

7-1-2014

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Recommended Citation

Kristine Schanbacher, *India's Gestational Surrogacy Market: An Exploitation of Poor, Uneducated Women*, 25 *Hastings Women's L.J.* 201 (2014).

Available at: <https://repository.uchastings.edu/hwlj/vol25/iss2/5>

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India's Gestational Surrogacy Market: An Exploitation of Poor, Uneducated Women

*Kristine Schanbacher**

I. INTRODUCTION

Approximately, “[t]en to 15 percent of couples in the United States are infertile. Infertility is defined as not being able to get pregnant despite having frequent, unprotected sex for at least a year for most people.”¹ A variety of factors in either or both partners can cause infertility.² However, due to various Assisted Reproductive Technology (“ART”) procedures, couples can “creat[e] conception through means other than coital reproduction.”³

Artificial insemination, the oldest and most common ART procedure, is a process whereby a sperm sample is directly inserted into the uterus via a catheter.⁴ In 1981, “America celebrated the birth of its first in vitro fertilization⁵ [(“IVF”)]-conceived baby.”⁶ IVF is the process of fertilization where an egg is manually combined with sperm in a laboratory dish.⁷ “When the IVF procedure is successful, the process is combined with a procedure known as embryo transfer, which involves physically placing the embryo in

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1. *Infertility*, MAYO CLINIC, <http://www.mayoclinic.com/health/infertility/DS00310> (last visited Feb. 9, 2014).

2. *Id.*

3. Brad Reich & Dawn Swink, *Outsourcing Human Reproduction: Embryos & Surrogacy Services in the Cyberprocreation Era*, 14 J. HEALTH CARE L. & POL’Y 241, 246 (2011).

4. Medicine.net, *Definition of Artificial Insemination*, <http://www.medterms.com/script/main/art.asp?articlekey=7001> (last visited Feb. 9, 2014). The donor of the sperm can either be the commissioning man or a third party. *Id.*

5. In vitro fertilization literally means “in glass” fertilization. Rachel Blatt, *Wombs for Rent? Gestational Surrogacy and the New Intimacies of the Global Market* 4 (April 2009) (unpublished B.A. honors thesis, Brown University) available at <http://www.thelizlibrary.org/surrogacy/blatt-wombs.pdf>. IVF was pioneered by Patrick Steptoe and Robert Edwards. *Id.*

6. Reich & Swink, *supra* note 3, at 249. By 2006, “at least 54,656 babies were born in the United States using IVF and IVF-related procedures.” *Id.*

7. *In Vitro Fertilization: IVF*, AMERICAN PREGNANCY ASSOCIATION, <http://www.americanpregnancy.org/infertility/ivf.html> (last visited Jan. 17, 2014).

the uterus.”⁸ The embryo can be placed into a woman’s uterus that provided the egg or a woman who is not genetically related to the embryo. It is at this stage of embryo transfer in which a surrogate’s services may be used.⁹ If a surrogate is used, the fertilized egg is implanted in the uterus of a third-party woman who gestates the resulting fertilized egg(s) for the commissioning couple.¹⁰ This type of surrogacy is called gestational surrogacy and “[u]nder this arrangement, the child is genetically related to the commissioning man and woman, or to the commissioning man and a third woman who provides eggs, but not to the surrogate birth mother.”¹¹

While gestational surrogacy is a rather recent development, “surrogacy is, in fact, a very old concept dating back to ancient times.”¹² Prior to the 1970s, the only surrogacy option available was if a husband of an infertile woman “consort[ed] with other women for the sake of having a baby for the couple to raise.”¹³ After the development of artificial insemination, a couple could pursue surrogacy without the husband engaging in intercourse,¹⁴ as the husband’s sperm could be inserted into a surrogate woman via a catheter.¹⁵ Under this arrangement, the child is genetically related to the commissioning man and the surrogate woman. Almost immediately after the debut of surrogacy through artificial insemination, “several sensational court battles” erupted.¹⁶ In these sensational court battles, “surrogates[,] who were also the genetic mothers[,] fought to keep the children they had carried for nine months [and they] were often awarded rights to the child equal to those of

8. AMERICAN PREGNANCY ASSOCIATION, *supra* note 7. Instead of immediate implantation, the embryo may be stored for future use. *See* Reich & Swink *supra* note 3, at 246. The ability to store a fertilized egg or a non-fertilized human egg has only been available since 2004. *Id.* at 250.

9. Reich & Swink *supra* note 3, at 246.

10. Emily Stehr, Note, *International Surrogacy Contract Regulation: National Governments’ and International Bodies’ Misguided Quests to Prevent Exploitation*, 35 HASTINGS INT’L & COMP. L. REV. 253, 254 (2012).

11. *Id.* Additionally, the commissioning couple may use donor sperm and under this arrangement the child would not be genetically related to the commissioning man. *Inter-Country Surrogacy and the Immigration Rules*, UK BORDER AGENCY, <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/residency/Inter-country-surrogacy-leaflet> (last visited Feb. 9, 2014).

12. Erica Davis, Note, *The Rise of Gestational Surrogacy and the Pressing Need for International Regulation*, 21 MINN. J. INT’L L. 120, 121 (2012). “The Old Testament offers the example of Abraham’s infertile wife, Sarah, who ‘commissions’ her maid Hagar to bear her a child by convincing Abraham to sleep with her. Similarly, Rachel the barren wife of Jacob, commissions her maid Bilhah to have a child by convincing Jacob to sleep with her.” Usha Rengachary Smerdon, *Crossing Bodies, Crossing Borders: International Surrogacy between the United States and India*, 39 CUMB. L. REV. 15, 16 (2009).

13. Davis, *supra* note 12, at 121.

14. Davis, *supra* note 12, at 122.

15. *Infertility*, OBSTETRICS AND GYNECOLOGY UCLA, <http://obgyn.ucla.edu/body.cfm?id=326> (last visited Feb. 9, 2014).

16. *Id.*

the biological father.”¹⁷ Thus, due to potential custody battles, this type of surrogacy was not a popular alternative for infertile couples.¹⁸

In vitro fertilization, “revolutionized the surrogacy industry [as] a gestational surrogate could be biologically unrelated to the child, potentially allowing the roles of the parties involved in a surrogacy arrangement to be clearer and easier to delineate.”¹⁹ Due to the perceived legal and genetic benefits of IVF, “[g]estational surrogacy has become increasingly more common and presently accounts for approximately 95% of all surrogate pregnancies in the United States.”²⁰

In the United States, there is no federal law on surrogacy and individual state regulations vary widely.²¹ Some state legislatures have banned surrogacy agreements or severely restricted their enforceability while other state legislatures “have declined to directly address the legality of surrogacy contracts and accordingly rely on contract law, as opposed to family law, to adjudicate such disputes.”²² In addition to the legal uncertainty, the total cost of gestational surrogacy in the United States is very high compared to other countries; the cost of gestational surrogacy in the United States costs “between \$59,000 and \$80,000.”²³ The unclear legal terrain and the high cost of gestational surrogacy has led many American couples to look beyond the borders of the United States in their search for a surrogate.²⁴ In fact,

17. OBSTETRICS AND GYNECOLOGY UCLA, *supra* note 15.

18. OBSTETRICS AND GYNECOLOGY UCLA, *supra* note 15.

19. OBSTETRICS AND GYNECOLOGY UCLA, *supra* note 15.

20. Smerdon, *supra* note 12, at 17.

21. Stehr, *supra* note 10, at 261–64.

22. Stehr, *supra* note 10, at 263. “[F]ive states explicitly provide[] for the enforceability of surrogacy contracts by statute.” Kevin Tuininga, *The Ethics of Surrogacy Contracts and Nebraska’s Surrogacy Law*, 41 CREIGHTON L. REV. 185, 189 (2008). These states are: Florida, Illinois, Nevada, New Hampshire, and Virginia. *Id.* Four of the states “forbid payment for surrogacy, but allow reimbursement for both direct and ancillary medical expenses.” *Id.* However, “Illinois allows reasonable compensation for the surrogate” in addition to medical expenses. *Id.* At least nine jurisdictions—Arizona, District of Columbia, Indiana, Louisiana, Michigan, New York, Nebraska, North Dakota, and Utah—have attempted to prohibit the enforcement of surrogacy contracts; however, some were repealed as they were deemed unconstitutional by their jurisdictional courts. *Id.* at 189–90. Five jurisdictions—District of Columbia, Michigan, New York, Utah, and Washington—have criminalized certain surrogacy contract activities. *Id.* For example, “Washington prohibits surrogacy contracts for compensation and involving certain individuals, namely un-emancipated minors, those diagnosed as mentally retarded or having a developmental disability or mental illness.” *Id.* The remaining states have no surrogacy contract legislation, leaving the issue to be resolved by the courts. *Id.* It is important to note that while California has no statute directly addressing surrogacy, a lot of surrogacy agreements occur in California, as California’s courts are accepting of surrogacy agreements and have even upheld paid surrogacy agreements. See *Surrogacy Laws By State*, THE SELECT SURROGATE, <http://www.selectsurrogate.com/surrogacy-laws-by-state.html> (last visited Jan. 17, 2014).

23. Smerdon, *supra* note 12, at 32. The total costs of gestational surrogacy in India ranges “between \$10,000 and \$35,000.” *Id.*

24. Stehr, *supra* note 10, at 261.

India²⁵ has become the top international destination for gestational surrogacy²⁶—an estimated \$500 million-a-year industry.²⁷

“Bioethicists often refer to the four basic principles of medical ethics when evaluating the merits and difficulties of medical procedures. Ideally, for a medical practice to be considered ‘ethical,’ it must respect all four of these principles: [non-maleficence, beneficence, autonomy, and justice].”²⁸ This paper examines India’s gestational surrogacy market and America’s use of this market through the four principles of medical ethics: (1) non-maleficence, (2) beneficence, (3) autonomy, and (4) justice.

A. NON-MALEFICENCE

The principle of non-maleficence dictates that a medical procedure should not intentionally create a needless harm or injury to the patient.²⁹ India’s current gestational surrogacy market violates this principle, as the procedure often disregards the health risks to surrogate women, fuels traditional racial and class hierarchies, and commodifies surrogate women.

1. Health Risk of Surrogate Women Disregarded

India’s gestational surrogacy market far too frequently puts the health of the surrogate woman at risk. For example, “[i]n the U.S., surrogates are given no more than two embryos for their safety, whereas in India, surrogates are implanted with up to five embryos in order to increase the chances of pregnancy.”³⁰ By implanting up to five embryos, there is a high probability that more than one embryo will turn into a viable pregnancy.³¹ If the

25. Davis, *supra* note 12, at 125. Academics may use the term “fertility tourism” to describe a couple’s use of India’s international gestational surrogacy market. “Fertility tourism describes the act of traveling abroad to take advantage of assisted reproductive technologies.” Jennifer Rimm, Comment, *Booming Baby Business: Regulating Commercial Surrogacy in India*, 30 U. PA. J. INT’L L. 1429, 1429 (2009).

26. Panama, Malaysia, Ukraine, Georgia, and Guatemala also provide international surrogacy services. See *More Americans Now Traveling to India for Surrogate Pregnancy*, ABC World News, <http://abcnews.go.com/WN/adoption-india-americans-plan-surrogacy-abroad/story?id=10487880#.T0ImjpgW995> (last visited Jan. 17, 2014).

27. Blatt, *supra* note 5, at 25. “There are 200 documented surrogacy clinics in India, through India’s National Commission for Women estimates that there could actually be up to 3,000 clinics in practices.” *Id.*

28. *What Are the Basic Principles of Medical Ethics*, STANFORD UNIVERSITY, <http://www.stanford.edu/class/siw198q/websites/reprotech/New%20Ways%20of%20Making%20Babies/EthicVoc.htm> (last visited Jan. 17, 2014) [hereinafter Stanford I].

29. Thomas R. McCormick, *Ethics in Medicine: Principles of Bioethics*. U. OF WASH. SCHOOL OF MED. (Oct. 1, 2013) available at <http://depts.washington.edu/bioethx/tools/princpl.html>. Non-maleficence was “first expressed by Hippocrates and translated into Latin as *primum non nocere*, first do no harm.” *Non-Maleficence*, MEDICAL DICTIONARY, <http://medical-dictionary.thefreedictionary.com/nonmaleficence> (last visited Jan. 17, 2014).

30. Ishika Arora, *Wombs for Rent: Outsourcing Surrogacy to India* (2012), <http://prospectjournal.org/2012/01/10/wombs-for-rent-outsourcing-surrogacy-to-india-2/>.

31. *Id.* It is important to note that “[o]nly a fraction of multiple pregnancies are conceived naturally,” while most are the result of ART procedures. Jean Weiss, *How Risky is Multiple Pregnancy*, MSN, <http://healthyliving.msn.com/pregnancy-parenting/advice/how-risky-is-a-multiple-pregnancy-1> (last visited Jan. 17, 2014).

surrogate woman becomes pregnant with more than one fetus and the commissioning parents do not choose to selectively abort the other fetuses, the surrogate woman faces severe health risks, including:

[p]reeclampsia (high blood pressure, which can lead to eclampsia, which is sometimes fatal); [g]estational diabetes (which has been linked to a greater likelihood of diabetes later in life); [b]lood clots... an increased chance in having a C-section, especially if pregnant with more than two babies.

Furthermore, the surrogate woman is at “a higher risk for postpartum complications, including: hemorrhaging, exhaustion, and postpartum depression.”³² Thus, the practice of implanting up to five embryos in Indian surrogates clearly favors the commissioning couple over the surrogate woman, as this practice “maximize[s] the profit in a ‘Costco-size’ manner (most number of children per round of IVF)” while disregarding the severe health risks to the surrogate woman.³³

Gestational surrogates also face mental health risks, such as postpartum depression and anxiety from the social stigma of surrogacy.³⁴ For example, Najima Vohra, a gestational surrogate, “explained that the local residents of her village would perceive her surrogacy to be ‘dirty’ [and] that her family would be shunned if her neighbors knew.”³⁵ This social stigma undoubtedly caused Vohra anxiety, as she was “forced to leave her family for nine months and join other surrogates in gestational dormitories” in order to keep her pregnancy a secret.³⁶ However, when a gestational surrogate suffers mental harm, this is likely to be ignored due to the lack of trained mental health personnel in the rural areas where most surrogate women are from.³⁷

32. *Id.* The health risks to the fetuses are also severe. *Id.* “The biggest risk factor for multiple babies is premature birth, which is defined as one that occurs before 37 weeks’ gestation. The average gestation for a single birth baby is 40 weeks; the average gestation for twins is 35 weeks. For triplets, it’s 33 weeks, and for quadruplets, the average gestation is 29 weeks [and] [t]he more premature the babies are, the more complications they suffer.” *Id.* Furthermore, “multiple babies can be undernourished, compared to babies who have a uterus all to themselves.” *Id.*

33. Arora, *supra* note 30.

34. Arora, *supra* note 30. “[E]vidence indicates that at least some surrogates suffer from postpartum depression and a sense of emptiness as a result of being unable to breastfeed the [commissioning couple’s] baby.” George Palattiyil et al., *Globalization and Cross Border Reproductive Services: Ethical Implications of Surrogacy in India for Social Work*, 53 INT’L SOC. WORK 686, 691 (2010).

35. Arora, *supra* note 30.

36. Arora, *supra* note 30.

37. Arora, *supra* note 30. One may argue that though there are potentially severe health risks involved in gestational surrogacy, gestational surrogates are paid to assume these health risks. However, such an argument assumes that the gestational surrogates fully understand the risks that they are undertaking. This assumption may not be merited as “245 million Indian women lack the basic capability to read and write”—only 46.4 million women above the age of 15 are literate. *The Status of Women: A Reality Check*, SWAYAM, http://www.swayam.info/swayam_gi_leaflet_31mar.pdf (last visited Jan. 17, 2014). Thus, the majority of Indian women are not able to read the surrogacy contract; rather they have to rely on

2. Fueling Traditional Class and Racial Hierarchies

The majority of women who become gestational surrogates in India are poor, uneducated, and often have families of their own to support.³⁸ Rachel Blatt, author of *Wombs for Rent? Gestational Surrogacy and the New Intimacies of the Global Market*, argues that “[c]ompared to the relationships between actors in the U.S. surrogacy industry, the relationships involved in India’s growing commercial surrogacy market demonstrate far greater discrepancies in terms of class, wealth, [and] education...”³⁹ Blatt’s argument is strengthened by comparing the GDP per capita of both countries. India’s GDP per capita is \$3,800,⁴⁰ whereas America’s GDP per capita is \$51,700.⁴¹ Therefore, while there are wealth disparities between commissioning couples and gestational surrogates here in the United States, the disparities are not as drastic as they are between American commissioning couples and Indian gestational surrogates.

Furthermore, the status of the majority of women in India as compared to the status of the majority of women in America is appalling.⁴² Unlike

someone else, usually a staff member at an ART center, to read the contract to them. *Id.* Such an arrangement is prone to corruption, as the staff member may not read all of the terms, mischaracterize the terms, or not fully explain the terms. *Id.*

38. Blatt, *supra* note 5, at 28.

39. Blatt, *supra* note 5, at 28. Though the issue of compensated surrogacy is largely unsettled in the U.S., some states currently allow compensated gestational surrogacy. See Tuininga, *supra* note 22, at 189–90; *The Select Surrogate*, *supra* note 22. This paper argues that ethical concerns arise when U.S. women who are poor and uneducated become paid gestational surrogates for the middle and upper class. Though the majority of paid gestational surrogates in the U.S. enjoy a higher economic status than the majority of paid gestational surrogates in India, such an arrangement is still prone to exploit women in the U.S. who desperately need money to support themselves and/or their family. See *Surrogacy in America*, COUNSEL FOR RESPONSIBLE GENETICS, <http://www.thelizlibrary.org/surrogacy/Surrogacy-in-America.pdf> (last visited Mar. 9, 2014) (stating “surrogates are typically paid far below any state’s minimum wage . . . [with] as low as 50 cents to \$3.00 per hour . . . Given anecdotal evidence that women serving as surrogates come from families of the lowest income brackets, these paltry [salary] figures further suggest that surrogacy agreements exploit vulnerable women.”) And if women in the U.S. were not choosing to become gestational surrogates largely due to economic need, but rather out of ‘compassion for the infertile,’ “we would [see] middle-and upper-class women bearing the babies of lower-class couples, where aiding those who cannot afford to pay would be an ever greater expression of altruism.” Smerdon, *supra* note 12, at 56. However, it is very doubtful that middle and upper class women bare babies for lower class infertile women in the U.S., as India’s gestational surrogacy market has yet to see this occur—India’s gestational surrogacy market is comprised of women from the “lower-income classes.” *Surrogate Motherhood in India: Understanding and Evaluating the Effects of Gestational Surrogacy on Women’s Health and Rights*, STANFORD UNIVERSITY, (2008) <http://www.stanford.edu/group/womenscourage/Surrogacy/economics.html> [hereinafter Stanford II]. Thus, similar to what is occurring in India, paid gestational surrogacy in the U.S. likely exploits poor, uneducated women. See generally Arora, *supra* note 30.

40. *World Fact Book: India*, CIA (2012), <https://www.cia.gov/library/publications/the-world-factbook/geos/in.html> (last visited Feb. 21, 2014).

41. *Id.*

42. See generally *2010 Human Rights Reports: India*, U.S. DEP’T OF STATE (Apr. 8, 2011), <http://www.state.gov/j/drl/rls/hrrpt/2010/sca/154480.htm>. The status of women in India is improving and not all Indian women suffer such societal hardships. For example, the 2010

women in the U.S., “[t]he average Indian woman ... has little control over her own fertility and reproductive health; for many Indian women, abortion is the only method of contraception available.” While there are gender disparities in the U.S. workforce, the gender disparities in India’s workforce are far greater; participation of women in India’s workforce is only “13.9% in the urban sector and 29.9% in the rural sector.”⁴³ Additionally, female infanticide is a regular practice in India, where⁴⁴ “[e]ducation and healthcare continue to be prioritized to sons rather than daughters, as [daughters] are seen as heavy burdens associated with traditional obligations of dowry paid to the groom’s family [and] domestic violence is commonplace ...”⁴⁵ Thus, Indian women who are both economically and socially disadvantaged are frequently and successfully targeted to become gestational surrogates for wealthier, infertile⁴⁶ American couples.⁴⁷

India’s gestational surrogacy market also caters to traditional racial hierarchies. In her article, *International Commercial Surrogacy and its Parties*, Margaret Ryznar asserts that many observers of India’s gestational surrogacy market view the expanding market as “exploitation of poor, nonwhite women by their richer [white] more indulgent sisters.”⁴⁸ In

Human Rights Report on India found that “[i]n India women held many high-level political offices, including the presidency, leader of the ruling Congress Party, 78 members (including the speaker) of the Lok Sabha, railways minister, chief minister position in Uttar Pradesh, and one seat on the Supreme Court bench.” *Id.* Furthermore, the report found that “women participated in politics throughout the country at all levels, including more than one million women in local village councils.” *Id.*

43. SWAYAM, *supra* note 37; *The Status of Women in India*, U.N. OFFICE ON DRUGS AND CRIME (May 6, 2003), available at http://www.unodc.org/pdf/india/publications/women_Book-6-503/09_statusofwomeninindia.pdf.

44. Stanford II, *supra* note 39. A recent BBC documentary exposed a grandfather who buried alive his newborn granddaughter. *Id.*

45. Stanford II, *supra* note 39. The 2010 Human Rights Report on India also found that “[c]rimes against women were common.” *2010 Human Rights Report: India*, *supra* note 42. During 2009, there were 194,787 reported crimes against women—including molestation, sexual harassment, rape, dowry deaths, and abduction. *Id.* The report also noted that underreporting is likely so the number of crimes against women is likely much higher. *Id.* “The United Nations Children’s Fund, estimated that up to 50 million girls and women are ‘missing’ from India’s population because of termination of the female foetus or high mortality of the girl child due to lack of proper care.” Swayam, *supra* note 37.

46. Not all couples seeking gestational surrogacy are infertile; in fact, some Indian clinics “offer IVF services to foreign women who do not want to get pregnant due to career decisions or other social inconveniences.” Arora, *supra* note 30.

47. It is important to note that “[c]ommissioning parents may be lured into surrogacy through unethical practices. One Indian ART practitioner remarked that the indications for gestational surrogacy are rare and most infertile patients can be helped with simpler procedures.” Smerdon, *supra* note 12, at 57–58. However, women without a uterus or who have an underdeveloped uterus would warrant the use of a surrogate. *Wombs for Rent: Is Paying the Poor to Have Children Wrong When Both Sides Reap Such Benefits*, THE FEMINIST E-ZINE, <http://www.feministzine.com/feminist/international/Wombs-for-Rent.html> (last visited Feb. 9, 2014).

48. Margaret Ryznar, *International Commercial Surrogacy and its Parties*, 43 J. MARSHALL L. REV. 1009, 1029 (2010). Rimm, author of *Booming Baby Business: Regulating Commercial Surrogacy in India*, argues that “[i]nternational surrogacy is especially

addition to the racial hierarchy caused by Indian women carrying and birthing babies for white American couples, there is a racial hierarchy within India's gestational surrogacy market. This racial hierarchy is readily apparent when examining the difference in fees paid to gestational surrogates. For example, at one surrogacy clinic, the Akanksha Infertility Clinic, some surrogates were paid \$6,500 while others were paid \$3,900.⁴⁹ This disparity is partly due to "what couples can afford" and partly due to what couples want, which is having their age-old prejudices satisfied.⁵⁰ The surrogates that command the highest fee are: fair-skinned, educated, Brahman,⁵¹ and English speakers.⁵² Dr. Patel, the medical director at Akanksha Infertility Clinic allows these prejudices to thrive, as "it's what the market demands."⁵³

3. Surrogate Women are Commodified

Several academics argue that India's gestational surrogacy market commodifies women because it creates strictly commercial arrangements.⁵⁴ In commercial surrogacy arrangements, "payment is made to the gestational women for her services, and may also be made to a third party broker or agent who brought the commissioners and gestational women together."⁵⁵ In noncommercial surrogacy arrangements, "the commissioning couple may pay expenses incurred by the surrogate as a result of her pregnancy, but does

problematic when performed at 'bargain prices' for wealthy foreigners because it promotes the racist and imperialist view that it is acceptable to exploit and dehumanize women of different origins, as well as the perception that the resources and services of less developed nations exist for the benefit of more developed nations . . . it may [also] 'create and perpetuate the notion that one role of poor and minority women is to serve as child bearers for more wealthy white commissioners.'" Rimm, *supra* note 25, at 1446.

49. THE FEMINIST EZONE, *supra* note 47. As of June 20, 2012, the Akanksha Infertility Clinic 'has produced 500 surrogate babies.' Home, AKANKSHA INFERTILITY CLINIC, <http://ivf-surrogate.com> (last visited Feb. 20, 2014).

50. THE FEMINIST EZONE, *supra* note 47.

51. A person who is a Brahman is "a member of the highest Hindu caste, that of the priesthood." Oxford Dictionaries, available at http://www.oxforddictionaries.com/us/definition/american_english/Brahman (last visited Feb. 20, 2014).

52. THE FEMINIST EZONE, *supra* note 47. Surrogates with these traits command the highest fee despite the fact that they will not be genetically related to the baby.

53. THE FEMINIST EZONE, *supra* note 47.

54. See Arora, *supra* note 30; Stanford II, *supra* note 39; Rimm, *supra* note 25, at 1435–36. It is important to note that not all commercial arrangements commodify women. However, there is "a fundamental difference between the 'goods' of my person and my external goods." Debra Satz, *Markets in Women's Sexual Labor*, 106 ETHICS 63, 69 (1995). Debra Satz, author of *Markets in Women's Sexual Labor*, analyzes women's sexual labor and asserts that "[h]uman capital' is not just another form of capital The circumstances in which I sell my capacities have a much more profound effect on who I am and who I become—through effects on my desires, capacities, and values—than the circumstances in which I sell my Honda Civic." *Id.* Satz's argument is applicable to a gestational surrogate who contracts out the use of her womb. Such an act has a much more profound effect on the woman than if the woman were to sell a tangible object apart from herself, such as a Honda Civic.

55. Rimm, *supra* note 25, at 1436.

not provide any additional consideration for the gestational woman's services as a surrogate."⁵⁶ Non-commercial surrogacy is more commonly accepted worldwide.⁵⁷ In fact, "[i]n many states, and in a number of countries around the world, surrogacy is legally recognized only if it is noncommercial or 'altruistic.'"⁵⁸

Ishika Arora, author of *Wombs for Rent: Outsourcing Surrogacy to India*, argues that it is the "sale" between the two parties in commercial surrogacy arrangements that "commoditizes motherhood and assigns the value of an Indian woman's womb to be roughly \$7,000."⁵⁹ The commodification of Indian surrogates into "breeder machines"⁶⁰ is evident when examining how some commissioning couples view the Indian surrogate woman. For example, one commissioning couple remarked, "[t]he eggs and sperms are ours. It's basically our child. . . [w]e are just renting somebody's womb and we are paying her for that."⁶¹ This statement depicts a far too frequent reality where Indian surrogate women have been dehumanized into empty vessels in which other couple's children are born.⁶²

Commodifying pregnancy is harmful because it "replac[es] the parental norms which usually govern the practice of gestating children with the economic norms which govern the ordinary production process. The application of commercial norms to women's labor reduces the surrogate mothers from persons worthy of respect and consideration to objects of mere use."⁶³ As stated by Debra Satz, "some goods seem to have a special status which requires that they be shielded from the market if their social meaning or role is to be preserved."⁶⁴ For example, "the sale of citizenship rights or friendship does not simply produce costs and benefits; it transforms the

56. Rimm, *supra* note 25, at 1435.

57. Arora, *supra* note 30.

58. Rimm, *supra* note 25, at 1435. Altruistic surrogacy is favored over commercial surrogacy, as it is seen as a way "to avoid the dangers of commodification [of women] and, at the same time, recognize that there are some situations in which a surrogate can be understood to be proceeding out of love or altruism and not out of economic necessity or desire for monetary gain." Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1932-33 (1987). Though altruistic surrogacy may avoid the commodification of women, it would also put Indian surrogates in an economically worse position, as they typically do not have other employment opportunities, let alone employment opportunities that would pay as much as being a gestational surrogate. See Mina Chang, *Wombs for Rent*, HARV. INT'L REV. (2009), <http://hir.harvard.edu/frontiers-of-conflict/womb-for-rent?page=0,0>.

59. Arora, *supra* note 30.

60. See Stanford II, *supra* note 39.

61. The Feminist eZine, *supra* note 47.

62. Stanford II, *supra* note 39.

63. Elizabeth S. Anderson, *Is Women's Labor a Commodity?*, 19 PHIL. & PUB. AFF. 71, 80 (1990) [hereinafter "Anderson I"]. "To respect a person is to treat her in accordance with principles she rationally accepts—principles consistent with the protection of her autonomy and her rational interests. To treat a person with consideration is to respond with sensitivity to her and her emotional relations with others, refraining from manipulating or denigrating these for one's own purpose." *Id.* at 81.

64. Satz, *supra* note 54, at 69.

nature of the goods sold.”⁶⁵ Thus, like citizenship or friendship, the very sale of pregnancy destroys the social meaning of pregnancy.⁶⁶

India's gestational surrogacy market unquestionably violates the principle of non-maleficence as it creates significant harms. However, this principle offers little guidance by itself, as even the most beneficial medical procedures can cause serious harms.⁶⁷ Therefore, the harms India's gestational surrogacy market creates must be considered with the benefits. The important ethical issue is whether the benefits outweigh the harms.⁶⁸

B. BENEFICENCE

The principle of beneficence dictates that a medical procedure must benefit those undergoing the procedure.⁶⁹ “Beneficent actions can be taken to help prevent or remove harms or to simply improve the situation of others.”⁷⁰ India's gestational surrogacy market benefits infertile couples and it economically benefits the women who provide gestational surrogacy services.

1. India's Gestational Surrogacy Market Benefits Infertile Couples

As stated previously, the medical need for a gestational surrogate in order to produce genetically related offspring is rare, and a majority of infertile couples can turn to other ART procedures to produce genetically related offspring.⁷¹ However, for women who suffer from: an absent, diseased or damaged uterus; a maternal disease that precludes pregnancy; recurrent pregnancy losses; or recurrent IVF implantation failures or ovarian failure, gestational surrogacy may be the only way in which these women can create genetically related children with their partner.⁷² Thus, for these women, gestational surrogacy offers a life changing opportunity—blood relation to their child—that no other ART procedure can provide for them.⁷³

65. Satz, *supra* note 54, at 69.

66. See Satz, *supra* note 54, at 69. “Pregnancy is not simply a biological process but also a social practice. Many social expectations and considerations surround women's gestational labor, marking it off as an occasion for the parents to prepare themselves to welcome a new life into their family.” Anderson I, *supra* note 63, at 81.

67. Steven Pantilat, *Beneficence vs. Non-maleficence*, UCSF SCHOOL OF MED. (2008), http://missing_link.ucsf.edu/lm/ethics/Content%20Pages/fast_fact_bene_nonmal.htm (last visited Feb. 9, 2014).

68. *Id.*

69. McCormick, *supra* note 29.

70. Pantilat, *supra* note 67.

71. Smerdon, *supra* note 12, at 57–58.

72. Palattiyil et al., *supra* note 34, at 689.

73. Palattiyil et al., *supra* note 34, at 689; Blatt, *supra* note 5, at 17. Though gestational surrogacy allows for genetic relation to the commissioning couple, some commissioning couples use donor eggs and sperm so there is no blood relation to the baby born through gestational surrogacy. See Rimm, *supra* note 25, at 1437. For example, in a U.S. gestational surrogacy case, “the donor sperm of a Japanese man was inseminated into seventeen eggs donated by a 21-year-old American student. Six of the eggs were then implanted into the womb of a 30-year-old American woman.” *Id.*

2. India's Gestational Surrogacy Market Benefits Surrogate Women

Most Indian surrogates are paid “US \$3,000-6,000” for each gestational surrogacy.⁷⁴ This is a significant amount of money for the super majority of Indian citizens, as “75% of the population lives on less than US \$2 a day. . . .”⁷⁵ In fact, for some Indian women from the lower socio-economic levels, \$6,000 is equivalent to 15 years of wages.⁷⁶ “In 2009, an Indian gestational surrogate for an American couple very openly told a Singaporean reporter ‘this is the fastest route to money.’”⁷⁷ Furthermore, given the status of women in India, most women who become surrogates have no other meaningful employment opportunities where they can earn a comparable wage.⁷⁸ Thus, gestational surrogacy provides poor Indian women with the opportunity “to escape the lower middle-class ghetto in what remains one of the most rigid class-bound democracies in the world.”⁷⁹

Though gestational surrogates have the opportunity to earn significant wages, many only get paid if they become pregnant and carry the baby to term.⁸⁰ This ‘pay on production’ system disregards the fact that many of the surrogates have left their jobs and spent significant amounts of time and energy going through various medical procedures necessary for gestational surrogacy. For example, at the implantation stage, if the embryos failed to implant, the gestational surrogate still had the embryo implementation

74. Palattiyil et al., *supra* note 34, at 690.

75. Blatt, *supra* note 5, at 22.

76. Chang, *supra* note 58.

77. Blatt, *supra* note 5, at 23. Smita Pandya became a gestational surrogate and was paid \$3,900 for her service. See THE FEMINIST EZINE, *supra* note 47. It would have taken Pandya years to earn this much money from her job as a clerk at an incense store. *Id.* Pandya “used the money to purchase a two-bedroom flat.” *Id.* She plans to go through another gestational surrogacy; “[t]he money from the next pregnancy will allow her to send her kids to a better school—where they can learn English and work with computers.” *Id.*

78. For example, Deepali, who was under severe economic pressure after she divorced her abusive husband, became a gestational surrogate so that she could afford her own home and provide for her two children. *Id.*

79. THE FEMINIST EZINE, *supra* note 47. Nandani Patel is another example of a woman who was able to improve her standard of living through gestational surrogacy. Stanford II, *supra* note 39. Patel, reflecting on her decision to become a surrogate, stated “I have done this for my kids and because I have one dream—a house. We are living in a rented place. From the money I earn as a surrogate mother I can buy a house. It’s not possible for my husband to earn more as he’s not educated and only earns \$50 a month, so nothing is saved.” *Id.* Navina Patel, her two sisters and sister-in-law also became gestational surrogates in order to “enhance their living standards.” THE FEMINIST eZINE, *supra* note 47. Hearing the social and economic hardships that many Indian surrogate women have endured, “it’s hard not to be thankful that these women have the financial option of surrogacy—and simultaneously outraged by an economic model that exploits such raw need.” *Id.*

80. THE FEMINIST EZINE, *supra* note 47. Some gestational surrogacy contracts pay through installments. *Id.* Thus, if a gestational surrogate miscarries after the first trimester she will be compensated for her time and services spent during the first trimester. *Id.* Though these installment contracts are better than the ‘pay on production’ contracts, they also may result in unjust outcomes. For example, one gestational surrogate contracted chikungunya, a viral fever, after she became pregnant. “She miscarried within the first trimester, which meant she wasn’t even paid the first installment of \$660.” *Id.*

procedure performed, she likely endured several medical tests, and she likely took hormones throughout the process.⁸¹ Thus, even at this beginning stage, the gestational surrogate has invested significant time, effort, and energy, which should merit compensation. And the longer the period that the gestational surrogate remains pregnant before a miscarriage, the more time, effort, and energy she will have spent on the pregnancy. Sadly, however, many gestational surrogates do not get paid at all unless they give birth to a live baby.⁸²

Thus, India's gestational surrogacy market provides infertile couples with the opportunity to create biological offspring, and it provides Indian surrogate women, who are fortunate enough to carry a baby full term, with an economic opportunity that they would not otherwise have. However, the benefits India's gestational surrogacy market creates can also be created through other less harmful means. For example, if the Indian government emphasized the importance of education and training for both men and women and implemented programs to help Indian women go to and stay in school, Indian women would have better job opportunities, and could therefore command higher wages outside of commercial gestational surrogacy.⁸³ Furthermore, this system would accomplish these benefits without putting the physical and mental health of women at risk or commodifying them like the commercial surrogacy market does. Thus, the economic benefit that Indian surrogate women receive as a result of India's gestational surrogacy market could be replicated in a less harmful system of education and training.

Furthermore, even without access to India's surrogacy market, infertile American couples can still create biological offspring, as they can arrange a non-commercial gestational surrogacy agreement with a friend or family member.⁸⁴ Thus, the harms of India's gestational surrogacy market drastically outweigh the benefits, since both of the benefits are achievable through less detrimental means.

81. *Embryo Transfer & Embryo Implantation*, MALPANI INFERTILITY CLINIC, <http://www.drimalpani.com/book/chapter25c.html#How%20can%20you%20maximise%20your%20chances%20of%20success%20after%20IVF> (last visited Feb. 9, 2014).

82. THE FEMINIST E-ZINE, *supra* note 47; Smerdon, *supra* note 12, at 33.

83. See Carol Coonrod, *Chronic Hunger and the Status of Women in India*, THE HUNGER PROJECT (June 1998), <http://www.thp.org/reports/india wom.htm>. Currently, "[t]here is still a big difference between male literacy and female literacy. More boys are enrolled in primary schools than girls. And more girls drop out of school before any kind of graduation or certificate than boys. [T]he reason for this result is [due to] the role of women in society and the idea, especially in poor areas, that women do not need education as they take care of the house and their husband goes to work and earns money. Even if girls get a basic education, they are often called back to stay at home . . . because they have to learn how to keep house in order to prepare for their future marriage." *Education for Girls and Women*, JAISIYARAM (Feb. 15, 2011), <http://www.jaisiyaram.com/blog/school/7412-literacy-rate-in-india-education-for-girls-and-women-15-feb-11.html>.

84. The commissioning couples must make sure that such an arrangement occurs in a state where noncommercial gestational surrogacy is legal.

C. AUTONOMY

In addition to failing the balancing of non-maleficence and beneficence, India's gestational surrogacy market also fails to satisfy the principle of autonomy. Autonomy requires that a "patient has the capacity to act intentionally, with understanding, and without controlling influences that would mitigate against a free and voluntary act."⁸⁵ Outside of the medical context, the principle of autonomy holds that "individual persons have the right to make their own choices and develop their own life plan."⁸⁶ This principle is particularly important, because "[t]o violate a person's autonomy is to treat that person merely as a means; that is, in accordance with the others' goals without regard to that person's own goals."⁸⁷ Lastly, autonomy is the "basis for the practice of 'informed consent'⁸⁸ in the physician/patient transaction regarding health care."⁸⁹ India's surrogacy market violates autonomy, as most women who become gestational surrogates do not freely choose to become surrogates, and once a woman becomes a surrogate, the surrogacy clinic controls that woman's life.⁹⁰

1. Most Indian Women Who Become Gestational Surrogates Did Not Exercise Free Choice

The Ethics Committee of the American Society for Reproductive Medicine asserts that "underlying financial arrangements affect the issue of informed consent."⁹¹ Therefore, the Ethics Committee holds that, in regards to egg donation⁹² in the United States: "[t]otal payments to donors in excess of \$5,000 require justification and sums above \$10,000, are not appropriate, payments above this level are likely to compromise the woman's ability to give her informed consent by encouraging her to minimize the risks involved in donation."⁹³ This same argument is applicable to India's gestational surrogacy market, as impoverished Indian women with very limited employment opportunities are offered thousands of dollars to gestate a fetus and, due to their often dire socioeconomic conditions, they "are unable to

85. McCormick, *supra* note 29.

86. Thomas Garrett et al., *Health Care Ethics*, 1–12 (1993), available at <http://www.utcom.chatt.org/docs/biomedethics.pdf>.

87. BEAUCHAMP & CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 103 (6th ed. 2009).

88. "Informed consent is the process by which a fully informed patient can participate in choices about her/his health care." McCormick, *supra* note 29.

89. McCormick, *supra* note 29.

90. See Stehr, *supra* note 10, at 275; Smerdon, *supra* note 12, at 54; Blatt, *supra* note 5, at 34.

91. Palattiyil et al., *supra* note 34, at 694.

92. The example of egg donation is used because surrogacy is not legal in every state, whereas egg donation is. Jennifer Fairfax, *Adoption and ART Law: Egg or Sperm Donor* (2013), <http://www.jenniferfairfax.com/egg-or-sperm-donor>.

93. Palattiyil et al., *supra* note 34, at 694.

refuse the offer of such high compensation . . . rendering their decision to participate less than truly voluntary.”⁹⁴

When an Indian woman ‘chooses’ to become a gestational surrogate due to severe economic hardship, she is acting under economic compulsion, which is when one “make[s] an unpalatable economic choice [that] any reasonable person would not make under normal conditions.”⁹⁵ Nirmala, a woman from Chandigarh, India, acted under economic compulsion when she decided to become a gestational surrogate, as she became a gestational surrogate in order to “procure much needed medical treatment for her paralyzed husband.”⁹⁶

In addition to the personal economic compulsion that an Indian woman may experience in regards to gestational surrogacy, a woman’s husband or relative(s) may force her to become a gestational surrogate in order to fulfill their material and financial needs.⁹⁷ Lastly, gestational surrogacy clinics also pressure women into becoming gestational surrogates in order to satisfy the growing demand for surrogates.⁹⁸ In fact, “Dr. Patel finds that convincing a woman to become a surrogate is the most difficult part, [stating that] ‘when they first come to me they are really a desperate lot because this is the last thing they would want to try. It’s not easy to carry a baby for 9 months for someone else.’”⁹⁹ Dr. Patel’s comment concisely conveys that, far too frequently, the woman did not freely choose to become a gestational surrogate. Rather, a medical professional convinced her to become a surrogate.¹⁰⁰ For example, one gestational surrogate recalls that “[Dr. Patel] told me I should become a surrogate . . . and if I do, all my worries will go away.”¹⁰¹

Significantly, many of the women who are convinced to become surrogates “have not heard of IVF, and though the complications are listed

94. Rimm, *supra* note 25, at 1445.

95. Albino Barrera, *Economic Compulsion and Christian Ethics* (2005), available at http://assets.cambridge.org/97805218/53415/frontmatter/9780521853415_frontmatter.pdf.

Other examples of economic compulsion, include: “migrants [who] leave their families and cross borders (legally or illegally) in search of a livelihood, and countless Third World families [who] rely on child labor to supplement meager household incomes.” *Id.*

96. Stehr, *supra* note 10, at 275. Another woman who became a surrogate out of economic compulsion stated, “[m]y husband lost his limbs working in the factory. We could not manage even a meal a day. This is when I decided to rent out my womb.” Krittiva Mukherjee, *Rent-a-womb in India Fuels Surrogate Mother Debate*, REUTERS (Feb. 5, 2007, 5:44 AM), <http://www.reuters.com/article/2007/02/05/us-india-surrogacy-idUSDEL29873520070205>.

97. Stanford II, *supra* note 39.

98. Smerdon, *supra* note 12, at 48. Jennifer Rimm, argues that “[h]igh fees create a dangerous incentive for commercial middlemen to satisfy the demands of infertile couples for ‘willing’ surrogates—incentives not counterbalanced by equal incentives to protect the interests of those surrogates. [Additionally] [i]ntermediaries might be tempted to force or deceive women into contracts if there is profit to be had in setting surrogates up with commissioning couples.” Rimm, *supra* note 25, at 1457.

99. Smerdon, *supra* note 12, at 49.

100. Smerdon, *supra* note 12, at 49.

101. THE FEMINIST E-ZINE, *supra* note 47.

in the contract, [they] may not fully understand the health ramifications of surrogacy.”¹⁰² Furthermore, the women may not be able to read the contract and, “[i]n a country with a high level of corruption, any staff member of the ART center could be easily bribed to relay incorrect information about the document that would encourage the woman to rent her womb.”¹⁰³ Under these conditions, a gestational surrogate is not able to adequately weigh the pros and cons of her decision; rather, she is forced to rely on the guidance of someone else, often an ART staff member, who has an incentive to manipulate her.¹⁰⁴

2. Surrogate Women Are Controlled by the Surrogacy Clinics

Not only are women pressured into becoming gestational surrogates, but also, once a woman becomes a surrogate, her daily actions may be controlled by the surrogacy clinic and/or the surrogacy contract.¹⁰⁵ In fact, in surrogacy agreements commissioned through Planet Hospital, “surrogates spend the entire duration of the pregnancy at the clinic or a guest house controlled by the clinic where their habits, medications, and diets are carefully regimented and monitored.”¹⁰⁶ At the Akanksha Infertility Clinic, Dr. Patel controls the finances of the surrogate women.¹⁰⁷ She personally sets up bank accounts for the surrogates and only releases funds into fixed-term deposits or other such plans, claiming that she does not want them to “waste the money on ordinary things.”¹⁰⁸ She also maintains detailed records of what each surrogate was paid and how she spent her money.¹⁰⁹

102. Arora, *supra* note 30.

103. Arora, *supra* note 30.

104. See Anderson I, *supra* note 63, at 85 (noting that the surrogate agency follows market norms). The surrogate agency tries to get the best deals for its clients and itself, leaving the surrogate to look after her own interests. *Id.* “This situation puts the surrogate agencies in a position to manipulate the surrogate mother’s emotions to gain favorable terms for themselves ... [and] when applicants question some of the terms of the contract, the broker sometimes intimidates them by questioning their character and morality: if they were really generous and loving they would not be so solicitous about their own interests.” *Id.*

105. Rimm, *supra* note 25, at 1448–49.

106. Douglas Pet, *Make Me a Baby as Fast as You Can*, SLATE (Jan. 9, 2012, 7:15 AM), http://www.slate.com/articles/double_x/doublex/2012/01/reproductive_tourism_how_surrogacy_provider_planethospital_speeds_up_pregnancies_and_lowers_costs.html (quoting a Planet Hospital packet). “Planet Hospital has more publicity and exposure than any other medical tourism company from media giants like, Time Magazine, Nightline, Good Housekeeping and more.” *About Us*, Planet Hospital, <http://www.planethospital.com/aboutus.jsp> (last visited Mar. 9, 2014).

107. THE FEMINIST EZINE, *supra* note 47.

108. THE FEMINIST EZINE, *supra* note 47.

109. THE FEMINIST EZINE, *supra* note 47. Dr. Patel’s control over the finances of gestational surrogates in her clinic adheres to the traditional systems of control over Indian women, as she is judging what is right and proper for the women to spend their money on, believing that they cannot judge that for themselves. Swayam, *supra* note 37; THE FEMINIST EZINE, *supra* note 47.

Lastly, a surrogate “cannot easily ‘quit’ her position if she no longer wishes to observe the terms of the contract.”¹¹⁰ Gestational surrogates commissioned through Planet Hospital are not allowed to terminate their pregnancy.¹¹¹ Geoff Moss, the vice president of corporate affairs and business development at Planet Hospital, stated that, “[i]f they feel like terminating the pregnancy, they can’t do that; there is a legal contract.”¹¹² Such a restriction clearly violates the surrogate woman’s autonomy; however, even if a surrogate’s contract allows her to terminate her pregnancy, the conditions of the termination may “effectively require[] the surrogate mother to relinquish her physical autonomy.”¹¹³ For example, some gestational surrogacy contracts provide that, if the surrogate terminates the pregnancy for nonmedical reasons, “she must refund all expenses incurred by the commissioning parents”¹¹⁴ and will “forfeit[] her right to compensation for those [services] which she has already provided.”¹¹⁵ Since most women who become gestational surrogates are very poor, there is no feasible way they can repay the expenses associated with gestational surrogacy.¹¹⁶ Therefore, even surrogates who are fortunate enough to have an elective termination provision in their contract will be effectively barred from seeking termination if the termination is conditioned upon repayment.¹¹⁷

India’s gestational surrogacy market violates the principle of autonomy because it creates controlling influences—extreme financial pressure, family pressure, and pressure from medical professionals—that mitigate against a

110. Rimm, *supra* note 25, at 1455. Gestational surrogacy contracts dictate “which parties, if any, have discretion to elect abortion of a fetus.” *Id.*

111. Pet, *supra* note 107.

112. Pet, *supra* note 107.

113. Rimm, *supra* note 25, at 1455.

114. Smerdon, *supra* note 12, at 40.

115. Rimm, *supra* note 25, at 1445.

116. Rimm, *supra* note 25, at 1445.

117. Rimm, *supra* note 25, at 1445. Though some may argue that surrogates should be able to contract away their right to terminate the fetus, as “fully informed autonomous adults should have the right to make whatever arrangements they wish for the use of their bodies and reproduction of children. . . .” Anderson I, *supra* note 63, at 74. This argument overlooks the fact that the right to freedom contract is not absolute and it is already constrained in society. See Elizabeth Anderson, *Why Commercial Surrogate Motherhood Unethically Commodifies Women and Children: Reply to McLachlan and Swales*, 8 HEALTH CARE ANALYSIS 19, 23 (2000) [hereinafter “Anderson II”]. For example, the law does not allow people to physically and/or emotionally abuse someone even if the abused consented to the abuse via a contract. *Id.* Under the eyes of the law, it does not matter if the person consented, the abuser will be punished for inflicting abuse upon another person. *Id.* In a more extreme case, a person cannot enter into a contract to be murdered, because under the eyes of the law, “some rights in one’s person are so essential to dignity and autonomy that they must be held inalienable. This is not a paternalistic claim. The claim is not that individuals must be protected from their own bad judgment. The claim is rather that there are some ways of treating people that are morally objectionable, even if they consent to being treated those ways.” *Id.* The right to terminate a fetus is also an essential right that must be protected from contract infringement. *Id.*

woman's free and voluntary act to become a gestational surrogate. India's gestational surrogacy market also prohibits surrogate women from being able to act intentionally because the surrogacy clinics frequently control the surrogate's diet, habits, finances, and the surrogacy contract often prohibits or effectively prevents the surrogate from being able to discontinue the pregnancy.

D. JUSTICE

The principle of justice is "defined as a form of fairness, or as Aristotle once said, 'giving to each that which is his due.'"¹¹⁸ India's gestational surrogacy market violates the principle of justice, because Indian surrogates are treated as inferior to Western surrogates and the rights of surrogate women are inadequately protected.

1. Indian Surrogates are Treated as Inferior to Western Surrogates

When the law permits, American surrogates are typically paid \$20,000 to gestate a fetus.¹¹⁹ While in India, most surrogates are paid between \$3,000 to \$6,000,¹²⁰ with the fee often influenced by the woman's social status.¹²¹ This payment scale seems to convey that Indian women are inferior to American women, as American women receive anywhere from two to six times the pay to provide the exact same service.¹²²

Furthermore, when the majority of gestational surrogates "gave birth to their own children, they and their babies received little to no prenatal and neonatal care."¹²³ In fact, in rural India, where a majority of gestational surrogates are from, "[t]here are barely four doctors for every 10,000 inhabitants [and] less than half of India's primary health centers have a labor room. . . ."¹²⁴ However, when gestational surrogates carry Western babies, they receive high quality health care—including prenatal and neonatal care. Thus, the state of health care for gestational surrogates "stands in marked contrast to the reality of health care for the majority of India's indigenous

118. McCormick, *supra* note 29.

119. Arora, *supra* note 30.

120. Palattiyil et al., *supra* note 34, at 690.

121. Palattiyil et al., *supra* note 34, at 690. It is important to note that payment for being a gestational surrogate is separate from paying medical expenses of the surrogate. Medical expenses are not included in the services payment. Thus, one cannot use the argument that medical expenses are higher in the U.S. to justify the difference in the payment between American and Indian surrogates.

122. Though many Indian workers are paid less than American workers for other jobs, paying Indian gestational surrogates less than American surrogates is particularly abhorrent, as pregnancy is more crucially tied to the nature of women's selves than other jobs. *See* Satz, *supra* note 54, at 70. Thus, the pay disparity conveys to Indian women in a very real way "that in numbers they are worth less in comparison to their foreign counterparts." Arora, *supra* note 30. In other words, Indian surrogates are told that their self worth is less valuable than the self worth of American surrogates.

123. Arora, *supra* note 30.

124. Palattiyil et al., *supra* note 34, at 687–88. These statistics are based upon the 2005 Reproductive and Child Health Facility Survey. *See id.*

population, especially those living in rural areas.”¹²⁵ By utilizing scarce medical resources on wealthy foreign couples, while failing to provide Indian women with basic medical care during their own pregnancies, India's gestational surrogacy market sends the message that Indian women and their children are “inferior to the foreign babies they carr[y] in their womb.”¹²⁶

2. The Rights of Surrogate Women are Inadequately Protected

Although India has no binding laws regulating the gestational surrogacy market,¹²⁷ “[c]linics are encouraged to follow the nonbinding guidelines the Indian Council of Medical Research issued in 2002.”¹²⁸ The guidelines provide, *inter alia*:

[n]o woman may act as a surrogate more than three times in her life;¹²⁹ the surrogate mother should not be over forty-five (45) years of age;¹³⁰ advertising regarding surrogacy should not be made by the ART clinic. The responsibility of finding a surrogate mother, through advertisement or otherwise, should rest with the couple, or a semen bank; and payments to surrogate mothers should cover all genuine expenses associated with the pregnancy. Documentary evidence of the financial arrangement for surrogacy must be available. The ART center should not be involved in this monetary aspect.¹³¹

However, even these minimal guidelines are usually not adhered to because they are not legally enforceable in Indian courts; rather, fertility clinics generally create their own rules of regulation.¹³² This self-regulation allows the rights and interests of gestational surrogates to be violated for the sake of capital gain. Most surrogacy clinics allow the free market to determine everything about the surrogacy process—from the cost of the surrogacy to the conditions by which surrogates must abide.¹³³ Furthermore, because the commissioning couple, not the surrogate, pays the surrogacy clinics are paid by the commissioning couple,¹³⁴ surrogacy clinics often disregard the interest and rights of the surrogates. Without mandatory government regulation, surrogacy clinics have no incentive to adequately

125. Palattiyil et al., *supra* note 34, at 687.

126. Arora, *supra* note 30.

127. Davis, *supra* note 12, at 126.

128. Davis, *supra* note 12, at 126.

129. It is important to note that the guidelines do not “place any limits on the number of miscarriages a surrogate may have.” Blatt, *supra* note 5, at 42.

130. “Interestingly, in the U.S., pregnant women who are older than 35 are pathologized as more ‘at risk’ to give birth to children with genetic disease.” Blatt, *supra* note 5, at 42.

131. See Smerdon, *supra* note 12, at 38–39. These guidelines do not provide adequate solutions or remedies for the ethical dilemmas present in India's gestational surrogacy market, but they are a necessary step in the right direction of government regulation.

132. Davis, *supra* note 12, at 126; Ryznar, *supra* note 48, at 1017.

133. Ryznar, *supra* note 48, at 1018.

134. Rimm, *supra* note 25, at 1459.

protect the rights and interests of gestational surrogates—especially when the clinic can make more money by disregarding their rights.

Thus, India's gestational surrogacy market fails to uphold the principle of justice because the market embodies no form of fairness. Rather, the market seems to embody the epitome of unfairness, as Indian women and their babies are treated as inferior to Western women, and the latter's babies and surrogacy clinics are free to trample over the rights and interests of surrogate women if they so desire.

II. CONCLUSION

India's gestational surrogacy market utterly fails to uphold the four principles of medical ethics. In fact, it further oppresses a class of women who desperately need empowerment. And though India's surrogacy market provides Indian surrogates with a significant source of income that they could not otherwise obtain in such a short amount of time, this benefit is starkly outweighed by the harms associated with commercial surrogacy—the commodification and exploitation of India's poor uneducated women. However, India is not without options to reduce the harm its gestational surrogacy market causes.

To truly reduce the size and the harm its surrogacy market causes, India should focus on creating nationwide educational and occupational programs for women. These programs would provide women with the skills and knowledge to obtain better paying jobs, allowing women to rise out of poverty without resorting to gestational surrogacy as a means for temporary financial stability. Thus, if educational and occupational programs were widely available to Indian women, fewer Indian women would “choose” to become gestational surrogates, which would shrink the supply of gestational surrogacy services.

In addition to implementing national educational and occupational programs for women, the guidelines the Indian Council of Medical Research issued should become mandatory. Furthermore, additional provisions such as: the right to surrogate participation and control; minimum wages (including payment for miscarriages); the right for the surrogate to terminate the pregnancy; and the surrogate's right to adequate information regarding the gestational surrogacy process, should be added to the guidelines.¹³⁵ Adding these provisions to the guidelines and mandating adherence to the guidelines will help India protect and promote the rights of gestational surrogates.¹³⁶

135. See Satz, *supra* note 54, at 74, 84; Tuninga, *supra* note 22, at 192–93.

136. Alternatively, Usha Rengachary Smerdon, author of *Crossing Bodies, Crossing Borders: International Surrogacy between the United States and India*, argues that “abolition of international surrogacy is the only solution that will protect all parties given the ethical concerns involved.” Smerdon, *supra* note 12, at 15–16.

To shrink the demand for India's commercial gestational surrogacy services, the United States should implement an international surrogacy application process that is similar to the international adoption process. Like the international adoption process, the U.S. Citizenship and Immigration Services could oversee international gestational surrogacy applications and determine whether to approve a couple's application.¹³⁷ Implementing an application process similar to the challenging and cumbersome international adoption process would likely disincentivize many American couples from seeking gestational surrogacy internationally, as the lack of "legal complications" is one of the primary reasons couples seek gestational surrogacy abroad.¹³⁸

The combination of these proposed policies would greatly reduce the supply and demand of India's gestational surrogacy market, and better serve and protect the rights of India's surrogate women. However, until these policies or other similar policies are enacted, an ever-increasing number of Indian women—with no other opportunities to improve their standard of living—will be exploited.

137. *Adoption*, U.S. CITIZEN AND IMMIGRATION SERVICES, <http://www.uscis.gov/adoption>.

138. See Maarten Pereboom, *The European Union and International Adoption*, available at <http://www.adoptionpolicy.org/pdf/4-28-05-MPereboomTheEUandInternationalAdoption.pdf> (last visited Feb. 10, 2014) ("the process of adopting internationally is challenging for individual families and for governments responsible for protecting and promoting the welfare and interests of all their citizens, including children. The laws are complex and the legal procedures are long and cumbersome"). See also Stehr, *supra* note 10, at 266; Ryznar, *supra* note 48, at 1019.