrogacy. Legal frameworks can be seen as having their basis in a certain ethical responsibility of balancing out vulnerabilities, providing frameworks to empower the vulnerable. In our analysis and drawing from Mackenzie et

al., the taxonomy of vulnerability that develops as a construct for surrogacy, broadly divided into intrinsic, extrinsic and relational vulnerabilities, is pictorially represented here.

The ICMR recognized and addressed surrogacy as a practice prevalent in India in the year 2000. Not many resources or information is available on whether surrogacy (as an Assisted Reproductive Technology) was being utilized by infertile couples to beget children before 2000<sup>106</sup> but such an assumption can be drawn, and it can be surmised that the ICMR's act of recognition was a consequence of the



practice already being in existence. Yet its treatment of surrogacy and the surrogate at the time was very different. The ICMR recognized the surrogate to be in a position of vulnerability in 2000<sup>107</sup> by treating her on par with a subject of bio-medical research. This treatment, though potentially problematic as being a form of extreme protection for a subject fully competent to consent, had the advantage of allowing a visibilization of various types of vulnerabilities that need to be addressed in the case of a surrogate also.

Returning now to the vulnerabilities delineated by the Belmont Report, we proceed to reinterpret our classification of intrinsic, extrinsic and relational vulnerabilities, and legitimise/valorise them contextually. As can be seen from our analysis of characteristics in Section C above, certain categories of vulnerability in the Belmont Classification such as communicative vulnerability, deferential vulnerability, economic vulnerability and social vulnerability directly correspond with our analysis. Medical vulnerability and study vulnerability do not appear to have any relevance. Institutional vulnerability may have some overlap but not of great magnitude.<sup>108</sup> Having identified

<sup>106</sup> CENTRE FOR SOCIAL RESEARCH, *supra* note 7.

<sup>107</sup> ICMR Research Guidelines 2000, *supra* note 28.

<sup>108</sup> From the research studies conducted by CSR, *supra* note 39 & 40, we see in the study conducted in Jamnagar that almost 40 percent of the respondent group of surrogates were working as nurses or had assisted in the clinic/hospital

the major corresponding categories, we will now proceed to place them in the vulnerability construct and elaborate on the legislative opportunities that become available by this identification.

### **D.2 Communicative Vulnerability**

This type of vulnerability is directly identifiable with the surrogacy arrangement in which a surrogate by virtue of inadequate education, illiteracy, or lack of understanding of the language in which the contract documentation is drawn up is unable to communicate her concerns effectively or even satisfy the requirements of informed consent. Similarly, resources and counselling which are not available at the level of her understanding fail her. It is also evident that any counselling is being provided by the ART Clinic/doctor/agent itself, which creates a conflict of interest. Also, such counselling is a one-off event, although the arrangement demands the availability of continuous counselling throughout.

Addressing communicative vulnerability is a key element that lawmakers need to cover in potential regulation. To be able to ensure informed consent, either minimum parameters of functional literacy need to be established by engaging with the surrogate or requirements for forms, contracts and counselling to be in a language of her choice may be necessary aspects along with the provision of neutral, unbiased legal assistance or other aids for supported decision-making.

### **D.3 Deferential Vulnerability**

In the studies conducted by CSR and Sama, deferential vulnerability was present in various ways. The CSR data shows that the majority of the surrogates from Anand, Surat and Jamnagar reported having taken the surrogacy decision jointly with their husbands. The researchers, however, report findings that the husband emotionally pressurized the wife.

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work<sup>108</sup> as mid wives or casual workers. The study does not reveal whether the surrogates were previously employed with the same clinic where they were acting as surrogates or not. In the study conducted in Delhi and Mumbai this was only the case for 6% and 2% of the respondent group respectively. In the Sama Study, *supra* note 41, none of the respondents from Punjab or Delhi were working with the clinics. Hence this may not be a large concern but may require safeguards.

The researchers expressed the concern that “while the surrogate mothers are in the shelter home, the payment made to them in instalments or entire amount, is coaxed by their husbands who spend it on alcohol or use it for setting up business which in most cases does not take up.” The husband’s role was quite dominant as one surrogate shared,

I don’t know anything. The doctor did not speak to me. [The] monetary issue was discussed with my bhabhi [agent]. I think my husband knows, but I have no idea about the money . . . I asked my husband to tell me about the money. He said you don’t worry, everything will be fine.

A surrogate in the Sama Study shared that instead of speaking to her, the commissioning parents spoke to her husband,

They did not tell me about this, but the parents had talked to my husband. They told him that they had kept two eggs (embryos). He said that was not an issue. So they had spoken to my husband and he had said that was fine. They talked with my husband while I was sitting inside. I did not know about this.

In practice, doctors prefer surrogates who are married and also make spousal consent a requirement. This certainly increases the deferential vulnerability of a potential surrogate.

Agents and doctors were also influential factors in the Sama Study. Their actions were more to resolve the surrogate’s initial dilemmas or confusions. For example, one surrogate described herself as, “I was confused and faced some dilemmas. How will it be possible [how will she conceive]? Will I have to sleep with anyone? The doctor explained that it is for someone’s happiness, and the bhabhi [agent] had earlier explained the procedure to me.” One surrogate related that the doctor told her, “Doctor sahib had told [me] this that if you eat well and take care of yourself and give a child like this, you are helping people and the nation. It will be a good thing. God will also bless you. Doctor sahib persuaded me. So I said okay.”

In the Sama Study one surrogate revealed that, “Doctor had told me one thing, they say that we [the surrogate and her husband] shouldn’t have sex. But she said if I am unable to conceive with the procedure, you can have your own child, I will not tell them [commissioning parents].”

Clearly, these situations suggest an enhanced need for a sensitive recruitment and consent plan where the surrogates have an opportunity to consent voluntarily and not feel obligated to follow the advice of another. Deferential vulnerability also becomes a profound concern if the law lays down requirements that the surrogate be related to the intending parents. The draft 2016 Surrogacy Bill, for example, requires that the surrogate mother be a close relative of the intending parents.

#### **D.4 Economic Vulnerability**

The category of economic vulnerability applies squarely to surrogacy. No matter what the narrative, it is clear that the driving force for a surrogate mother is money. Amrita Pande's interactions with surrogates reflect that most of the surrogate's narratives worked towards downplaying the choice aspect in their decision to become surrogates by highlighting their economic desperation or the needs of their husbands or children as if they are saying, "It is not in my hands, so I cannot be held responsible and should not be stigmatized."<sup>109</sup>

However, there have been examples that reveal different positions on the matter. One woman in the Sama Study who was acting as a surrogate for the second time, drew on her experiences and said that women need to communicate openly about their monetary interests. "But communication needs to be open, like I did. I am confessing that in my case, I was quite afraid and I did not communicate. Women should communicate. They should talk openly, the way I have talked about money, one should talk openly." She clearly articulated herself and exhibited greater confidence in negotiating the money involved. She pointed out that self-stigmatization and fear inhibited women from asking for their fair share. Yet another surrogate revealed a different perspective about feeling inhibited about receiving any payment at all, as the commissioning parents were distant relatives of her husband. "It is in my relations and she [the commissioning mother] is known. It feels strange to talk about money. It is like it is going to our family only." She was certain that expenses would be taken care of, though.

In the Vulnerability Construct, economic vulnerability overlaps with extrinsic vulnerability due to the state of the income, prior employment and education of a surrogate. Economic vulnerability in surrogacy requires specific caution in the recruitment of surrogates. It is important that the payment

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<sup>109</sup> Pande, *supra* note 76.

offered does not encourage an individual to put herself at greater risk than they would otherwise. Does this mean that if payment were to be done away with altogether, this nature of vulnerability would be done away with?

At present, the proposed regulation of surrogacy by way of the 2016 Surrogacy bill has suggested that surrogacy should be altruistic. A strict definition of altruism has been taken to cover only the medical expenses incurred by the surrogate mother and insurance coverage.<sup>110</sup> There is no room for reimbursement of any other expenses of the surrogate or remuneration for their involvement, time and effort.

The statement of general principles issued in the ICMR Research Guidelines 2000 includes the principle of non-exploitation, whereby “as a general rule, research subjects are remunerated for their involvement in the research or experiment.” The principle of non-exploitation insists that research subjects should be remunerated for their involvement in a research or experiment, at least to compensate for the “physical and psychological risks” and “foreseeable and unforeseeable risks”. Regarding the general ethical issues elaborated in the ICMR Research Guidelines 2000 under seven headings, one of them is “Compensation for Participation”, which specifically calls for reasonable payments that do not amount to inducement and are approved by an appropriately constituted committee and allow for the withdrawal of a subject from the study with the benefit of full participation (if she does so due to medical reasons) or payments proportionate to her participation (if she withdraws for any other reasons).<sup>111</sup> As already introduced above, the ICMR Research Guidelines 2000 addressed surrogacy for the very first time and likened surrogates to

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<sup>110</sup> 2016 Surrogacy Bill, *supra* note 45 at Section 2(b) - “Altruistic Surrogacy” means the surrogacy in which no charges, expenses, fees, remuneration or monetary incentive of whatever nature, except the medical expenses incurred on surrogate mother and the insurance coverage for the surrogate mother, are given to the surrogate mother or her dependents or her representative.

<sup>111</sup> ICMR Research Guidelines 2000, *supra* note 28. “Subjects may be paid for the inconvenience and time spent and should be reimbursed for expenses incurred due to their participation. They may also receive free medical services. However, it is stipulated that such payments should not be so large or the medical services so extensive as to induce prospective subjects to consent to participate in research against their better judgment (inducement). Moreover, all payments rendered need to be approved by an appropriately constituted Institutional Ethics Committee. In case the subject withdraws from the research for medical reasons related to the study she should be given the benefit for full participation and if she withdraws for any other reasons she should be paid in proportion to the amount of her participation.”



subjects of bio-medical research. It follows that those principles would also guide the manner of conduct of a doctor or clinic with a surrogate.

In contrast, the proposed regulation suggests payment only of medical expenses, and here too, upon withdrawal of participation by the surrogate at her request, she would need to refund all certified and documented expenses incurred for the pregnancy by the biological parents or their representative.<sup>112</sup> This in itself amounts to a compulsion, particularly where economic vulnerability is high.

Therefore, the safeguard for economic vulnerability is not doing away with payments altogether but rather making the payments more visible, reasonable and non-contingent to full participation. This may require monitoring by an outside body and thorough counselling of a surrogate, keeping in mind her state of income and employability. Safeguards such as pre-approved payments, payments that are compensatory in nature and reasonable (not so high that they serve as inducements), insurance cover for foreseeable and unforeseeable risk, free medical treatment and medical treatment that extends to after the delivery may be considered protection against such vulnerability.

### **D.5 Social Vulnerability**

Social vulnerability recognizes the vulnerability of participants who are at risk of discrimination on account of race, gender, ethnicity and age. This type of vulnerability, particularly when present with communicative vulnerability, may often result in discriminatory stances towards surrogates. Social vulnerability needs to be kept in mind when considering the nature and training of support required for a surrogate to exercise informed decision-making. While age and gender<sup>113</sup> have been recognized as factors in the intrinsic vulnerability of a surrogate, the role played by factors of race

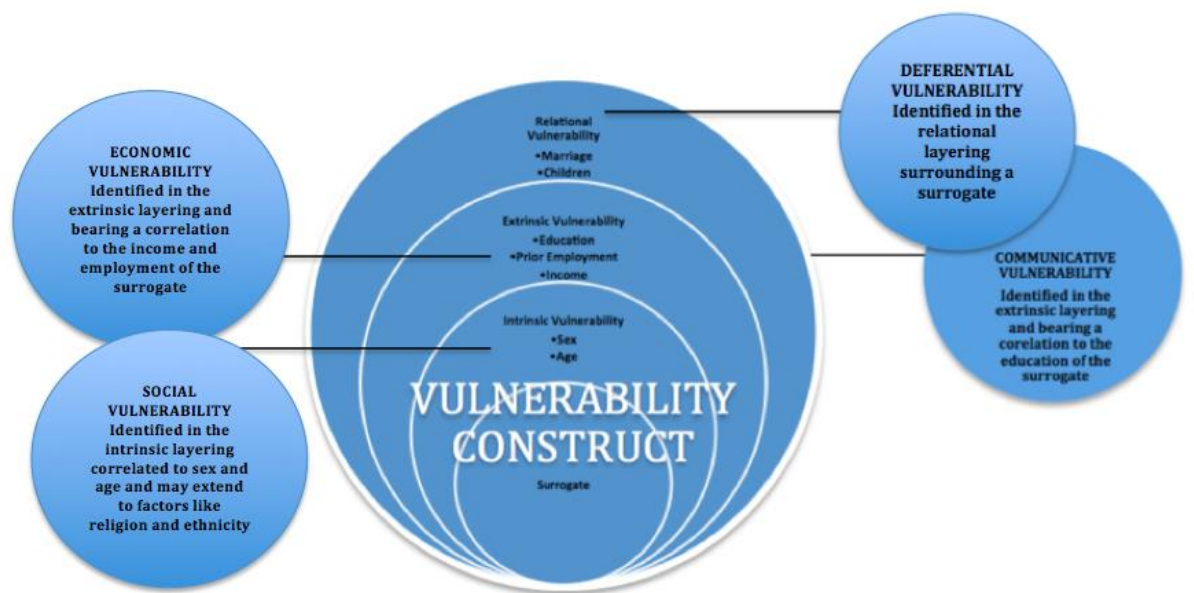
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<sup>112</sup> ART Bill 2010, *supra* note 44 Form J (Annexures) – Agreement for Surrogacy ‘Under Rule 15.1 of ART Rules, <http://www.worldfertilityservices.com/wp-content/uploads/2014/03/ART-REGULATION-Draft-Rules-1.pdf>.

<sup>113</sup> For a general and critical understanding of women’s status in India *see* Pamela S. Johnson, Jennifer A. Johnson, *The Oppression on Women in India*, 7(9) VIOLENCE AGAINST WOMEN 1051-1068 (Sep. 2001) <http://www.bbc.com/news/world-asia-india-17398004>.

and ethnicity or even religion require much more widescale research studies than the ones presently relied on.

On the whole, as we visibilise each category of vulnerability and develop the vulnerability construct further, the following pictorial representation arises.



The intersection of each layer of vulnerability is also of import as its helps us understand the relationship each has with the other. It can be extrapolated from our analysis that intrinsic vulnerability – factors like sex and age – may deepen deferential vulnerability. Similarly, social vulnerability may become enhanced on account of intrinsic vulnerability (especially sex) when combined with more marginalizing factors like religion, caste or ethnicity, especially where extrinsic vulnerability exists – lack of education, low income or limited employability. Economic vulnerability bears a direct correlation with communicative vulnerability as an



economically unsound position may lead to compulsive situations in which a surrogate is unable to vocalize her own concerns. This may be exacerbated if relational vulnerability is high. Hence, each layer bears on the other, influences the other, and may even become lighter or stronger in relation to the other. This suggests a complex interplay which marks the need for a variety of regulatory nuances and emphasises that there is no single solution to the various vulnerabilities surrounding the surrogate.

#### **D.6 Legal Vulnerability**

A critical category of vulnerability in the Belmont Classification is that of legal vulnerability. It is acknowledged that legal vulnerability is not immediately visible in the socio-economic and demographic characteristics of the surrogates which were analysed to develop the surrogacy construct. However, an interplay of all the vulnerabilities – intrinsic, social, extrinsic, communicative, economic, relational, deferential – highlights several quagmires that are ripe for exploitation if the law is unsupportive or unable to attend to each opportunity created by the various vulnerabilities.

This particularly concerns surrogacy if it or its commercial aspects are outlawed and surrogates are compelled to continue their participation, having at the outset agreed to an illegal act. It may also concern surrogates who may not qualify as a surrogate but may be acting as one contrary to the law. It would also be a concern if the surrogate herself is a foreign national who has been brought to India for the purpose of surrogacy.

In 2012, when the Government of India took the position that surrogacy would not be available to homosexual couples, various news reports stated that some infertility clinics in Delhi continued to sign on gay clients from all over the world. According to one report,

Clients shipped their frozen sperm to Delhi, which was used to fertilize eggs from Indian donors. The resulting embryos, legally belonging to the gay men, were implanted into Indian surrogate mothers. To avoid the ban, infertility clinics then

moved surrogate mothers across international borders into Nepal. There, they gave birth, and clients arrived to pick up their children.<sup>114</sup>

It is a matter of concern that post prohibitory stances on surragcy, surrogates are far more vulnerable than before. Sharmila Rudrappa writes,

They [surrogates] are wholly dependent on agencies that have brought them into countries where they are strangers and unfamiliar with the language, culture and social norms. Surrogacy agencies provide them with housing and food in these foreign countries. And they control the money. As a result, the women are powerless to terminate their contracts, or go back home if they choose to do so. They are isolated from friends and family and have no legal recourse to address financial abuses or medical malpractice.<sup>115</sup>

It is evident that the surrogate mothers are often mute spectators. Rather than building on autonomy, freedom and choice, surrogacy reinforces the image of women as selfless, dutiful mothers whose primary role is to serve the family, their husbands and in-laws,<sup>116</sup> and their need is borne of economic desperation.<sup>117</sup> In the CSR Studies, the researchers identified that the surrogates were at times made to feel like money banks. A surrogate in the Sama Study shared,

Here the thing is that you can neither talk to the doctors nor to the couple [commissioning parents]. You have to keep your thoughts to your own self. Whatever they say, you have to do it. Madam said, 'Do this, do that.' And you have to do it. You can't talk freely. She [doctor] just asks, everything is fine, is there any problem, eat this, eat that. They will ask about all the things that they are concerned with as part of their work. The rest comes in the report. The doctors look at the report in front of them. They won't share an experience with a human, but they will do it with a file and that is it. They won't look at you. They will look at your file. 'How are you? Do

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<sup>114</sup> Sharmila Rudrappa, *India outlawed Commercial Surrogacy – Clinics are finding Loopholes*, THE CONVERSATION (Oct. 24, 2017) <https://theconversation.com/india-outlawed-commercial-surrogacy-clinics-are-finding-loopholes-81784>.

<sup>115</sup> *Id.*

<sup>116</sup> Pande, *supra* note 76.

<sup>117</sup> Pande, *supra* note 76.

you feel fine? Are you eating? Is the movement okay?’ . . . That is all they say. Even if you try to talk to them, they will say, ‘I don’t just have one patient to see, I have many.’ They are all meethi chhuri [sweet knife]. . . Madam doesn’t have any time. It is a fixed timetable. Right now, in this hospital, then that. Here, if there is a new patient, there is no one who can explain anything to you. They only talk to the family [commissioning parents], as if it is them and not us who are pregnant.

The surrogates spoke of being excluded from the process - the only concern being the health of the foetus and the identifiable patients being the commissioning parents. Surrogates reported experiencing a general atmosphere of intimidation to open communication and access to doctors being mediated by the presence of the agent. There was concern expressed about rubbing the agent the wrong way, as a surrogate shared when questioned if she had asked details of her medication. “No. I have not asked them. They will wonder why I am so curious or what my motive is. If I ask him that, he will say I do all your work, what medicines, etc., [are required], everything I take care of. So why are you asking this?” One surrogate in the Sama Study also described the secrecy that surrounded the practice and the invisibilization of the surrogate. In the CSR studies, some surrogates shared that if they spoke too much or asked too many questions, they could be replaced by other women.

All these factors may cause surrogates to place themselves in a legally vulnerable situation, which they may feel they need to continue with as they had agreed to it to begin with. The nature of the arrangement, i.e., a pregnancy, also entails a compulsion in itself beyond, say the 24-week mark, after which a medical termination may not be legally possible. Disquietingly, it has been observed in the two studies done by CSR that “clinics/doctors normally prefer to prepare and sign the agreement when the pregnancy is confirmed by the end of the first trimester till the middle of the 4th–5th months of pregnancy.”<sup>118</sup> It was noted that,

More than 85% of the contracts were found to be signed around the second trimester of the pregnancy as it takes one to two months more for the commissioning parents

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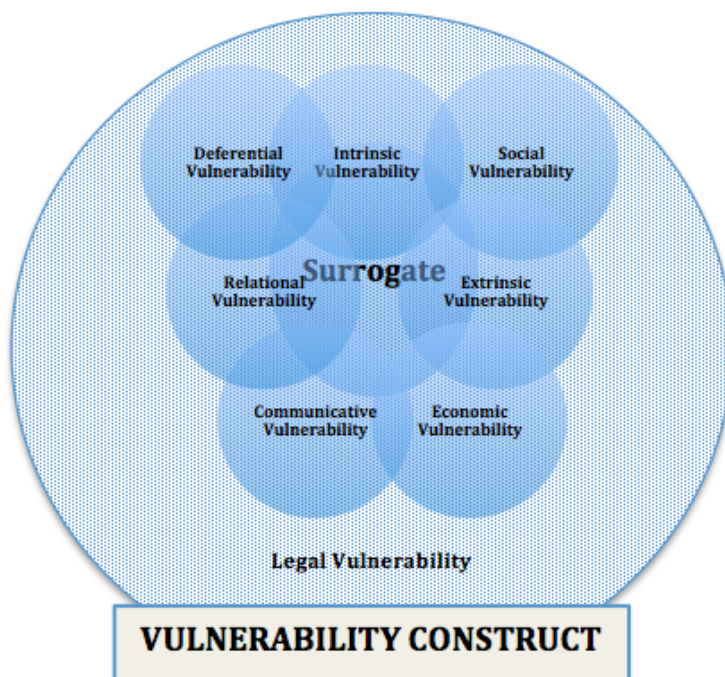
<sup>118</sup> CSR DM Report, *supra* note 39 at 60.



to arrange their visit to India after being informed about the confirmation of pregnancy of the surrogate mother by the clinic/infertility physician.<sup>119</sup>

In the statement of general principles issued in the ICMR Research Guidelines 2000, one heading of identified principles is the “principles of voluntariness, informed consent and community agreement”, which assumes research subjects are fully apprised of the research and the impact and risk of such research on themselves and others; and the research subjects retain the right to abstain from further participation in the research irrespective of any legal or other obligation that may have been entered into by them or someone on their behalf, subject to only minimal restitutive obligations of any advance consideration received and outstanding.

According to the ICMR Research Guidelines 2000, the principles of informed consent and voluntariness are cardinal principles to be observed throughout the research and experiment,



including its aftermath and applied use so that research subjects are continually kept informed of any and all developments that affect them and others. However, without in any way undermining the cardinal importance of obtaining informed consent from any human subject involved in research, the nature and form of the consent and the evidentiary requirements to prove that such consent was taken depend upon the degree and

seriousness of the invasiveness into the concerned human subject's person and privacy, health and life generally, and the overall purpose and importance of the research. As a proposed law moves to more restrictive positions or is unable to address the interplay of vulnerabilities we have identified above, the scope of legal vulnerability deepens. Hence, legal vulnerability should be understood

<sup>119</sup> CSR DM Report, *supra* note 39 at 60.



as an all-encompassing risk that would need to be assessed not only when a woman agrees to act as a surrogate but also at various stages of the surrogacy arrangement and even after it ends. Minimizing the risk of legal vulnerability would require that the surrogate be more visible to third-party assessment. Its specific risk requires an all-encompassing visibilization in the Vulnerability Construct as it affects all layers of vulnerability identified and has the potential of exacerbating or ameliorating each layer, in effect increasing or decreasing the possibility of exploitation of the surrogate.

It is ironic that the Surrogacy (Regulation) Bill 2016 is taking steps in the opposite direction. Commentators have noted their concern on this stating,

Today, when surrogate mothers have legal rights, there are accusations of exploitation. If commercial surrogacy is banned, the intended parents and surrogates would be forced to operate underground with a very high risk exposure. Then these poor women would have no legal rights and the chances for exploitation would be even more.<sup>120</sup>

## **E. LIMITATIONS OF THIS STUDY AND SCOPE FOR FUTURE RESEARCH**

One of the main limitations of this research is the lack of exploration of the corporeality of vulnerability. The surrogate mother has a specifically corporeal embodiment in the exchange, a body at stake with its needs and requirements. Pregnancy carries a great emotional and physical strain, and brings with it a specific kind of situational vulnerability that is at once intrinsic and extrinsic. Further research could pick up on this matter.

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<sup>120</sup> Hari G Ramasubramaniam, *Banning Commercial Surrogacy will expose Women to Exploitation*, THE ECONOMIC TIMES (Aug. 28, 2016) <https://economictimes.indiatimes.com/magazines/panache/banning-commercial-surrogacy-will-expose-women-to-exploitation/articleshow/53889509.cms>.

Another point of concern arises from the studies reviewed. When analysing the trio of factors (education, previous employment and household income) together, it can be seen that the majority of surrogates in the respondent groups were neither jobless nor illiterate nor even below the poverty line. Then where has the narrative of the poor, illiterate surrogate come from?

From Amrita Pandey's work in Anand,<sup>121</sup> the chief motive for surrogacy was economic: 34 out of 42 surrogates she had interacted with had family incomes below the poverty line. Saravanan,<sup>122</sup> in her 2010 study of gestational surrogacy in Anand, described the women she interviewed to be 'on the edge of poverty' because of indebtedness or homelessness, and that they were not educated beyond the higher secondary level. In the CSR Study conducted in Anand, the incidence of unemployment amongst surrogate mothers was much higher compared to the other locations. It was noted that while almost half of the respondents in Anand, Surat and Jamnagar were educated to the primary level, illiteracy was much more prevalent in Anand. This in turn impacted their ability to be in gainful employment in the public or private sector.

Could it be that it was through studies based in Anand, an area that appears intrinsically to have lower literacy levels and lower employment amongst women that the narrative of the poor, illiterate surrogate came about? Could times have moved on from this narrative as surrogacy became more and more prevalent in Tier 1 cities in India? Anand was never a tier 1 city or even an identifiable Tier 2 city to begin with. It merely rose to fame due to the work of Dr. Nayna Patel, who pioneered the practice of surrogacy in India. This is also what led the first wave of researchers to Anand. It is a question worth asking, and only wider studies amongst surrogates in India from multiple locations can give us that answer.

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<sup>121</sup> Gina Maranto, 'They are just Wombs' CENTRE FOR GENETICS AND SOCIETY (June 12, 2010) quoting Sociologist Amrita Pande of the University of Cape Town <https://www.geneticsandsociety.org/article/they-are-just-wombs>.

<sup>122</sup> Sheela Saravanan, *Transnational Surrogacy and Objectification of Gestational Mothers*, 45 (16) Economic and Political Weekly (2010).

## F. CONCLUSION

Through a close reading of the findings of three studies, two conducted by CSR and one by Sama - Research Group on Health, we have identified that a surrogate mother is enveloped by various layers of vulnerability. These layers may be intrinsic to her on account of her age or sex or may be extrinsic to her on account of her income or literacy levels or state of previous employment. We further identified that a surrogate's capacity to act autonomously may at times be hampered on account of relational vulnerabilities, which involve factors like marriage or children.

By likening the practice of surrogacy to biomedical research being conducted on the human subject (i.e., the surrogate mother) as was done by the ICMR 2000 Guidelines, several further and differentiated layers of vulnerability become visible. By comparatively analysing the vulnerability construct with these categories, it can be seen that various categories such as cognitive or communicative vulnerability, deferential vulnerability, economic vulnerability and social vulnerability do in fact exist as separate layers or even overlap with the vulnerabilities identified in surrogates. As the ultimate element, we have identified the category of legal vulnerability that makes an impact on every layer of vulnerability and is capable of exacerbating or ameliorating them.

The mere existence of vulnerability does not automatically suggest the existence of exploitation. Indeed, some situations may be unjust without being exploitative, and some may involve harm inflicted on vulnerable people without having exploited them.<sup>123</sup> Potential laws need to visibilise vulnerability and address it through recognition, for the ultimate goal of a constitutionally sound legislation is to prevent exploitation.

The majority of the surrogates who participated in the research studies appear to be making very active choices among the limited options they have. They also appear to be exerting their agency, sometimes even against their spouses and family members, to achieve their aspirations. As they learn from their experiences, they find themselves in better positions of negotiation. This is the roadmap of empowerment.

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<sup>123</sup> Macklin, *supra* note 15 at 473.

An empowering legislation's best hope is to put safeguards and protections in place that reduce the various layers of vulnerability and equip a person with coping strategies that help her to make a choice of whether to act as a surrogate or not and make decisions later during the surrogate arrangement. Our analysis emphasizes that given the complex interplay of each layer of vulnerability, no one solution is a good fit.

It appears from the direction that the Surrogacy (Regulation) Bill of 2016 is taking that regulators are heavily invested in singular solutions. Our analysis suggests that they may fail to protect the surrogate and would disempower her and – more worryingly – create further opportunity for exploitation as her vulnerabilities grow.

Historically, Indian lawmakers have a penchant for short-changing Indian women's labour prospects in the guise of protection. Take for example the Factories Act, 1948 and the Shops and Commercial Establishments Act, 1961, through which restrictions were imposed on women engaged in night-time work. These provisions, which were to ensure the safety of women at night, were used instead to blame them, as whenever a crime against women was reported at night, it became a fashion for law enforcement officials to question why the women had to be working at night and even asking that women only work from 8 am to 8 pm.<sup>124</sup> Or consider the 2005 ban on dance bars in Maharashtra by the state government, which effectively put more than 75,000 women out of work. Even when the Supreme Court ordered that the ban be lifted, the Maharashtra Chief Minister imposed an obscenity ban through the Maharashtra Prohibition of Obscene Dance in Bars and Hotels and Protection of Dignity of Women Act, 2016<sup>125</sup>. It seems that what women can and can't do with their body is a constant battle for regulators in the guise of protecting the dignity of woman. This may well be what is guiding the present regulation on surrogacy, rather than an understanding of an Indian surrogate's realities or a real concern to address her vulnerability. This construct of human dignity is not empowering. In a patriarchal society, everything viewed through a moral prism could act as a constraint on how women are able to exercise control over their bodies.

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<sup>124</sup> PV Swati, *Gurgaon Police: After 8 PM Women would be 'Inviting' Rape*, YKA (March 19, 2012) <http://www.youthkiawaaz.com/2012/03/gurgaon-police-after-8-pm-women-would-be-inviting-rape/>.

<sup>125</sup> Mohamed Thaver, *Mumbai Police go after Dance Bars with Hidden Cameras*, THE INDIAN EXPRESS (June 10, 2016) <http://indianexpress.com/article/india/india-news-india/maharashtra-dance-bar-mumbai-police-hidden-camera-government-ban-licence-supreme-court-2844263/>.

It is necessary that debates on dignity and morality are not carried out in a vacuum and without thought to the circumstances in which women exist. We cannot afford to sermonize, pity or sympathize. Lawmakers should instead empathize – for this is just the way things are for the women they are attempting to regulate. In order to address the concerns arising from surrogacy arrangements, regulation is necessary. Such regulation cannot be indifferent to her vulnerability. The draft 2016 Surrogacy Bill, in which the Government has opted to make surrogacy altruistic, suggests that lawmakers are of the opinion that removing the financial aspects of a surrogacy arrangement, in effect the surrogate's own reimbursement, would be the most effective tool against vulnerability. However, this may be a misguided approach. As shown above, restrictive positions of law actually exacerbate legal vulnerability. Also, by retaining payment of medical expenses, the Government has in effect retained the gains of the entire medical machinery driven by the doctors and the ART Clinics, which were the primary stimulus for the burgeoning industry. It is ironic that the measures to end the exploitation of surrogates may actually become more exploitative themselves. Merely banning the “commercial” aspect of surrogacy may have an opposite effect and lead to invisible transactions in which a surrogate would find herself even more vulnerable and easily exploited - for it is easy to hide a money trail but difficult to hide a pregnancy.