ALTRUISTIC AGENCIES AND COMPASSIONATE CONSUMERS:

Moral Framing of Transnational Surrogacy

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What makes a multimillion-dollar, transnational intimate industry possible when most people see it as exploitative? Using the newly emergent case of commercial surrogacy in India, this article extends the literature on stratified reproduction and intimate industries by examining how surrogacy persists and thrives despite its common portrayal as the "rent-a-womb industry" and "baby factory." Using interview data with eight infertility specialists, 20 intended parents, and 70 Indian surrogate mothers, as well as blogs and media stories, we demonstrate how market actors justify their pursuits through narrating moral frames of compassion and altruism that are not incidental but systematic to and constitutive of transnational surrogacy. We observed two predominant moral frames: (1) surrogacy liberates and empowers Indian women from patriarchal control; and (2) surrogacy furthers reproductive rights. Within these frames, the market exchange of money for babies is cast as compassion, which allows commissioning clients to sidestep accusations of racism, classism, and sexism. Yet, we reveal that the ability to navigate around these threats relies on racist, classist, and sexist tropes about Third World working-class women. Further, we find that surrogate mothers did not experience significant changes in economic status after surrogacy.

Keywords: *gender; race; labor; surrogacy; India*

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Transnational surrogacy in India is variously described in the media as the nation's "rent-a-womb industry" (Bhalla and Thapliyal 2013; Carney 2010; Desai 2012; Vogt 2014), "baby factory" (Dolnick 2007; Jayaraman 2013), "life factory" (Schulz 2008), and the "global market in bargain basement price babies" (Shulevitz 2012). In the face of such criticism, consumers of surrogacy defend their practices. For example, Adrienne Arieff, who had two daughters through an Indian surrogate mother, explains,

> This was a win–win, allowing the surrogate to have a brighter future and the couple to have a child. If my money was going to benefit an Indian woman financially for a service she willingly provided, I preferred that it be a poor woman who really needed help because the money that a surrogate earns in India is, to be blunt, life-changing. (Grinberg 2012)

Economic sociologist Viviana Zelizer (2007) posits that money and intimacy have a long, entangled history. Economic transactions do not poison intimacy; instead, they characterize, nourish, or amend the various intimacies that inform social life. Building from there, Parreñas, Thai, and Silvey (forthcoming) describe the emergence of intimate industries in Asia where intimate labor exchanges such as sex work and child care are institutionalized. We argue that central to this institutionalization are moral frames, which are "complicated stories" social actors narrate in situations where "economic transactions and intimacy" co-mingle (Zelizer 2007, 12). Specifically, we describe how surrogacy agencies, intended parents from the United States and Australia, and surrogate mothers account for their engagements with transnational surrogacy. We conclude that moral frameworks are not incidental, but *central*, to processes of institutionalization of the intimate exchanges entailed in surrogacy.

The case of transnational surrogacy is critical to studying intimate industries because, while other forms of intimacy (sexual exchange and child care, for example) have longer histories of commodification, surrogacy is an emergent intimate industry. Societies at large express anxieties around surrogacy, as evinced in the media portrayal cited earlier, and by scholars who variously describe it as the "baby business" (Spar 2006), "outsourcing the womb" (Twine 2011), and "wombs in labor" (Pande 2014). Hence we ask: Given that the commercialization of pregnancy and childbirth is cast as morally fraught, how do the various actors account for their engagement in surrogacy? What moral frames constitute transnational surrogacy?

This article is based on a triangulation of in-depth interviews with eight infertility specialists, 20 intended parents, and 70 surrogate mothers in Bangalore, India, as well as blogs and media stories. We posit that transnational surrogacy as an intimate industry unfolds within a discrete reproductive landscape, or "reproscape" (Inhorn 2011). This reproscape, we reveal, relies on particular moral frames that justify market actors' participation in this newly emergent and highly unequal reproductive exchange. That intimate industries are structured along the contours of gendered/racialized international divisions of labor is established (Boris and Parreñas 2010; Briggs 2010; Colen 1995; Parreñas 2001). We show that precisely because of these inequalities, surrogacy agencies and intended parents reproduce narratives of compassionate feelings and acts of altruism, which frame transnational surrogacy and lead to its growth and sustenance as a global business. To unpack why transnational surrogacy raises an inordinate amount of public curiosity and approbation, we first describe surrogacy in India as a form of intimate industry (Parreñas, Thai, and Silvey, forthcoming) to contextualize the moral frames that shape various agents' engagements with it.

TRANSNATIONAL SURROGACY IN INDIA

Surrogacy is a medically, legally, and market-mediated process by which a woman of prime fertility age gets pregnant and births a child for a client parent or parents. Clients seek surrogacy arrangements either because one or both partners are biologically infertile. Or, gay men who want to father and nurture children enter into surrogacy arrangements. The most common form of surrogacy prevalent today is gestational, commercial surrogacy, wherein the human ova and sperm are legally owned by a couple or individual, and as a result they also exercise legal rights over the embryos prepared from these sex cells. The couple or individual can be the source of those sex cells, or they can purchase them from sperm or egg banks. The ova are fertilized in vitro and transferred to the surrogate mother's body three to five days after fertilization. The surrogate mother has no genetic relationship to the baby she gestates and births, which in some countries, such as India, translates to little or no parental rights over the resultant child. She receives wages from the intended couple for having delivered "their" baby, which signals the end of the social relationship between her, the baby, and the clients. Gestational surrogacy thus involves a multitude of bodies in making a single baby. Often, there are multiple

mothers and fathers—the biological mother and father who provide the ova and sperm, the birth mother who labors to produce the baby, and the social mother(s) and father(s) who nurture and raise that baby.

For much of in vitro fertilization's short market history, the United States was the leading provider of surrogacy services in the world (Ikemoto 2009; Lee 2009; Ragone 1998). In 2009, assisted reproductive technologies comprised an annual business of $4 billion in the United States alone (Rapp 2009). But surrogacy in the United States is very expensive with an estimated $80,000–120,000 price tag, and lower-cost surrogacy options have cropped up elsewhere. For example, Russia and Slovenia tap into markets in France, Italy, or the Netherlands. Also, some countries have made commercial surrogacy illegal, necessitating reproductive tourism for those who want to use surrogates to have children (Lee 2009).

It is within this context of global surrogacy that India has emerged as an infertility tourism hotspot. Ova can be procured from white women in the Republic of Georgia or South Africa if parents desire racially white children, sperm can be shipped from the United States, and surrogate mothers from India can all be brought together to make babies at some of the lowest costs for intended parents anywhere in the world (Rudrappa 2010). With the medical expertise in place, the facilitation of global trade through the General Agreement in Trade in Services, the availability of inexpensive drugs and cheap labor, weak regulatory apparatus, and the commercialization of surrogacy in 2002, India is the "mother destination" (Rudrappa 2010). More than 200 infertility clinics are registered with the National Association for Assisted Reproduction in India, although estimates range from 500 to 3,000 clinics in operation. The surrogacy business earns more than $400 million a year in India (Bhalla and Thapliyal 2013; Pratap 2011). Currently, surrogacy in India is available only for heterosexual couples because the country banned access to these services to gay couples and single individuals in 2012 (Sarma 2012).

GLOBAL INTIMATE LABOR, REPROSCAPES, AND STRATIFIED REPRODUCTION

Surrogacy in India is a form of intimate labor, which is defined as the paid employment involved in forging, maintaining, and managing interpersonal ties through tending to the bodily needs and wants of care recipients (Boris and Parreñas 2010). Intimate labors are performed by

mostly migrant women in work such as child care, nursing, or sex work that deepens forms of commodification to encompass emotions and affective states of being. Intimate labor "focuses on the personal or the daily praxis of intimacy" that is increasingly "subject to market forces and ideological views on gender, ethnicity, race, and sexuality, and structural constraints" (Boris and Parreñas 2010, 8, 9). Parreñas, Thai, and Silvey (forthcoming) note that intimate labor exchanges are institutionalized into intimate industries, which must be deliberated empirically rather than perceived through a moral lens.

Building from here, we posit transnational surrogacy as an intimate industry that entails a bureaucratized movement of hundreds of thousands of individuals who crisscross the globe in pursuit of fertility assistance, human eggs, and sperm. Anthropologist Marcia Inhorn observes that these movements occur within discrete spaces, which she calls reproductive landscapes or "reproscapes." Specifically, reproscapes are "a distinct geography traversed by global flows of reproductive actors, technologies, body parts, money, and reproductive imaginaries" (Inhorn 2011, 90). These reproscapes, Inhorn notes, are sustained by Third World women who are willing to undergo risky forms of hormonal stimulation, egg harvesting, and high-risk pregnancies in order to assist privileged others, including First World clients, in meeting their reproductive goals.

That global surrogacy is highly unbalanced is not a new observation, especially given the plethora of studies on stratified reproduction. Shellee Colen first introduced the term "stratified reproduction" in 1995. Her now classic study of West Indian nannies in New York City reveals how their mothering abilities are both valued and devalued. They are sought out because they are seen as phenomenal caregivers yet their labor expended in raising their own children is elided. She defines stratified reproduction as the "physical and social reproductive tasks [that] are accomplished differentially according to the inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status . . . [which are] . . . structured by social, economic, and political forces" (Colen 1995, 87). Various scholars have subsequently built from Colen's work to examine the consequences of globalized reproductive practices and outcomes for one valorized group of people for the parental activities of Third World women who are actively discouraged in fulfilling their reproductive and parental desires (Boris and Parreñas 2010; Briggs 2010; Parreñas 2001; Rudrappa 2012). Writing specifically about surrogacy in India, Kalindi Vora (2009, 2012) too unwraps the ways by which technologies and socioeconomic inequalities are intertwined in making

Third World women's bodies available for First World reproductive consumption and accumulation of surplus value.

In sum, transnational surrogacy is cast as a morally suspect activity primarily because it hyper-exploits Third World women, specifically Indian working-class women (Majumdar 2014; Markens 2012; Menon 2012; Qadeer and John 2009). Yet, the industry has grown exponentially. How do the various actors who have made surrogacy in India a multimillion-dollar industry justify their market pursuits, when even popular media describes it as a rent-a-womb industry, baby farm, baby factory, and life factory? They justify their pursuits, we show, through narrating specific moral frames.

Arguably, the co-mingling of emotions and surrogacy is not a new line of inquiry. In her study of surrogacy in India, anthropologist Daisy Deomampo (2013a) notes that though clients and surrogate mothers have differential access to agency and power, and though infertility specialists treat surrogate mothers as no more than "wombs-for-rent," the women themselves struggle to participate in globalized reproductive work on "the best terms they can muster" (Deomampo 2013b, 184). Thus, even when disempowered, women workers marshal the emotional wherewithal required to endure and participate in transnational surrogacy on terms they find acceptable. Sociologist Amrita Pande extends this line of argument to describe surrogate mothers' and clients' interactions. Surrogate mothers may be created into "perfect mother workers" (Pande 2010) in surrogacy dormitories, but they recognize that their affective labor far exceeds the market. They recast surrogacy as kin work central to forming ties with babies, with other surrogate mothers living in dormitories, and with intended mothers (Pande 2009). Specifically, surrogate mothers and intended mothers perceive their relationship as gift-giving between global sisters (Pande 2011). That is, surrogate mothers cast their reproductive labor as gifts to infertile women from the West in order to make the latter's desires for children possible. And, intended parents describe their economic transactions as a rescue mission because their payments assisted Indian surrogate mothers in raising their "own" children by providing cash for better schools, homes, and luxury items.

We build on these studies but extend our analysis to think through how transnational surrogacy is instituted by the circulation of emotional narratives, or moral frames. That is, moral frames are not just what workers and clients feel about surrogacy; and, neither are moral frames incidental to these sorts of market exchanges. Instead, we show that moral frames are systematic to, and *constitutive* of, transnational surrogacy. Thus, it is not just

surrogate mothers and clients who hold particular views on surrogacy as Deomampo and Pande show, but also surrogacy agencies and infertility clinics, who actively endorse particular moral frames, which then assuage clients' anxieties around exploitation, bring them in as active participants, and assist them in positing themselves as compassionate people. No doubt the desperate desire for genetically descended children fuels the fertility market, yet this particular market persists because of a specific *moral framing*, that is, feelings of compassion on the part of clients, which then leads to acts of altruism that in actuality are market exchange of wages for babies.

Used extensively in social movements literature, we find the concept of moral frames useful to explain how firms and consumers signify their actions. Frames are schemes of interpretation that enable actors "to locate, perceive, identify, and label" events in their social worlds (Goffman 1974, 21). Not only do individuals make sense of their worlds through frames, which are modes of interpretation, but also, these moral frames legitimize their actions to others, thereby attempting to garner social sanction rather than disapproval. Framing "denotes an active, processual phenomenon that implies agency and contention at the level of reality construction. . . . [I]t is contentious in the sense that it involves the generation of interpretive frames that not only differ from existing ones but that may also challenge them" (Benford and Snow 2000, 614).

Thus, various accounts might perceive surrogacy as exploitative, but firms and intended parents cast their market engagements directed at building their families in morally sanctified ways. While there are degrees of instrumentality in the ways by which surrogacy agencies mobilize the rubric of compassion and altruism, as we will show, intended parents are far less cynical. Many of our interviewees deeply believe that by engaging in surrogacy in India they have behaved in an altruistic manner. Thus, reproscapes, we argue, are not only traversed by transnational flows of reproductive actors, technologies, and sex cells, but crucially, these traversals are solidified through the moral frames of compassion that lead to acts of altruism.

METHODS

We conducted in-depth, semi-structured interviews with eight heterosexual and 12 gay individuals/couples availing of infertility services in Mumbai, Anand, and Delhi in 2011–2012. All these families reside in the United States and Australia (pseudonyms are used for all clients). The gay

couples, all men, had gone to India before 2012 when the ban against gay couples and single parents was instituted. Parameters for inclusion in our purposive sample required respondents to be in the midst of or finished with the process of having a baby/babies via an Indian surrogate mother. More than half of our interviewees (12 couples) were recruited through the blogs we read about their surrogacy experiences in India; these online blogs have been critical sources of information because parents consider them "public diaries"—they consciously fashion themselves in particular ways as they present their story to the world. Respondents referenced their own blogs often during interviews, and also suggested others we could read. Because transnational surrogacy is long, complex, confusing, and often arduous, these blogs serve as a sort of institutional memory for the couples. In addition, these blogs functioned as a resource for others interested in pursuing surrogacy in India.

The rest of our intended parent interviewees were recruited through snowball sampling from the blogger intended parent interviewees. We contacted respondents via email about their interest in participating and interviewed everyone who replied affirmatively. Interviews lasted from 90 minutes to three hours in person, on Skype, or by telephone. Three in-person interviews were conducted in the Washington, DC, area in one of the intended parents' homes. The remainder were conducted virtually using Skype (with video and voice connection) or voice-to-voice by telephone. Respondents were at their homes during all of these technology-assisted interviews. Interview topics included the following: deciding to pursue surrogacy, choosing India as their destination, selecting egg donors and surrogate mothers, waiting many thousands of miles away as an Indian woman carries a baby that will legally become their own, and, finally, traveling to India and bringing the infant(s) home.

We also interviewed eight infertility specialists in the southern Indian cities of Bangalore and Hyderabad. We supplement these interviews with print media stories published in India, the United States, Canada, and Germany, because these stories are based on interviews with the most popular infertility doctors in India. In addition, we use websites and blogs maintained by infertility agencies in India in order to gather information on how they morally frame their businesses.

Finally, our analysis is complemented by findings from a larger research project based on interviews with 70 women in Bangalore. Most of these women had already served as surrogate mothers, or were pregnant and housed in surrogacy dormitories at the time of the interviews. Nineteen of the women had either failed attempts at surrogacy and were back on the

agency's roster as potential surrogate mothers, or they were undergoing hormonal infusions but had not as yet undergone embryo transfer.

Our methods are inductive rather than deductive. That is, over the course of fieldwork and interviews, infertility doctors, surrogacy agencies, and client parents—but *not* the surrogate mothers—invariably shifted the course of the interview to explain why transnational surrogacy was not exploitative. Without prompting, our respondents outlined the various ways by which clients and surrogate mothers benefited mutually from this market exchange.

CASTING COMMERCIAL SURROGACY AS REPRODUCTION JUSTICE

Medical Interventions

Prior to describing the moral frames agencies and clients used to understand surrogacy, it is crucial to outline the specifics of surrogacy in India, and the kinds of medical interventions performed on women's bodies in order to prepare them for surrogacy. In the first instance, in vitro fertilizations that characterize surrogacy in India are not foolproof. Though there are no studies in India, Centers for Disease Control and Prevention reports are informative; for example, a 2009 CDC report based on clinic self-reports in the United States notes that only 22.4 percent of all in vitro fertilization cycles (which includes surrogacy) resulted in live births. Failure rates in surrogacy are very high. Infertility specialists can increase the odds by using younger women's eggs and healthy sperm, and implanting embryos in women who are at ideal fertility age. Yet, even these measures do not guarantee a pregnancy, let alone a successful birth. Our interviewees explained that in order to increase the chance of live births, infertility specialists in India routinely hired two surrogate mothers for each client they worked with. Each woman, upon being hormonally stimulated for pregnancy, was implanted with four embryos each. The women then underwent what doctors and clients euphemistically referred to as "fetal reduction" procedures to achieve an "optimal birth outcome," which was one to two viable fetuses per surrogate mother. Infertility doctors and clients, and *not* the surrogate mothers, decided on optimal birth outcomes. In some cases, among the individuals we interviewed, client parents went back home with two to three children borne by two different surrogate mothers.

Interviews with surrogate mothers in Bangalore revealed that medical disclosure and informed consent were absent; none of the surrogate

mother interviewees had received information regarding the kinds of medical interventions they would eventually undergo. Neither had they received information on health risks involved in repeated hormonal hyperstimulation. Many women were unaware they would probably deliver through Cesarean surgery at weeks 36 to 38 of gestation. Even though almost all of them had delivered their own children vaginally, a majority of the surrogate mother interviewees underwent Cesarean surgeries. Finally, none of the surrogate mother interviewees had received postnatal care from the agencies that hired them.

The remainder of our analysis examines how agencies and clients explain their continued engagement in surrogacy. First, we discuss the power held by surrogacy agencies in shaping/disseminating the moral frames surrounding this market exchange in ways that are crucial to their financial success and market endurance. We then analyze the two dominant moral frames that agencies and clients employ to rationalize their engagement in surrogacy as altruism: (1) empowering Indian women by freeing them from patriarchal social control; (2) furthering reproductive rights, which includes children for infertile couples and assistance for Indian women in caring for their own children. The final section explains what happens to surrogate mothers during pregnancy and after they give birth.

Mediating the Relationship between Surrogate Mothers and Client Parents

Surrogacy agencies actively control the images of the surrogate mothers that circulate in popular media, and among clients: First, the agencies *all* speak about how well they treat surrogate mothers, and how happy the women are to be of service to others. Second, surrogate mothers are characterized as generous yet desperately poor individuals who are good mothers. Third, they are also depicted as shy, sensitive, and secretive about their choice, eager to return back to their own families, and unwilling or unable to speak with clients, researchers, or journalists. Western clients are especially seen as clueless because they ostensibly do not understand the cultural nuances involved in communicating with "traditional" Indian women. As a result, agencies insist that direct communication with surrogate mothers is an unwanted hardship imposed on the women. To ease the discomfort the surrogate mothers feel in talking with "strangers," the agencies insist that their staff must mediate all contact with surrogate mothers. Thus, agencies shape conversations between surrogate mothers and clients.

Many surrogacy agencies maintain websites with pictures of smiling, pregnant surrogate mothers and infants. These websites feature information about why Indian women pursue surrogacy, the rigorous psychological and medical testing they undergo, and how their lives are improved by becoming a surrogate mother. A prominent agency, Surrogacy Centre India, says of the mothers on its website:

> It takes a generous and loving woman to act as a surrogate mother for an infertile couple. . . . SCI Healthcare's surrogate mothers give up more than one year of their lives for our program. They are women with big hearts, who feel deeply for our clients and the pain they have endured trying to become parents. . . . SCI Healthcare's surrogate mothers are well paid and well cared for, both physically and emotionally. The excellent healthcare, family support and monetary compensation is the least we can offer our surrogates for the amazing gift they give—the gift of life! Our surrogate mothers feel immense pride and satisfaction in being able to help our clients become families.

An Australian couple, Scott and James, said that their biggest concern before pursuing overseas surrogacy was the treatment of the surrogate mothers. They flew to India and toured a surrogacy dormitory and hospital, and the firm's administrator assured them the women lived in comfortable conditions and received excellent medical care and healthy food. Based on this assurance, they decided to begin the surrogacy process on that trip.

However, many respondents complained that they had no direct contact with the mothers. They recounted the difficulties they encountered in accessing information about the well-being of the surrogate mother(s) during the pregnancy, which for them was a major downside to pursuing transnational surrogacy; agency employees provided them only with brief, vague updates. Several respondents said that their agencies claimed surrogate mothers were uncomfortable having their photo taken and were unwilling to Skype with them. Some clients were prohibited from meeting the mothers during pregnancies, and met with them only after childbirth in the presence of agency staff. In spite of specifically noting the difficulties in accessing information, respondents believed that the Indian women were happy during their dormitory residencies, and received an unparalleled level of care in better conditions than in their family homes. One couple, Colin and Phil, went to Delhi to retrieve the infants from the agency after two surrogate mothers had recently given birth to them. They ran into one of the mothers at the hospital, they said, and were touched by

"how happy and smiling she was." She was a "'spitfire'—she had the biggest smile." Colin did not answer us directly when we asked him if they spent time with or spoke with her; he replied instead that the women were "eager to get back to their village before Diwali, eager to get back to their children." He paused and then reflected,

> They did it for the money, they both did. They both lived in housing that we ultimately paid for. That was the first time they had ever had electricity, or a fridge. They had their meals prepared for them, had people cleaning their homes, and giving them vitamins. . . . In some ways, they received superior prenatal care over the average person in the U.S. during their pregnancy.

Thus, it is not just "under western eyes," but Indian surrogacy agencies and infertility doctors, too, produce the "'Third World Woman' as a singular monolithic subject" (Mohanty 1984, 333) that authorizes particular kinds of discourses to circulate about working-class Indian women, which then sanctions specific political and economic interventions. Maintaining distance between surrogate mothers and parents-to-be facilitates the agency's ability to shape interactions in carefully scripted ways that preserve the image of the agency, surrogate mother, and clients. They posit an image of working-class Indian women as poor mothers who are victims of their culture, dependent on men in their families, and inextricably tied to their familial and kinship networks. And, agencies claim that women's eight- to nine-month stays in the surrogacy agency dormitories are luxurious interludes because they come from such abject conditions. These tropes, then, allow clients to understand themselves as moral social actors who do not exploit surrogate mothers; instead, clients ease the latter's entry into better lives. While we are in no way suggesting that consumers are gullible, we note that these frames remove the anxiety surrounding the exchange of money for babies, and allow surrogacy agencies and clients to understand themselves as kindhearted actors with generous intentions.

"I Don't Want to Consider It Exploitation": The Moral Framing of Transnational Surrogacy

Quinn and Antonio, a gay couple in their late thirties and forties who lived in Los Angeles, were expecting twins through a surrogate mother in Delhi. Antonio, who is a high school teacher, said he weighed the question of exploitation, but ultimately decided that this was a mutually beneficial transaction:

> I was afraid that Indian women were being subjected to some sort of exploitation. And then I realized I fell into my own trap: thinking these women are less empowered to make their own decisions for themselves. They are intelligent—they can make the decision that they can get this money to help their kids or start a new business or buy a new house or whatever—so I don't consider it exploitation. *I don't want to consider it exploitation* (our emphasis).

Every parent we interviewed said they were glad to have used surrogacy services in India for its ability to empower Indian mothers. From our data, we discerned two distinct emergent moral frames:

1. Surrogacy facilitates Indian women's access to wage labor, which liberates them from patriarchal social control.
2. Surrogacy furthers reproductive rights for infertile individuals as well as working-class Indian mothers who are better able to provide for their own children.

We draw from our interviews, popular media stories, and agency websites to reveal how infertility specialists, surrogacy firms, and client parents framed transnational surrogacy as inherently liberatory, and as furthering reproductive rights for all families. The two frames overlap, but we address them as distinctive "imaginaries" to provide thicker descriptions of each.

1. Surrogacy liberates and empowers working-class Indian women. Our interview with Dr. Sulochana Gunasheela embodied this perspective. Dr. Gunasheela was a prominent Bangalore infertility specialist who, in 2005, served as a member on the Indian Council for Medical Research (ICMR) committee that drafted the National Guidelines for Accreditation, Supervision, and Regulation of ART Clinics in India, which forms the basis for surrogacy contracts and the country's current ART Bill. Dr. Gunasheela believed that cases of "altruistic surrogacy" in India, where women did not receive monetary compensation for surrogacy, tended to be exploitative. She said that upper-middle-class families felt entitled to working-class women's bodies and labor, and the surrogate mothers had little recourse in avoiding demands on their reproductive abilities, especially if their extended families had a long history of dependent interactions with employers or wealthier relatives. Many clients assumed that they had already assisted these "altruistic" surrogate mothers by paying for their children's education, or providing the women or their husbands with employment. Commercial surrogacy, according to Dr. Gunasheela, circumvents exploitative relations because the surrogate mother receives

a salary for her work in producing that baby, which she can then use to potentially negotiate a powerful position for herself within her own household. Dr. Gunasheela spoke of workers as being empowered by commercial surrogacy because it removed exploitative, hierarchical notions of gift exchange exemplified in altruistic, noncommercial surrogacy arrangements.

Quinn explained, "The way I think about it is, the going rate in the States for a surrogate is $20,000, and in India they get $8,000. It's a life-changing thing there. Here, you maybe help somebody pay off their credit cards, but there, you may be helping them move into the middle class or something." Quinn elaborated that an American surrogate mother probably has an annual salary of $40,000 or less, so earning $20,000 for surrogacy is about half her annual income. In comparison, he said, an Indian woman makes three or four times her annual income by being a surrogate mother. For this reason, Quinn explained that his money is potentially more meaningful to an Indian woman than an American woman.

Another couple who initially worried about the moral implications of surrogacy were Colin and Phil, who live in New York and now have three children via two Indian surrogate mothers. They explained:

> The argument I tried to make at the time is that if we had a surrogate in the U.S. and paid all this money, and the surrogates are paid $25,000—tell me what that does to anyone in the U.S. They pay tax on it. It doesn't fundamentally change their lives. It's probably a nice windfall of cash, but that's it.

In India, though, Colin guessed that the women received between $4,000 and $5,000 for being a surrogate mother. "This fundamentally changes their lives. It's the equivalent of maybe five years of income—it has enabled them to move into a home, to get an education for their children." Colin argued that people who are "unfamiliar with the extreme poverty in India" don't realize that "there are a whole lot of winners here. No one was hurt." Addressing their detractors, Colin asked, "What have you ever done to make the lives of these women better? You are so quick to judge me, but I have. I can point to two people who have homes and have sent their kids to school as a result of our direct involvement with them."

Like the couples cited here, many of the intended parents were unable to pinpoint how much surrogate mothers earned, but believed that women earned three to five times their annual income, which then transitioned them out of poverty. In addition, they spoke of how surrogacy expanded reproductive rights for clients *and* surrogate mothers.

2. Surrogacy furthers reproductive rights. Reproductive rights encompass the plethora of policies that strengthen reproductive decision making, including choice of marriage partners, family formation, determination of the number, timing, and spacing of one's children, and the right to information and means needed to exercise voluntary choice in reproduction. Various activists and scholars tie reproductive rights to basic human rights especially because children are seen as essential to individuals' access to adulthood and financial security in resource-poor countries. In addition, infertility is acknowledged to be a psychologically and socially devastating medical diagnosis, with women being more stigmatized than their male partners even when the latter are diagnosed with infertility. Therefore, the lack of fertility assistance is seen as a human rights violation (Deech 2003). Various scholars endorse wider availability of assisted reproductive technologies, given that infertility is far more prevalent in resource-poor countries and among the indigent (Greenhalgh 1995; Unisa 1999). Gay rights advocates in the global North too make the connection between basic human rights and gay parents' rights to birth children and raise them in queer families. Placed in this context, comparatively inexpensive surrogacy in India can be seen as widening access to reproductive rights because surrogacy is now an option for those individuals who may have been priced out of the market.

Our respondents expressed an overwhelming sense of joy and validation that their struggles to become parents—their inalienable reproductive rights—had a market solution. Many interviewees recounted emotive anecdotes about first hearing of Indian surrogacy on the radio, reading online articles, or catching a news clip on television. Beth and Cory, for example, are in their early forties and living in Melbourne, and had come to terms with the fact that they would never have children because of Beth's infertility since age 24. In 2011, Beth saw a news segment on Australian television about a gay couple who went to India for surrogacy; she said she wept with happiness, realizing that their 20 years of childless married life now had a potentially happy ending.

In addition to achieving the reproductive rights of infertile couples, surrogacy in India is also cast as furthering the reproductive rights of working-class women because surrogacy enables them to improve their children's life opportunities. Dr. Nayna Patel of Akanksha Infertility Clinic in Anand, Gujarat, who has appeared in diverse media outlets like *The Oprah Winfrey Show*, BBC, CNN, *Der Spiegel*, PBS, *Forbes*, and *The Nation*, elaborates:

> There is this one woman who desperately needs a baby and cannot have her own child without the help of a surrogate. And at the other end there is this

> woman who badly wants to help her [own] family. . . . If this female wants to help the other one why not allow that? It's not for any bad cause. They're helping one another to have a new life in this world. (Dolnick 2007)

Patel holds the same perspective five years later: "There is nothing immoral or wrong in this. A woman is helping another woman, one who does not have the capacity to have a baby and the other who lacks the capacity to lead a good life" (Bhalla and Thapliyal 2013). The resilience of such a frame, half a decade later, is noteworthy. Dr. Patel explains that with the money they earn surrogate mothers are "able to buy a house, educate their children and even start a small business. These are things they could only dream of before. It's a win–win situation" (Bhalla and Thapliyal 2013). Thus, the story of transnational surrogacy is framed as an event where two women who are vastly different assist one another in the maternal work of birthing and nurturing children (Lewis 2015; Pande 2014).

Like the businesses, client parents also cast surrogacy in India as a compassionate act: Antonio, quoted earlier, said, "With the money they are going to get, they are going to have a better life for them and their kids." His partner Quinn chimed in, "And what they talk about doing with the money is quite impressive." When we asked how they had heard what the surrogate mothers do with their earnings, Quinn replied that the women's profiles they read when selecting a surrogate explain why they want to be a surrogate mother. They also depended on agency websites and journalistic accounts they read.

The information in the profiles of both surrogate mothers and egg donors—provided by the agencies—heavily shape the commissioning clients' decisions about whom to hire. James and Scott, an Australian couple in their midforties, spent a long time deciding about which Indian women they wanted as egg donors. In the end, they opted for an Indian woman on the "B-list" who had very little education because they thought she would benefit more from the money than a woman on the "A-list" who had at least a high school education, and therefore was likely from a family with more financial capital. When they narrowed the list down to two final candidates from the "B-list," they chose the woman who said she would use the money to further her son's education over the other childless woman.

Although a moral frame of compassion dominated our respondents' explanations for pursuing Indian surrogacy, it was clear that other factors also influenced their decision—one primary influence being the cost. Adam and Brian, for example, typed "budget surrogacy" into Google when they began to consider having children, and all the hits returned were about India, which is how they first discovered India as a destination. Phil and

Colin mentioned offhandedly that they had "sticker shock" when first researching surrogacy, and loved their clinic in Delhi because it was truly "First World medicine at Third World prices." Thus, even though some of our interviewees spoke about the financial savings, they continued to frame their decision to employ Indian surrogate mothers with the language of compassion. Such language helped some clients cope with the instrumentality that drove the decision-making process in having children.

However, a few individuals were unapologetic about the surrogacy process being strictly a business transaction. For example, Richard and Keith, who live in the Midwest and were expecting twins from one Delhi-based surrogate mother, scoffed when we asked whether they were planning to meet her: "The bottom line is that these women are paid, they are held accountable. There is really no reason for us to interact with them. They get paid, we have the outcome we want."

It seems that because clients utilize surrogacy in India once, or at most twice, in their lifetimes they may be more likely to express instrumentality. Infertility assistance businesses, however, may face approbation if they express such instrumentality and, as a result, are more careful. They need to sustain their businesses and bring in more clients. For example, Dr. Patel is said to have delivered more than 650 surrogated babies from 2004 to 2014; she charges clients an average of $25,000 to $30,000 for the entire procedure and pays her surrogate mothers $6,500 (Vogt 2014). In order to continue to attract clients, she necessarily must speak of how her business model assists clients and surrogate mothers equally. Surrogacy is, as she and her clients say repeatedly in various media sources, a "win–win" situation. Thus, infertility businesses in India, like Dr. Patel's Akanksha Infertility Clinic in Anand, posit themselves as social businesses, an ethical capitalism that ameliorates inequalities resulting from First World infertility and Third World poverty (Lewis 2015).

Creative Options Trust for Women (COTW) in Bangalore, where we first began fieldwork with surrogate mothers in India, has gone so far as to officially register itself as a nonprofit social work organization. Along with surrogacy services and recruiting egg donors, COTW claims that it provides a vast array of services: shelter to newborn orphans, adoption assistance to childless couples, protection of girl babies, self-employment training and job placement for women, employment and marriage assistance for widows and women divorcees, free AIDS counseling and treatment, and more. Surrogacy, then, becomes a way by which COTW funds all these charitable interventions for the overall benefit of India's women and children.

Thus, many of our client interviewees believed themselves to be "compassionate consumers" who participated in generating social change for

themselves and for working-class women and children in India. Such perceptions enable them to adopt a positive self-image invested with moral significance that testifies to their good character (Deeb-Sossa 2007; Kleinman 1996). This framing also helps couples shield themselves from accusations that they are intermingling economic activity with the intimate labor of creating a family, two worlds that are often seen as morally opposed (Zelizer 2007). Instead, by framing commercial surrogacy as compassionate consumerism, couples adopt a moral identity that allows them to navigate around threats of racism (Deeb-Sossa 2007), classism, or sexism. Yet, as we reveal, the ability to navigate around these threats is shaped by moral frames that *rely upon* racist, classist, and sexist tropes about Third World working-class women.

Surrogate Mothers before and after Surrogacy

Most of the 70 surrogate mothers we interviewed in Bangalore had earned $4,000, and not $7,000 to $8,000 as reported in media accounts. A few had been paid less than that. Some surrogate mothers drew our attention to the unfairness of the exchange because their wages fell short of the economic, personal, and social costs they had incurred. They explained that because they had to live in surrogacy dormitories during their pregnancies, their household expenses increased due to child care. Some husbands balanced the additional household tasks and wage employment if the children were ten years and older because these children took on the absent mother's household responsibilities. But younger children were unable to do so, and were sent to grandparents' homes. Still others paid friends and neighbors, or depended on these women's generosity to care for the children. Thus, it was not just their individual labor effort, but their kith and kin also expended energy, emotions, and made sacrifices in order to assist the mothers through surrogacy. These kinds of familial labor subsidized Bangalore's surrogacy industry, but the social and financial costs of such relationships fell on the mothers. If extended family members who had assisted them during surrogacy requested gifts or loans, they were unable to say no.

Moreover, contrary to what surrogacy agencies and clients maintained, many of our interviewees pointed out that surrogacy was *not* a "mother friendly" job. They were separated from their children because of the compulsory dormitory residence; during this time apart, they worried if their children were eating their meals, completing school work, and safe at school and home. The mothers' worst fears were realized when their children fell ill because they could not be there to take care of them. Being apart from their own young children was especially hard on the surrogate

mothers in unhappy marriages. Roopa, a garment worker in her midthirties who is now separated, was a surrogate mother three years ago when she and her physically abusive, alcoholic husband still lived together. She said that her stay at the dormitory was emotionally excruciating for her because even though she saw her seven-year-old daughter on weekends, nine months was an exceptionally long time to stay away from her child. The child was often scared in the evenings because after having dinner in her mother's friend's home, she had to wait alone at home for her drunken father to return. Surrogacy, which guaranteed her a lump sum of money and a promise of independence, also meant that she had to compromise her daughter's well-being while they were apart.

Moreover, the money mothers earned through surrogacy disappeared in a matter of months. As with individuals in other industries that deal in body parts, namely, kidneys (Goyal et al. 2002), almost all the surrogate mothers we spoke with initially believed that their market engagements would save them from economic precarity. However, the change in economic status did not pan out. They were grateful for the earnings, but because they were often the only individual in their extended families to hold that much liquid capital, the money quickly dried up. Surrogate mothers and their families live in financially precarious states with very little savings and no financial safety net. They had debts, deposits to make toward renting livable homes, refrigerators, televisions, and scooters to be purchased to make everyday life easier, the costs of private education for children, sick relatives who needed immediate attention, and small agricultural holdings that needed capital. They were constantly short on money in their struggles to make a decent life, and their earnings quickly ran out. Some women wanted to sign onto becoming surrogate mothers all over again. Thus, contrary to agencies' and clients' notions that surrogacy was "life-changing" for working-class women, the reality was that there was often no marked difference in mothers' lives after surrogacy.

CONCLUSION

What makes a multimillion-dollar, transnational intimate industry possible when most people see it as exploitative? By focusing on the newly emergent case of commercial surrogacy in India, this article extends the literature on intimate industries by examining how they thrive despite their portrayal as highly unequal in popular and scholarly accounts. Through our uniquely triangulated data, we demonstrate that clients and firms use *strategic moral frames* of altruism and compassion

that nonetheless rely on racist, classist, and sexist tropes about Third World working-class women. We show that these moral frames are not incidental but *systematic to and constitutive of* such kinds of intimate industries.

We observed two predominant moral frames: (1) Surrogacy liberates Indian women by facilitating their access to wage labor, and (2) surrogacy enhances reproductive rights for infertile individuals and working-class Indian mothers who are better able to provide for their own children. Through these frames, surrogate mothers are produced as "singular monolithic subjects" (Mohanty 1984, 333): loving, but also shy, needy, and dependent; generous and eager to help fulfill the dreams of parents-to-be, yet living in deplorable conditions and desperate to move to a better home and send their own children to better schools; happy to be in the service of others, yet nervously unwilling or unable to speak with clients, researchers, or journalists.

These frames facilitate surrogacy as an economic intervention, and inculcate upper-middle-class clients into this intimate industry while maintaining distance between the intended parents and surrogate mothers themselves. The enforced social distance between surrogate mothers and clients protects the latter from learning that the former earn less than agencies claim, and that for some mothers, surrogacy detracted from, rather than enhanced, their own children's well-being. None of the 70 surrogate mothers we interviewed were saved from economic precarity by having a child for relatively privileged clients.

This article has built upon previous theorizing on stratified reproduction and transnational surrogacy to demonstrate that the lack of economic privilege working-class Indian women experience because of their class and global race locations allows for the circulation of the ideology that they need to be rescued. This rescue then is fostered by their employment as surrogate mothers. These working-class Indian women's bodies form the material basis for the growth of transnational surrogacy as an organized intimate industry replete with legal clauses, legislation, and well-established modes of transaction. Their bodies are sites for drastic medical interventions entailing hormonal hyperstimulation and major abdominal surgery, yet surrogacy firms and middle-class families hold on to the fallacy that surrogacy is a "win–win" situation. The very structural factors that make working-class Indian women particularly suited for surrogacy also allows for the circulation of reproductive imaginaries of benevolence and rescue from poverty. This reproductive imaginary is a myth.

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