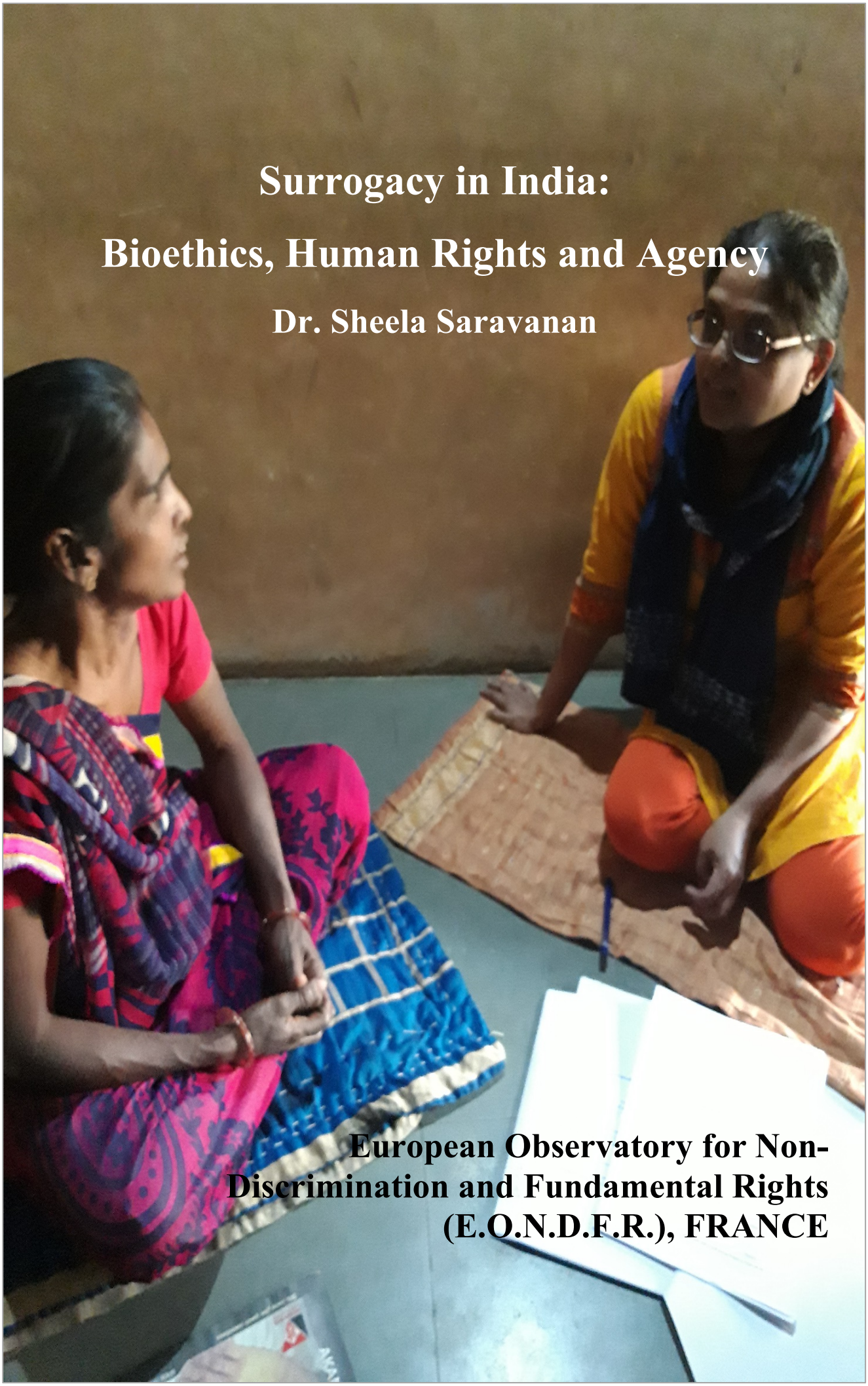

Surrogacy in India:
Bioethics, Human Rights and Agency

Dr. Sheela Saravanan

European Observatory for Non-Discrimination and Fundamental Rights (E.O.N.D.F.R.), FRANCE

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Dr. Sheela Saravanan

Independent Researcher, Bonn, GERMANY.

Email: vssarav@gmail.com

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Email : contact@europeanobsndfr.org

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About

Dr. Sheela Saravanan

Since 1998, **Dr. Sheela Saravanan** has two Master`s degrees in Geography and Development Studies from Mumbai and Pune Universities, India, respectively. Her academic focus has been on women and health in Asia and Europe. She has specialized on reproductive health since her PhD on birthing practices in India from the School of Public Health, Queensland University of Technology, Brisbane, Australia. Her post-doctoral work in German Universities was on maternal and child health, selective abortions, reproductive technologies, surrogacy and prenatal screening. Conceptually, she has applied authoritative knowledge, intersectionality, reproductive justice and transnational feminism in her research on reproductive health. Author of a book on commercial surrogacy in India, she has been invited as a keynote speaker on this topic on several prestigious forums, including the United Nations.

The European Observatory for Non-Discrimination and Fundamental Rights (E.O.N.D.F.R.) - FRANCE.

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- attending sessions of the Council of Europe, in Strasbourg (FRANCE);
- promoting and facilitating the exchange of information and experiences between its Members, to devise a dynamic and cross-cutting approach of issues.

ABSTRACT

At the juncture when India has banned commercial, it was an appropriate time to examine what is the situation of commercial surrogacy and its transition to altruism in India. This was a follow-up study, from the previous study conducted in 2009-2010. I interviewed 45 surrogate mothers (SMs), who had completed 63 births and given away 89 babies since 2007 to 2017. All the surrogate mothers had completed surrogacy when I interviewed them.

Some of my findings reiterated my previous findings. Some serious violations of human rights and medical ethics continues to take place; women are detained in surrogate homes against their wishes and desires, sex selective abortions are performed, the restrictions imposed on women in the surrogate homes are inhuman, none of them are given a copy of their contract, the manner in which the children have been relinquished is also inhuman as some are shown the face of the children, some are not, some are expected to bond with the babies, some are alienated. Women are selected into surrogacy based on their class, age, skin color, religion, caste and payment varied accordingly. Women are doing all this for money. Most of the households are poor, some are very poor and the remaining are at subsistence level, doing this to gain a higher order in their present class status. Couples from abroad and non-resident Indians formed the bulk of the clients. Almost all surrogate mothers (93%) think this is a form of slavery and most (67%) felt the process was similar to a form of sexual exploitation of their reproductive organs. Most didn't repeat surrogacy again and those very poor who did repeat surrogacy were the only ones who could build/buy a house. Financially, it was only the very poor without any agricultural land or house ownership who have repeated surrogacy more than once could buy or build a house. The very poor one timers have not been able to buy a house, some slipped backed into abject poverty. The few who were already at a subsistence level have been able to take advantage of the extra money to enhance their economic situation. Most women did surrogacy for building/buying a house. It is the housing, health and education situation that is the root cause of surrogacy practices in India. It is important that the public and private educational, health and housing sector in India is focused towards health and education for all and also to provide low-cost housing.

Overall the physical and emotional impact of surrogacy has been immense on their lives. Many are suffering from an emotional setback, physically they have become weak after the surrogacy treatment, multiple embryo transfer trials, miscarriages, uterus removal and do not have the capacity to work as they used to earlier and many have developed some kinds of morbidities and have experienced near-death situations during surrogacies. Some surrogacy and egg donor deaths have been hushed up and not been reported. Not only the surrogate mothers, but also their children carry the sorrow of giving away the children born through surrogacy.

From a global perspective, India is a typical case of how rampant violations of human and child rights, women's bodily integrity and medical ethics thrived on global structural inequalities. In the garb of reproductive liberty, the surrogacy practice promotes deeply embedded pronatalist, patriarch, racial, ageist, casteist, sexist and ableist hegemony. This raises globally relevant questions of geneticisation, alienation of the gestational role, human and child rights violations, trafficking and reproductive injustice. Surrogacy hence needs to be included as a form of universal human rights violation.

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1. Introduction

India had become one of the most popular destinations for third-party childbearing in the last one decade, until commercial surrogacy was banned in India in September 2015. According to some estimates that it had grown into a 2-Billion-dollar business (Perappadan 2014). Media and research sources estimated that around 60–90% of surrogacy in India has catered to foreign couples (Bhalla and Thapiyal 2013; NDTV 2015). As Nepal, India, Thailand, Mexico[1] and Cambodia limited or proposed a prohibition on commercial surrogacy, the practice has moved to Laos, Malaysia, Kenya, Nigeria, Ghana, South Africa, Argentina and Guatemala. The ethical concern of this pattern is the development of biomarkets, in which certain bodies (generally poor and women) become more bioavailable within the existing global or national structural inequalities. This global pattern of moving reproductive biomarkets is based on exploitative capitalization of women's bodies. The control over human reproductive biomaterial[2] by the affluent using global inequalities and vulnerabilities is a form of recolonization of women's bodies and labour. Several ethical issues have been raised on commercial surrogacy in India such as; reproductive justice, exploitation of structural inequalities, physical, medical and emotional control over women's bodies, child rights and the reinforcing of social hegemonies. It also raises human rights concerns of; right to movement and right against arbitrary detention, right to dignity, right against sale of body part for financial gains, reproductive distinction, and protection of child rights against separation from parents, knowledge about their birth, sale/trafficking of children and additionally the rights of the surrogate mother`s children.

I conducted one research study on transnational commercial surrogacy in India in 2009-10. This report is the findings of a follow up study conducted in February 2019 funded by The European Observatory for Non- Discrimination and Fundamental Rights (EONDFR), France. The research aimed to explore some of above-mentioned ethical issues, human rights violations and the physical, psychological and monetary impacts of surrogacy on the surrogate mothers (SMs) and their family. I conducted in-depth interviews in Anand, Nadiad and Ahmedabad with 45 surrogate mothers who had completed 63 surrogacies and had given birth to 89 babies. Most surrogate mothers had participated in surrogacy with a very popular clinic in the region.

[1] Mexico prohibited surrogacy in Tabasco state (Photopoulos, 2015). In Nepal, The Supreme Court (SC) of Nepal has issued an interim order to immediately halt the surrogacy (The Himalayan 2018). Thailand banned commercial surrogacy for foreigners (BBC 2015). India has proposed a ban on commercial surrogacy since Sept 2016 with the Surrogacy (Regulation) Bill (MoHFW 2016). Cambodia has proposed a ban on commercial surrogacy (Meta 2017).

[2] Reproductive biomaterial refers to the child making industry that is based on biological material such as oocyte, sperms, stem cell, tissues, breast milk and the surrogate mother's womb.

2. Methodology

I visited the surrogate mother`s house wherever possible, except for few who met me at various locations in Nadiad, Anand and Ahmedabad. The interviews lasted from 25 to 60 minutes based on how much the surrogate mothers shared about their life experience. The questionnaire was primarily designed by OENDFR along with my inputs. All names (of surrogate mothers, doctors & clinic) have been changed to maintain the confidentiality of the participants. The major themes covered in the interview were:

1. Violation of medical ethics,
2. illegal surrogacy practices,
3. the surrogate mother`s socio-economic background,
4. details regarding the surrogacy,
5. motivation to do surrogacy,
6. agency and decision making, (decision making to do surrogacy, selection criteria, surrogacy contract),
7. medical aspects,
8. relationship with the child(ren),
9. the commissioning parents and
10. the clinic,
11. the psychological,
12. physical and
13. financial impact of surrogacy on their life,
14. judicial aspects of surrogacy and
15. their fundamental rights.

The present study conducted in 2019 reconfirmed many of my previous research findings, filled some gaps and there were several new evidences that emerged on;

1. violation of medical ethics,
2. impact on surrogate mother`s lives,
3. impact on the surrogate mother`s existing children`s lives,
4. their relationship with the clinic, commissioning parents and the children born,
5. the violation of human and child rights and
6. trafficking of women.
7. The impact of the present laws preventing commercial surrogacy on the ground in India was also an important finding of this study.

A structured questionnaire on the above-mentioned topics was primarily to guide the interview but being a sensitive topic, the surrogate mothers were allowed to guide the interview in the direction they wanted to speak and not probed further if they felt any discomfort or had other serious issues ongoing in their life. Attempt was made to cover all the questions in the questionnaire as much as possible. Their consent was taken and accordingly interviews were recorded and analyzed using ethnomethodology. Apart from their responses, the surrogate mother and her family member`s language, expression, talk and interaction were also analyzed.

I was unable to enter the surrogate homes (dormitories/hostels managed by the clinic), as it would have been very dangerous for me to do so. The surrogate mothers were scared for

themselves and my safety and hence they advised me to interview those surrogate mothers who have completed surrogacy. Hence, I interviewed 45 surrogate mothers post-surrogacy at their home, at their workplace, in the car outside their workplace and wherever they felt comfortable to speak to me. The advantage of this methodology was that; the surrogate mothers were able to share the impact of surrogacy on their life.

I begin the report with the ongoing illegal practices in the IVF surrogacy clinics that are a violation of the ART (Bill) 2005, the violation of fundamental human rights and the violation of medical and human ethics.

3. Violation of Fundamental Human Rights

The Universal Declaration on Bioethics and Human Rights 2005 recognizes that technological advancements in medical science should be ethically sound, giving "due respect to the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms" (UNESCO 2006: 3). The study reveals that this fundamental right was violated in the surrogacy practices.

The Universal Declaration of Human Rights, Article 9 states, "No one shall be subjected to arbitrary arrest, detention or exile" (UNESCO 2006). However, this popular clinic forcefully detains displeased women in dormitories throughout the surrogacy that has a detrimental psychological impact on them. (Refer section 13a) Surrogate mothers are retained in these dormitories without any freedom of movement, food and are restricted from sexual intimacy with their husband, sharing food with their children, keeping their children in the surrogate home, restricted on the music they listen to and what they watch on television and some surrogate mothers were prevented from calling up their husband until after the results of the embryo transfer, followed to the toilet, restricted from laughing or talking loudly, confined to their beds with legs crossed and raised, restricted from drinking coffee and several more such rules.

Indeed, almost all surrogate mothers (93%) think this is a form of slavery and most (67%) felt the process is similar to a form of sexual exploitation of their reproductive organs. None of them felt the surrogacy contract protected them from the risks of pregnancy. After the birth, some surrogate mothers are not allowed to see the face of the babies, most are expected to provide breastmilk using a pump, some are expected to become the nannies to these babies and abruptly separated thereafter, in some cases these babies are shown to the surrogate mother`s young children as their sibling and then abruptly separated.

"Here it's all her (Dr. Nisha`s[3]) wishes, she can do whatever she wants."
(Surrogate Mother - SM 14)

[3] Dr. Nisha runs a popular clinic in Anand, Gujarat.

3.1 Restrictions imposed on Surrogate Mothers

Invariably all surrogate mothers said, they were restricted from movement during the pregnancy. In 52 out of the 63 pregnancies, the surrogate mothers (SMs) were restricted from movement throughout the pregnancy. While in 11 pregnancies, the surrogate mothers were restricted in movement in some periods during the pregnancy (after embryo transfer and before delivery). Their husbands were not allowed inside the room during embryo transfer or delivery. The restriction hence goes far beyond allowing any sexual intimacy with their husbands.

One main surrogate agent of this clinic explained the detailed rules that women were supposed to follow in the surrogate home. (Refer SM 39) Women were supposed to remain on the bed for two months. The sleeping position was also specific; legs crossed and raised. They were not allowed to talk loudly. Women were restricted from laughing loudly. They can walk but very slowly only to use the toilet and nowhere else. They were warned against urinating forcefully. They are made to believe that it is only if they follow these rules that the pregnancy report would be positive. They should not take any tension and do whatever they do very peacefully and hence they are restricted from speaking to their husband and family members after the embryo transfer until the pregnancy results. They are told that the child is placed in their womb artificially and these rules are followed to take utmost care to avoid miscarriage. The surrogate mothers had to eat whatever they were given. Some women did not like the protein mixture but they were forcefully given this mixture.

In one case, Banu (SM 5) was restricted to the extent of making her feel suffocated. She was followed until the toilet, the commissioning parents snatched her phone and personally kept 24 hours watch on her until her positive pregnancy result.

The Universal Declaration of Human Rights, Article 14 states, “Everyone has the right to freedom of movement and residence within the borders of each state”. The clinic now has a newly built all-inclusive complex, with the clinic, surrogate home, residence for the commissioning parents, canteens, shops, everything within the building. The present surrogate home in this newly built clinic is located at the basement. Hence there was no fresh air, no windows or balconies. There were two guards at the gate and hence the surrogate mothers cannot step out of the building easily. In the previous surrogate home, I visited in 2009, women used to step out sometimes or manage to smuggle inside some food of their liking but here in the basement they couldn’t do all that and felt even more caged.

3.2 Other Violations

Most (69%) of the surrogate mothers (31 out of 45) felt that the medical practices were violating to the extent of drawing analogies to sexual exploitation. All said the process of surrogacy can be compared to slavery. If they were not helpless for money they would never do it. Most (82%) of the surrogate mothers (37 out of 45) said that they felt their physical integrity was violated at the maternity hospital and ward.

The other violations were; the surrogate mothers were restricted from sharing fruits, food and dry fruits with their children when they came to meet them at the surrogate home. The surrogate mothers are mistreated after the delivery such as; not showing the face of the baby to the surrogate mother, abruptly taking the children away after bonding, commissioning parents

cutting off all contact with them and the clinic chasing them away if they return with a health problem.

4. Illegal Practices

One of the findings from my previous study was that; India had become a classic case of rampant violations of medical ethics practiced by clinics because of the structural inequalities and that surrogacy in India was unregulated within a permissive legal paradigm until Sept 2015.

This study revealed that the clinics were engaging in illegal practices by;

- not giving a copy of the contract to the surrogate mothers,
- performing in-utero sex selective abortion if more than two embryos progressed into positive pregnancies,
- engaging in traditional surrogacy (using the surrogate mother`s oocyte)
- simultaneously transferring embryos in more than one surrogate mothers

5. Copy of the contract

None of the surrogate mothers were given a copy of their contract. Despite realizing that this is a violation of their basic human rights, they accept this fact because there is nothing they can do about it. The surrogate mothers have no control over their body, the children throughout the process and they cannot question any medical or physical intervention on their body whatsoever. There was no additional payment for miscarriages. I heard from the few surrogate mothers I met that; and there was no health of life insurance. They are not given a copy of the contract lest they have a record that can be used for any legal procedure against the clinic. Even the payment was made in cash, so that there is no evidence of the surrogacy or how much money was paid to the surrogate mother.

5.1 (Sex) Selective Abortions

During my last visit 10 years ago, I was told by surrogate mothers that they had witnessed other women who experienced complications after selective abortion. I was told that this is a risky procedure and might cause abortion of all fetuses. I assumed that sex determination and selective abortions may also be used in this procedure.

This follow-up study in 2019 confirmed that sex selective abortions was actually being performed with all its evident complications. Gracy (SM 2) said she had two surviving girls and one boy growing in her uterus after a transfer of five embryos. One of the female fetuses was identified and selectively aborted by Dr. Nisha. She merely informed Gracy that there are two girls and one boy, so she will be aborting one of the girl fetuses. She didn't take Gracy`s consent for the same, Gracy became emotionally very upset after this procedure.

Bhavya (SM 33) was carrying twins and one fetus was aborted inside the uterus on the request of the commissioning parents. Selective abortion was performed on Ujwala as she was carrying triplets. She faced complications and experienced a complete fifth month miscarriage because of this fetal reduction procedure. Similar fetal reduction procedure was also performed on Nargisa (SM 14). Neither Bhavya, nor Ujwala or Nargisa was given any information about the sex of the children they were carrying or whether it was a girl or a boy fetus that was aborted.

Madeeha (SM 39) was taken to a clinic in Kerala for surrogacy, catering to the demands of Muslim commissioning parents from the Middle-East. After a few months into the pregnancy her agent told her that there are two children, and that she should abort one foetus. She refused to abort one child. The agent warned her that she would not get any money from the clinic if she refused an abortion. She shouted and screamed and demanded they allow her to speak to the commissioning parents directly. They didn't allow her to talk to them, but she didn't allow the abortion and gave birth to twins. Her friend Rabeena was not so lucky; she was carrying twins and selective abortion was performed on her. She felt the commissioning parents are also to be blamed for allowing this.

This recent study revealed evidence that sex selective abortions were being conducted which is illegal and moreover selective abortions were being conducted without the consent of the surrogate mother.

5.2 Traditional Surrogacy

Use of traditional surrogacy has been illegal in India since the first Assisted Reproductive Technology (Regulation) Bill in 2008. Traditional surrogacy means using the surrogate mother`s egg for a surrogacy which makes her also a genetic provider of the child. But a smaller clinic in Anand engaged in this procedure, using Banu`s (SM 5) oocytes for her second surrogacy.

5.3 Simultaneous Embryo Transfer into two Surrogate Mothers

Several commissioning parents had embryos transferred into two surrogate mothers simultaneously, such as in Kaavya`s (SM 12) case. Both the surrogate mothers became pregnant with one baby each and both gave birth to one girl child each. In this clinic, at any point of time, at least two surrogate mothers' body were always prepared for an embryo transfer.

Sriya`s (SM 20) commissioning parents chose both the surrogate mothers who`s uteruses were ready for transfer. The embryos were transferred simultaneously and while Sriya became pregnant, the transfer into the other surrogate mother was unsuccessful. Finally, the commissioning parents didn't pay Sriya much saying that they had spent a lot of money on two sets of embryo trials on two surrogate mothers. Sriya didn't even know what would be her final payment, she couldn't read the contract written in English nor was she informed, she never asked.

Dr. Nisha suggested to Yasifa`s (SM 29) commissioning parents that as her egg quality was weak, another surrogate mother should be transferred with embryos simultaneously. Yasifa became pregnant while the other surrogate mother didn't.

6. The Surrogate Mother`s Socio-economic Background

In this study, many (38%) surrogate mothers had attended school only up to primary level and very few completed 10th (15%) or 12th (11%) class. Almost 40 percent of the surrogacy mothers were non-literates or studied only up to primary schooling level. This has an effect on their bargaining power, understanding of the contract and their agency within the surrogacy. None of the surrogate mothers I met, could read English and hence they were unable to read and understand the contract they had signed.

Another important aspect that is related with the lower education of surrogate mothers is that; many of these women have been pulled out of school only to care of younger siblings, for participating as an agricultural laborer or to be pushed into early marriage. Some faced traumas such as illness and death of one or both parents. Almost all the women interviewed in this study openly mentioned that they have been married below the legal age (18 years). Child marriage is a serious barrier for the girls involved leading to early birthing that has an adverse impact not only on women`s health and wellbeing but also on their self-identity and confidence. Although the purpose of this study did not include an analysis of the impact of women`s childhood neglect on their adulthood. But surrogate mothers gave several signs of self-perceived subordinate or subdued positioning in the decision making regarding their involvement in surrogacy.

Overall the surrogate mothers were largely home makers, and those who were involved in paid labour were employed in varied jobs such as; cleaners in malls or hospitals (SM 31,32,33) and as housemaids. One surrogate mother worked as an old age carer SM (35), some were labourers (SM 25, 36, 38), garland makers (4,5,6) and home based tailors (SM 11,39). One ex-surrogate mother just returned from working as a housemaid from Saudi Arabia, (SM 22).

The surrogate mothers had an average of two children. All the women were married and living with their husbands except for three widows. Two of the husbands who passed away were alcoholic, and the third died due to kidney failure.

Table 1: Economic Condition of Surrogate Mothers

Economic Condition	Number of Surrogate mothers	In percentage
Land/house owners	12	27
Poor[4]	22	49
Very Poor[5]	11	24
Total	45	100

[4] Poor: Non land/house owners with a subsistence income.
[5] Very Poor: Non land/house owners with no subsistence income.

Most (63%) of the of the surrogate mother`s household were poor and very poor. Almost one quarter were very poor (11/45) and half (22/45) were poor. (Refer Table 1) The other twelve (22%) households were house or land owners along with earning household members and hence they have not been considered as poor. The land/house owners have invested the surrogacy money into education or buying an extra piece of land or livestock (buffaloes, cows). I have defined poor as non-land/house owners households but at a subsistence level with both husband and wife working and earning a steady flow of income. The poor and very poor are the non-land/house owners households with only one or no steady earning member in the household respectively .

There were three seasoned surrogacy agents among those I interviewed (SM 1,3,32) and their primary household earnings continued to be based on the commission they earned as a body market agent for surrogacy, egg donation and clinical trials.

Although this was not part of the questionnaire, I found myself asking the surrogate mothers this question because apart from surrogacy other forms of body market was also a source of their household income. Almost half the surrogate mothers spontaneously told me that have been egg donors. Once they go for any of these body market activity; follow-up calls from clinics constantly inviting them again and again for surrogacy, egg donation and drugs trial was a common feature.

Most surrogate mothers told me that they would never become a surrogate agent and take any women to the clinic in return for money because they feel surrogacy is a risky process and their conscience wouldn't allow them to put another woman through this risk.

"I sacrificed my health and risked my life, but I will never put another woman through this just to earn an extra Rs 10 thousand rupees"
(Manjula SM 44).

This is precisely what I have referred to in my book as `reproductive justice` (Saravanan 2018). As long as commissioning parents use IVF technology on their own bodies to have children, it is their reproductive rights. But when they use surrogacy they are likely to put another woman (the surrogate mother) through social stigma, psychological challenges, violation of her bodily integrity, and also put the surrogate mother's health, freedom, liberty and even her life at stake. Hence, surrogacy cannot be considered a socially justified practice. The surrogate mothers I met in India are using the same approach in explaining why they were unwilling to put another women`s health and life at risk. Their conscience doesn't allow them to do it, according to what they said. Some were also worried about physical violence directed towards them by the woman`s relatives in case anything untoward happens to the women they introduce to the clinic

7. The Surrogacy Information

To understand the surrogacy practice in the study area, this section specifies the details regarding;

- the clinics that the surrogate mothers were linked with during their surrogacy contract,
- the number of surrogacies the surrogate mothers were involved in,
- the number of children given,

- the sex of the children born,
- the year the surrogacies and
- their remuneration.

The 45 surrogate mothers I had interviewed were involved in totally 63 surrogacies and had given birth to 89 babies. Of the total 63 surrogacies in this study, 52 (82%) were from one particular popular clinic in Anand, 8 (13%) were from other clinics in Ahmedabad, Surat and Anand and remaining three (5%) were from Atthani (Kochi) Kerala. 16 percent did surrogacy more recently between 2016 and 2018, almost half (49%) of the total surrogacies were in the year range 2011 to 2015. A little more than one-third were surrogacies between 2007 and 2010 (Refer table 2)

Table 2: Distribution of Surrogacies by Year Range

Year range	Number of surrogacies	Percentage to Total
2007 to 2010	22	35
2011 to 2015	31	49
2016 to 2018	10	16
Total	63	100

Most (62%) of the surrogate mothers (28 out of 45) were involved in surrogacy only once. A little more than one-third (35%) repeated surrogacy (16 out of 45) for a second time. Only one surrogate mother (SM 1) repeated it thrice. She is also a seasoned body market agent. Half (8 out of 16) of the surrogate mothers who repeated surrogacies, did it because their remuneration after the first surrogacy was insufficient to build/buy a house.

Table: 3: Number of Surrogacies by surrogate mothers

Surrogacies per surrogate mother	Number of Surrogate mothers	Percentage to Total
1	28	62.22
2	16	35.56
3	1	2.22
Total	63	100

There were totally 38 single babies, 24 twins and one triplet born to surrogate mothers adding to a total of 89 babies. (Refer Table 4) According to the surrogate mothers, at the clinic in Anand, five embryos were transferred into their womb. If only one embryo progresses into a positive pregnancy in the surrogate mother`s womb, Dr. Nisha does not interfere with the foetus in-utero unless specifically requested by the commissioning parents. But if more than two foetuses survive, she invariably selectively aborts the remaining foetuses. According to the surrogate mothers, Dr. Nisha is very particular about keeping a minimum of only two embryos in the womb. There is also clear evidence that Dr. Nisha identifies the sex of the foetus to selectively abort according to the information gathered in this study.

Gracy (SM 2) mentioned that there were two girls and one boy in her womb and Dr. Nisha specifically aborted the second girl foetus without asking her consent. Nargisa (SM 14) and Ujwala (SM 9) also mentioned that they were carrying triplets and she had selectively aborted one baby in-utero during their surrogacy pregnancies. (Photo 1) They were not even informed about any details regarding the foetuses before this procedure was conducted on them. According to Dimpy (SM 15) in-utero selective abortions is commonly practiced in the clinic, usually in more than two babies, after identifying the sex of the foetus. Nargisa (SM 14) questions the morality of Dr.Nisha when she kills female foetuses in the surrogate mother`s womb, in spite of putting up a huge notice board in the clinic against killing of girls in the womb.

Knowing that, it is usually the surviving ttriplets (three), quadruplets(four), and quintuplets (five) that are tampered with and reduced to twins by Dr. Nisha, it is interesting to analyse the number of boys as compared to girls among the twins born. Among twins, there was a much higher number of boys (32) born as compared to girls (18). While amongst singles born, the number of girls (23) was much higher than boys (14). (Refer Table 4) Of the 25 twins born, 7 twins were two boys each and 18 were 1 boy and one girl each. There have been no twins of the combination of ´two girls` that were born.

Table 4 : Number of Babies born and Sex Distribution

Sex Composition among Twins, Singles & Triplets		Total Babies	Boys	Girls
Twins	25	50	32	18
Singles	37	37	14	23
Triplets	1	3	1	2
Total	63	90	47	43

As the surrogacy clinics are not accountable to submit any official list regarding surrogacy, there is no exact account of the number of surrogacies or number of surrogacy babies born in India. However, there are estimates made by other different sources. According to one estimate, one-third to half of the total commissioning parents seeking surrogacy in India were from abroad (Bhalla and Thapiyal 2013; Desai 2012). Frontline, a media journal in India, estimated approximately 60-80% percent of foreigners involved in surrogacy in India (Frontline 2016). A popular clinic in Anand claimed the birth of more than 1100 babies born through surrogacy until 2016 and two-thirds of the commissioning parents at this clinic were from abroad.

This study reveals a total of 57 percent of the commissioning parents came from abroad (Refer Table 5). This includes the 16 percent Non-Resident Indians (NRIs) living abroad and 41 percent of commissioning parents from; Africa, Dubai, Canada, Turkey, USA, Bahrain, Bangladesh, Nigeria and the Gulf. Another 41 percent of the commissioning parents came to Gujarat from different parts of India (Delhi, Mumbai, Ahmedabad, Baruch, Bangalore, Andhra Pradesh, Hyderabad, Bhopal, Rajasthan and Belgaum). The not-known case is because this one surrogate mother had neither met the commissioning parent nor has she seen the face of the children (Refer SM1).

Table 5 : Source Countries of Commissioning Parents (CMs) and payment pattern

Source Countries	Number of CMs	Percentage of CMs	Average payment to SMs in lakhs[6]
NRIs	10	15.87	4.09
From abroad	26	41.27	4.26
Indians	26	41.27	3.37
not known	1	1.59	
Total	63	100.00	3.85

The average remuneration received by surrogate mothers was 3.85 lakhs (Refer Table 5). On an average the remuneration paid by commissioning parents from abroad (4.26 lakhs) was slightly more than local Indians (3.37 lakhs). The average remuneration paid to surrogate mothers by NRIs (4.09 lakhs) was also slightly more than local Indians (3.37 lakhs).

Surrogate mothers mentioned that; the payment for twins was higher as compared to single babies, birth of boys meant a higher payment as compared to single girl babies. Even the complexion of the babies has determined the payment of surrogate mothers. SM1 was paid lesser for the twins she gave because their complexion was not to the liking of the commissioning parents. Some commissioning parents who are slammed with huge bills by the clinic compensated it by reducing the remuneration of the surrogate mothers. Surrogate mothers do not know how much remuneration is actually mentioned on the contract as they don't have a copy of the same. The commissioning parents pay a lot more for the surrogacy to the clinic. I was informed that the commissioning parents paid Rs 14 lakhs for one child and about 20 lakhs for twins. The commissioning parents from abroad were charged a much higher cost. The profits the clinics made from their surrogacy clients from abroad as against the marginal payment they make to the surrogate mothers had hence turned this into a very lucrative business using women`s bodies.

8. Purpose of surrogacy

All the surrogate mothers opted for surrogacy as a means to earn money in a short span of time. They all said they would have done surrogacy even if the remuneration amount was lesser. Whatever money they received was anyways a big amount, says Parul (SM 7). Being poor, they would accept any amount but the remuneration of a surrogacy is generally quite low to be able to buy/build a house. All surrogate mothers said that they would not have done surrogacy if there was no money involved. *"There's no point risking one's life for nothing in return"*, says Parul (SM 7). *"We were already poor, who would do it for free"*, said Nitya (SM 4). Others said, they were doing surrogacy for a specific purpose, for their children`s education or for housing, they wouldn't do it for free. Savita (SM 36) described the entire surrogacy exercise as physically, and emotionally draining, hence she explains no one would do it for free of cost. Hence, altruism as a primary purpose of surrogacy can be completely ruled out.

[6] 100 thousand is referred to as lakh in India.

Most (77%) of the surrogate mothers (35 out of 45) got involved in surrogacy to buy/build a house. Out of them, most (25 out of 35) did manage to build/buy a house (71%). Of the 25 surrogate mothers who bought a house 15 (60%) had repeated surrogacies, and the others were additionally involved in egg donation and clinical trials selling their body in this market to buy a house. A few did surrogacy for saving money for their children`s education (3 households). None of the surrogate mothers who were poor and wanted to buy a house could do so in one surrogacy. It was only with a second round of surrogacy or involvement in all forms of body market such as egg donation and clinical trials that they were able to earn enough money to buy or build a house.

All the surrogate mother`s households had some means of livelihood, they were in a condition to work and were working but they wanted to upgrade their economic status, such as; from a labourer a more stable employment situation. Basic subsistence was not an issue in these households. However some households faced challenging situation such as; debts (two households) and loss of their home due to flood or deterioration (two households). Some specific family conditions such as; drunkard husbands or sick family members puts them further into a helpless position (SM 1, 16, 26, 31, 39). There are many more drunken husbands' cases, but these were the only ones who were severe and hence the surrogate mothers openly shared their situation. Sriya and Kalpika had children with disability and spent some of their surrogacy money on their treatment (SM 20, 32).

Food and clothing was not a major problem, the households were surviving, but health, education and housing was the main reason to do surrogacy in India. The reasons for doing surrogacy may be different from how they actually spend the money after surrogacy. (Refer section 15) The Government of India needs to focus on providing cost-efficient housing, education and health care for the poorer people of India, as a priority.

9. Agency and Decision Making

Before the surrogacy contracts are actually signed there is a ground work being done by the clinics through a widely spread out network of surrogacy agents, doctors and nurses in the Western India belt from Ahmedabad to Mumbai. The surrogate agents look for poor women in their neighbourhood, among friends and relatives, in drug trial clinics and among egg donors. Everyone involved in bringing a surrogate mother to the clinic gets a commissioning after the child(ren) is handed over to the commissioning parents.

In this study, three major surrogacy agents; Narmada & Sarala (SM3), Kalpika (SM32). and other smaller agents take women to the clinic for surrogacy for a commission in return. Dr. Nisha is well connected with clinics throughout the Western belt in India and she spreads a word to all her networking clinics to supply her with poor women willing to become surrogate mothers.

One of the agents in my study, also asked me several times to provide her with the contact information of the surrogate mothers who have slipped back into abject poverty so that they can approach them for the body market business. I didn't share such information, but this is very much the approach adopted by surrogacy agents to prey women into earning quick money

by coercing and convincing them into surrogacy. If the women seem to be disinterested, their husbands are convinced to influence the minds of the women.

Those women who have already become a surrogate mother once are constantly called up repeatedly by the clinic requesting them to return for another surrogacy. They are encouraged into this again by saying that they have a healthy uterus and they should come for another surrogacy. Similarly, the clinic calls up ex-egg donors regularly to return for egg donation. This is also the case for drug trials, the clinics maintain a database of all those who have participated in clinical trials once and their marketing strategy is to repeatedly call them up to return for upcoming trials.

9.1 Decision making regarding surrogacy

Women`s agency in getting involved in surrogacy is included in section II (motivation) and III (decision making) of the questionnaire. The narratives further reveals different forms of coercion by the husbands, family members and the role played by surrogate agents and clinics at this stage of the process.

All the surrogate mothers said that they were apprehensive about surrogacy. Most surrogate mothers were coerced by the big surrogacy agents; Narmada & Sarala (SM 2), and other smaller agents; Kalpika (SM 32). The second level of coercion is done by Dr. Usha or Dr. Nisha from this popular clinic in Anand. Dr Nisha informs doctors in other clinics to keep a watch on poor women working in their clinics to persuade them into surrogacy.

Dr, Nish had requested Dr Sejal (her sister-in-law) running another clinic in Anand, to watch out for poor women in her clinic. Dr.Sejal asked Mariam (SM31) to enrol for surrogacy. Mariam didn't want to do surrogacy; she felt it is like selling one`s own baby`. But Dr. Sejal persistently chased her. Dr. Sejal also spoke to her husband and coerced her through him into surrogacy. After one surrogacy, Dr.Nisha called her again to repeat surrogacy and she refused saying *"this money is sinful, I cannot do it again"*. While in another case, Nitya (SM4) wanted to go for surrogacy but her husband didn't allow her, so Dr. Nisha helped her in convincing her husband to allow her.

Gracy (SM2) felt surrogacy is not good for the society and her husband felt the same, but Sarala (SM3, also a surrogacy agent) coerced both her and her husband for hours and pulled her into surrogacy. Dimpy (SM15) was coerced by her husband to accompany his sister into the surrogate home. Several surrogate mothers was very apprehensive about surrogacy but their husband convinced them to go (SM11, SM5). Kalpika (SM32) was very scared about surrogacy but was convinced by a popular surrogacy agent and Kalpika herself went on to become a surrogate agent coercing other women into surrogacy in return for money. Madeeha (SM39) felt it was morally wrong to do surrogacy, but her husband convinced her into it. Several surrogate mothers felt, even if they die, its fine, but they would sacrifice their life for the sake of their family. (Refer SM7, 20, 21, 24, 28, 35, 42)

9.2 Selection Criteria

The Universal Declaration of Human Rights, Article 2, states, "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property,

birth or other status" (UNESCO 2006). But the surrogacy clinics in India blatantly violate this human rights by choosing surrogate mothers on the basis of their class, colour, religion and social origin (caste). This human right is blatantly violated in the surrogacy selection criteria adopted by the clinics. A popular surrogacy agent revealed that good looks, religion and caste preference is strongly practiced in selecting surrogate mothers in clinics not only in Anand but also all over Gujarat. Fair complexion was the clinic`s criteria for choosing Madhuri (SM1). Especially after she gained popularity among commissioning parents as an egg donor. `Younger women` was another factor of preference in selecting surrogate mothers. Madhuri (SM1) was rebuked by the commissioning parents when she gave birth to children not as fair in their complexion as her own skin.

A popular surrogacy agent said Christians from abroad wanted Christian surrogate mothers (SM 3, 31). Muslim commissioning parents from Middle-East and Bangladesh specifically looked for Muslim surrogate mothers (SM 3, 29). Poor women were transported from Western India (Gujarat) to South India (Kerala) to cater to the needs of Muslim commissioning parents coming from the Middle-East. Kerala is a state in India that has been supplying labour force to the Middle-East since the 1970s and more recently has been providing medical tourism to people from the Middle-East. This is a new form of reproductive market developing in this Southern state. In this study, Madeeha, Saara and Rabia (SM 39, 40 & 41) were transported to Kerala, confined in a house for 10 months, exploited and paid lesser than the promised amounts and sent back in trains to their respective home towns.

Hindu commissioning parents and the clinics preferred certain castes in selecting women as surrogate mothers. Patels[7] were generally preferred as surrogate mothers and were also paid more compared to other castes. Especially Patel commissioning parents wanted Patel surrogate mothers. (SM 3,4,5) The behaviour of the surrogate mothers was also another criteria. Neelam (SM 38) explained that commissioning parents are justified is choosing women with a nice appearance, behaviour, caste and religion of their preference, as surrogate mothers carry their child(ren).

9.3 The Surrogacy Contract

None of the surrogate mothers were able to read the contract as it was in English language and hence could not understand what is written in the contract. The main points that Dr. Nisha explained to the surrogate mother and her husband while signing the contract were; she could die of surrogacy and if that happens it is not the responsibility of the clinic, she has no right over the child, she will have to obey all the rules stipulated by the clinic during the surrogacy and the husband is specially warned that if she dies or her uterus is removed, it is not their responsibility and he should not come fighting at the clinic.

Gracy (SM2) was made to sign on blank papers and the contract was printed on it later. None of them were given a copy of their contract. They all realise that this is a violation of their basic human rights, but they do it because they feel helpless at the mercy of the clinic for money. The payment pattern is designed in such a way that the power is maintained in the hands of the clinic until the child(ren) is handed over to the commissioning parents.

According to the rules of the clinic, all the payment that the commissioning parents make to the surrogate mothers has to be routed through the clinic. One surrogate mother was

[7] Patel is a business caste in Gujarat.

complaining that many a times the nurse handing over the cash, flicks some money on the way. As the payment is all made in cash, nobody has any record. It was this sort of unaccounted money transfers that the Government of India, since its demonetisation policy in 2016 tried to curb by increasing the reach of digital payments by using mobile applications and smart cards. But it is yet to catch on in a big way. Since 2016, the cash transfers that was the norm in the clinic has now changed to direct back transfers and hence there is now proof on how much payment was made to the surrogate mothers.

The surrogate mothers cannot argue or bargain, they are supposed to receive quietly whatever money they are given as remuneration and many are given bonus amounts too, that is typical of India. The surrogacy contract was for 2.5 lakhs before 2012, which increased to 3.5 lakhs in 2013. 25 thousand was paid to the surrogate mother on the successful completion of 4th month and another 25 thousand on the completion of 6th month of pregnancy. This payment was supposed to be cut from the final payment but sometimes the commissioning parents don't cut this amount. Some commissioning parents pay an extra bonus at the end of the surrogacy, after the baby is handed over. For example, Kaavya (SM 12) was paid an extra of 1 lakh Rupees. There is not much payment for miscarriage even if it happens later in the pregnancy. For example, Ujwala (SM9) was paid Rs 35000 for miscarriage at the fifth month.

10. Medical Aspects

In a natural pregnancy, the woman's entire body prepares itself for the process and childbirth. The uterus lining thickens itself preparing for embryo implantation. Implantation is a process in which the growing embryo attaches itself to the thickened uterine wall. Accordingly, the body enables formation of the hormones needed to prepare the uterus for conception, maintain the pregnancy and help the embryo grow and develop until childbirth. However, a surrogate pregnancy is not a natural conception and these hormones must be introduced into the surrogate mother`s body through medication. To maintain the pregnancy, the surrogate mothers are injected with hormones throughout the pregnancy. The hormones; oestrogen, progesterone and lupron used to create and maintain this artificial pregnancy has several side effects and sometimes severe detrimental long-term health impacts. This information is not given to the surrogate mothers beforehand.

Some surrogate mothers had breastfeeding children at home. The first medication given to such women was to dry up their breastmilk (SM2). This medication also has several side-effects that are not informed to surrogate mothers.

`Over-medicalisation` and `painful` were the two commonly expressed words used by almost all surrogate mothers to describe their entire surrogacy pregnancy and especially the embryo transfer stage. Over-medicalisation meant ultrasound every second week, at least 12 to 20 medicines given every day, the hormone injections, caesarean section and all the medical procedures or specific emergencies that they experienced during the surrogacy.

Gracy (SM 2) described the surrogacy process, *"as soon as I put my foot into the hospital for surrogacy, the endless saga of medicines and injections began"*. They are neither informed about any of the medications given to them nor can they question anything. She described the

hormone injection as; painful, unbearable. Surrogate mothers carrying twins are given injections every day, while those carrying a single baby were given the same on alternate days.

Renuka (SM 45) had a haemorrhage after her delivery and her uterus had to be removed and hence she explained her pain (SM 45). *"The gestone injections were very painful"*, Sarala (SM3) said and hence she didn't take any injections throughout her pregnancy. Being a nurse, she convinced them that she would take it herself but she actually threw the injections. Many of the surrogate mothers specifically described the injections after embryo transfer and later in the pregnancy as extremely painful and that they are still suffering pain in places they received the injections (SM 4, 5, 8, 9, 14, 17, 22, 24, 26, 29, 32, 38, 43). Others expressed the pain they experienced in general with the medical interventions (SM 6, 10, 11, 12, 17, 22, 36). Some said they didn't return for another surrogacy due to the pain experienced (SM 36). One surrogate mother expressed pain during and after egg donation (SM15). While a very few said, "it doesn't matter" and that for the sake of money one has to endure some pain (SM11). Some expressed the pain after caesarean as unbearable and they continue to experience some pain years after the operation (SM 14, 21, 26, 29, 31, 44). Some of the surrogate mother`s present economic situation is so disastrous that the medical pain seems trivial (SM (8, 14, 23, 30, 31, 43). Madeeha`s cervix was stitched (cervical cerclage) throughout her pregnancy and hence she experienced severe pain (SM 39).

There are some specific cases that need a mention; one is Ujwala`s second surrogacy miscarriage and the second is Renuka`s removal of her uterus. Ujwala went for a second surrogacy because her remuneration after the first surrogacy €5500 was insufficient for her to buy a house. She became pregnant on the fourth IVF attempt with two girls and one boy. Dr. Nisha decided to selectively aborted the second girl foetus. Selective abortion of girl foetus is illegal in India under the PCPNDT Act 1994[8]. Nargisa (SM 14) says she was very upset that Dr. Nisha had done this procedure on her. After this procedure, Ujwala developed uterine infection and began bleeding. She was kept in an intensive care unit as her blood pressure kept on increasing and the heartbeat of the children was falling. In the fifth month, the babies were removed after a caesarean and the other two died ten days after birth as well. She was badly shaken by this experience, which was a near-death incidence. Renuka (SM 45) developed haemorrhage after delivery and her uterus had to be removed. Hence more than the pain during the pregnancy, she spoke about this near-death situation.

11. Relationship with the children

All the surrogate mothers invariably said that they felt an attachment with the babies and this attachment was as much as they felt for their own children. Except for one surrogate mother (SM 36) who felt she didn't feel the same extent of attachment as compared to her own children. They all said that there should be a system in place that allows the children to find out their surrogate mothers if they wanted to. The clinic plays a gatekeeper`s role in restricting contact

[8] Pre-Conception and Pre-Natal Diagnostic Techniques 1994 that was enacted with the intent to prohibit prenatal diagnostic techniques for determination of the sex of the foetus leading to female foeticide.

and information between the commissioning parents and the surrogate mothers. Saadia gave me her commissioning parent`s email address and told me not to inform Dr. Nisha and contact to them directly, otherwise if she gets to know she chastises the surrogate mothers for contacting the commissioning parents.

Those who were unable to see the child(ren) keep wondering thinking *how the babies would like? how big they would have grown?* Parul (SM 7) had a disheartening experience. She couldn't bear the separation. At some point she felt, she didn't want the money, it was just the child that she wanted. She thinks she could have asked for custody of one of the children before she signed the contract. Some surrogate mothers were never shown the face of the babies, others were shown but keep aloof (that allowed to touch/hold them). Madhuri (SM1) said *"they didn't allow any sort of bonding after birth"*. Their duty was confined to providing breastmilk using pumps. Some surrogate mothers were looking after the babies as nannies and they bonded intensely with the babies. All these surrogate mothers are experiencing the pangs of separation. More about the impact of this separation on the children is detailed in section 13.2.

12. Relationship with the commissioning parents

The clinic does not allow the commissioning parents to contact the surrogate mothers directly. This is one of the reasons why they are kept in surrogate home. They also restrict direct money transaction to take place between the two parties. Even after the surrogacy, if Dr. Nisha comes to know that the commissioning parents have paid the surrogate mother any money directly, she calls the surrogate mother to the clinic and scolds her. This disturbs the surrogate mothers because except for a very few who have been paid well, most surrogate mothers feel the payment was very low for the extent of physical and emotional burdens that they have endured.

Additionally, all the surrogate mothers were unhappy with behavior of the commissioning parents describing them as heartless, selfish and insecure. The abrupt way in which they walk away with the children after using the surrogate mothers for birthing and breastfeeding the child(ren) has hurt them. Haught, cruel, inhuman, distanced, secretive, cunning, ungrateful and non-communicative are some of the words that surrogate mothers have used to describe the commissioning parents. A very few surrogate mothers had some nice words to describe them.

Regarding the payment, Yasifa (SM 29) says "we sacrificed our life for this, if we don't even get a decent payment in return, what is the purpose of doing this." The extreme inequalities between the commissioning parents and surrogate mothers leaves expectation among the surrogate mothers that the couple should help them more than what is written in the contract. The surrogate mothers feel that there needs to be a continued support from the commissioning parents to help them out of poverty or for them to build a house and have a sustainability in their lives. The surrogate mother considers the commissioning parents to be their extended family members. Hence this contract is not as simple as it seems, there are several complexities of human relationships that are knowing or unknowingly ignored by the commissioning parents. The clinic knows these expectations in minds of the surrogate mothers but they choose to ignore it.

Several surrogate mothers described the commissioning parents as, *"once their work is over, they have nothing to do with us anymore"*. (SM 4, 5, 7, 8, 12)

Almost all surrogate mothers felt the commissioning parents were to be equally blamed for their sorrow. *"We cut open our stomach only for their children, for our children we have normal deliveries. They rented our womb, used us like a material, paid some money and left, as though we mean nothing more to them. No humanity in them, at least once in a year wouldn't they remember us and call us up, if they have any humanity left in them"*, said Megha (SM 44).

There are also serious issues that some surrogate mothers mentioned. Manjula (SM 23), who had a serious complication in the next pregnancy after her surrogacy. Her case is detailed in section 12. The question that remains is that if the surrogate mothers face a serious birthing complication in her life following the surrogacy, will it not be a responsibility of the commissioning parents to know about this and help her if possible? When some of these surrogate mothers continue to live in abject poverty wouldn't it be more humane that the children born and the commissioning parents are at least aware of this situation and help if possible.

13. Relationship with the clinic

All surrogate mothers, except a very few, described the clinic and Dr. Nisha as opportunist, exploitative and dominating. One surrogate agent told me that the surrogate mothers treat her like God and would fall at her feet when she entered the room. She controlled the surrogate mothers with an overpowering aura; her dressing style as well as her speech.

There are several inhuman activities that are being practiced by the clinics. There is no law that restricts women from being detained during pregnancies and Dr. Nisha misuses this to her advantage. None of the surrogate mothers were happy leaving their children and family behind to stay at the surrogate home. They are doing so only because the clinic has imposed such a mandatory rule supported by the commissioning parents.

"After we have signed the contract, we cannot speak. Whatever is the hospital rules, we have to follow. We can't speak to Madam (Dr. Nisha) regarding any matter."
In Kaavya`s (SM 12) words

Dr. Nisha has imbibed a fear psychosis into the surrogate mothers that if they don't follow the clinic rules, they would have a miscarriage. Hence most of the surrogate mothers followed the rules diligently. Some who raised any opposition were harassed further or not allowed to return home under any circumstances. Sangeeta, who died as a surrogate mother, was blamed for not following the clinic rules as a reason for her own death.

Most surrogate mothers do not understand the meaning of psychological counselling but a few who understand it. say they have not received any such support and all surrogate mothers should be supported with counselling.

Most surrogate mothers complained that the clinic pocketed most of the profits and paid a meagre amount to the surrogate mothers. Some of the cash and gifts that commissioning parents sent to the surrogate mothers at the surrogate homes was pocketed by the hostel matron. Some

of the money that was meant to be spent on buying grocery, dry fruits and fruits for the surrogate mothers was also pocketed by the hostel matron. They are even more angry after the clinic built a massive all-inclusive hospital complex; with an in-built surrogate home, neonatal clinic, rooms for the commissioning parents and shopping area. The inequalities have become even more stark after her clinic complex was built. (Photo 2)

Many surrogate mothers said they were treated in an inhuman manner. After delivery (almost all caesareans except two cases), the surrogate mothers were kept for two days in the hospital and thereafter they were shifted to the children`s hospital to provide milk for the newly born using breast pumps. In the children`s hospital, they were kept on the third floor while the children were kept in a special care unit on the first floor. The surrogate mothers were strictly restricted from entering the room in which the babies were kept in incubators. They could stand outside and see the babies through the glass. Third day after the operation, they have to climb down the stairs, pump out milk and the bottles are given to nannies or nurses to feed the babies. They are not allowed to touch/hold the babies. Only some commissioning parents allow them to touch/hold the babies. They not only feel alienated and humiliated but also the pain of climbing up and down the stairs and pumping out milk using pumps immediately after the operation is felt more intensely. They have to keep doing this from 8 days to one month as desired by the commissioning parents.

They are given good beds and rooms until the delivery and this quality of services drops drastically after the delivery. They hence feel they are used for the purpose of the child and thrown thereafter. Surrogate mothers who face health problems post-delivery are not entertained easily by the clinic, unless it emerges as something very serious. Some surrogate mothers return to the clinic for their own pregnancies and are slammed with high bills so that they turn to government hospitals. Once the surrogacy is done, the clinic has nothing to do with the surrogate mothers. The surrogate mothers said, they are not allowed to meet Madam (Dr.Nisha) easily.

Manjula (SM 23) became pregnant after surrogacy and had approached Dr. Nisha for her antenatal care but she couldn't afford their huge bill and went to a Civil Hospital. She experienced a severe obstetric fistula while giving birth to a boy child. She approached Dr. Nisha again for help and she was then treated at a concessional rate. Manjula cried while talking to me thinking about her experience.

The sisterhood that researchers have referred to, is not visible in the relationship between the surrogate mothers and the commissioning parents (Pande 2011). It ends as soon as the baby is handed over and the surrogate mothers are paid for their birthing, breastmilk and nanny service. But when she faces health crises such as Manjula did, neither the clinic, nor the commissioning parents or the co-surrogate mothers with whom she associated as sisterhood had anything to do with her troubles.

Yasifa`s (SM 29) sister-in-law also attempted surrogacy and had a miscarriage. 15 days after she was sent home she began to bleed heavily and approached the clinic but she was refused treatment. It was only when her health deteriorated very badly that she was taken in the clinic for treatment. Yasifa had to request one of the nurses to speak to Dr. Nisha to provide her with treatment. The nurse convinced Dr. Nisha to treat the surrogate mother, before something serious happens and she dies, it is only then that she took her case.

One surrogate mother, Sangeeta, who died during surrogacy in the year 2012 was not reported in any media. Another surrogate mother who died during egg donation, this was also never reported in media. Both were associated with this popular clinic in Anand.

Many surrogate mothers complained that Dr. Nisha promised that she would provide a pension for the surrogate mothers, but has not kept her promise. Some wanted me to approach the clinic with this demand.

The clinic provides one school bag and a few books for the children of the surrogate mothers every year. But this year, they have stopped this distribution saying that the law banning surrogacy will be implemented soon and since surrogacy will be closing down soon, hereafter they will not get any bags.

The clinic is frantically calling up all the surrogate agents and surrogate mothers to enroll for surrogacy one last time, as this would be their last chance before the law banning commercial surrogacy is enforced. Once the law is passed at the Rajya Sabha, commercial surrogacy will no longer be possible.

14. Psychological (emotional) Impact

Sadness was mentioned by almost all surrogate mothers, except for a few. Some of the major emotional impact that surrogate mothers have experienced are; attachment with the child(ren) and the depression of parting or not having ever seen their face, the depression of leaving their family and living in the surrogate home and the rejection and alienating attitude of the commissioning parents. Some of the problems faced with the commissioning parents and attachment with the surrogacy child(ren) has already been discussed in sections 6 and 7.

14.1 Impact of leaving home

All the surrogate mothers expressed grave sorrow in leaving their family and children to stay in a surrogate home that is not far away from their family home. Gomati (SM 17) shared symptoms that were clear signs of depression, but she was not supported with any psychological counselling. The children are left at home with the father, in-laws, or other relatives.

Kamala (SM22), a single mother at that time, had left children with her brother and his wife. The children were harassed by them and they are still angry that Kamala left them there. Shruti (SM 16) pulled her children out of school for one year to live with her at the surrogate home. Her husband was an alcoholic and she couldn't leave them home alone with him. Mercy's (SM 8) husband started drinking and became an alcoholic, her daughter ran away with a boy. She feels guilty about not being able to take care of her family when her work required her to remain out of home for months together. Nitya`s(SM4) husband fell in love with another woman while she was in the surrogate home. Similarly, Banu`s (SM 5) husband started having affairs since she left home for her first surrogacy.

The surrogate home in the new building is underground and the surrogate mothers who did surrogacy after 2014 expressed the distress of staying in the basement. Earlier they had some open air, a balcony or windows for fresh air, but the new clinic seems like a cage where they feel very uncomfortable and distressed staying. Earlier they could step out of the building occasionally but now they are completely caged.

14.2 Impact of the Attachment with the child(ren)

None of the surrogate mothers could maintain any contact with the children, except for one. They are living with the pangs of separation, except one surrogate mother who said she has managed to disentangle from that emotional bond. But invariably all the surrogate mothers said they would want to know the well-being of the babies after giving them away in any possible. Some surrogate mothers argued that it is the right of the child to know about their birth mothers. Other surrogate mothers questioned why their name was not on the birth certificate of the child. Some requested me if I could do something about this situation.

The only time Nitya (SM4) was allowed to see the children and hold them was for a media video shoot which lasted only for about 10 minutes. She has saved that newspaper dearly as that is the only time she held the babies and is the only proof she holds about her surrogacy and of the children.

The helplessness on having no rights over the children was expressed by all the surrogate mothers. The common expressions were; what can we do? what right do we have? what is the point of bonding? how would they (the children) be looking now? what would they be doing now?

When I was asking Sneha about the children she began weeping and weeping and I had to stop my interview and give her time to recoup. (Photo 3)

Parul (SM 7) was called upon to take care of the twin boy child when he fell sick after birth. She obliged and helped in caring for him for three months. During this time, Parul bonded with the baby boy and felt extreme loss and alienation when they walked away without any further contact. She repeated surrogacy and the second time, they didn't show her the face of the baby girl just because she had become attached to the baby boy after the first surrogacy. Anyone who doesn't follow the rule is chastised is some form or the other. Cameras were allowed inside the operation theater and her entire second surrogacy delivery was videoed without her consent. And when she pleaded to see the child, they were abruptly taken away. Seeing her plight, the camera person returned briefly just to show her the face of the girl child. (Photo 4)

Deepti (SM 10) bonded with the single girl child because she doesn't have any girls. Similarly, Mercy (SM 8) became attached with the surrogacy baby boy because she had lost her boy child after delivery a few years before the surrogacy. She was also attached to the children she looked after as a nanny and the commissioning parents went away without keeping any further contact. (Photo 4) Hence it was not only the surrogate mothers but the nannies who were also treated in a similar alienated manner.

Ujwala, the best-case scenario in my previous study, where the commissioning mother Caroline had kept in touch with her, is detailed in my book (Saravanan 2018). Now after 10 years, Caroline has maintained no further contact with Ujwala and she was yearning to hear

something from the children or from them. She requested me to send her an email, which I did, but that email is not valid anymore.

Almost every case mentioned in the report reveal a saga of sorrow, yearning, emotional attachment and the feeling of being used and cheated by the commissioning parents and the clinic.

14.3 Impact of social stigma

Mercy (SM 8) spoke about her neighborhoods; they speak ill about her character because she was involved in surrogacy. since she went for surrogacy, she was mostly out of the house taking care of babies for commissioning parents as a nanny,

Gracy (SM2) herself feels that she has sold her child and rented her womb and feels guilty about this. She feels surrogacy being a sinful and dishonest act, she couldn't put that money she earned to any useful purpose. All her neighbors and relatives tell her that she has done something sinful by selling her babies. Similarly, Mariam (SM 13) was upset that her husband met with an accident on the same day she heard about the embryo transfer result. Hence, she feels this is a sinful act and hence her husband paid a price for it.

Kamini (SM 26) said, *"What I did, was a sin. Why should I take another person to commit the same sin? That other lady will also suffer like me."*

The pastors in Catholic churches give speeches dissuading women to do surrogacy and one surrogate mother expressed her sadness when she hears him speaking against it.

14.4 Impact on the surrogate mother`s existing children`s lives

Gracy's young son was two years old and remembers that she gave away two babies. He questions her on why, to whom did she give the children and where are they now? When she has no answers to these questions and cries, he pacifies her by saying maybe it's good she gave the baby away because she struggles to take care of him, caring for other two children would have been a big burden on her.

Shruti`s (SM 16) young children were present during her delivery. They were shown the baby girl on birth and introduced as "your baby sister" and then taken away from them forever.

Kamala`s (SM 22), 21-year-old grown up daughter questioned, "aren't those babies my mother`s too?". She questions the intentions of the commissioning parents who choose to use other women`s bodies to have children just because they think their genetics is superior over others. (Photos 5 & 6) There needs to be more research focus on the impact of surrogacy on the children of the surrogate mothers.

15. Physical (health) Impact

According to WHO, 99 percent of the maternal deaths occur in developing countries (WHO 2018). In India, maternal death is known to be highest among the poor and non-literates (Khan and Pradhan 2013). A lower economic status, early marriage, early childbirth and substandard adolescent health are factors that make the surrogate mothers in India vulnerable to maternal morbidity and mortality and also impacts their bargaining capacity within the surrogacy process

A recent study found that "surrogate births had significantly higher obstetrical complications, including gestational diabetes, hypertension, use of amniocentesis, placenta previa, antibiotic requirement during labour, and caesarean section" (Woo et al., 2017: 993). Corroborating this information, many of the surrogate mothers in this study had experienced serious maternal morbidities in the surrogacy pregnancies which they had not experienced in their own pregnancies. A few women in this study had themselves experienced near death situation, some had serious complications and others developed morbidities during the pregnancy, while some witnessed others experiencing near-death situation or death.

In this study, Raksha (SM 45) experienced a near-death situation; she had a hemorrhage after her caesarean and her uterus had to be removed.

All deliveries were caesarean except for one surrogate mother who gave birth spontaneously before she could be operated upon.

There were severe problems experienced by some surrogate mothers. When Gracy (SM 2) was inside the surrogate home, one surrogate mother died. She also witnessed one near death incidence of another surrogate mother when she was in the surrogate home and was petrified with this experience. Sarala (SM 3) witnessed a surrogate mother who experienced a near-death situation during her delivery and her uterus had to be removed. Gomati (SM 17) also witnessed another surrogate mother who experienced near-death situation when she was in the clinic and hence she was depressed while she was inside there.

Gracy (SM 2) developed thyroid, Banu (SM 5) had high Blood Pressure, Mercy (SM8) experienced meralgia paresthetica post C-section (paraesthesia and numbness of the upper lateral thigh area). Other problems faced by Gracy (2), during the medical interventions was that her nerve has been affected adversely. Kamini (SM 26) developed blood pressure and thyroid, Ujwala (SM 9), Nargisa (SM 14) and Yasifa (SM 29) also had blood pressure during pregnancy. Sunita (SM 24) and Kamini (SM 26) developed diabetes. Sarala (SM 3) and Sunita (SM 24) were discussing about other surrogate mothers who developed cancer and HIV post surrogacy. There is evidence that maternal-foetal genetic sharing increases maternal susceptibility to some diseases such as autoimmune diseases and cancer (Boddy et al 2015). While the maternal-foetal resource conflict causes maternal blood pressure, diabetes and thyroid.

Many of the surrogate mothers believed that it was the excessive hormone medication that caused these health problems. They also had a feeling that many of these diseases that they developed during pregnancy was actually transferred from the commissioning parents into their body through the child.

Many surrogate mothers revealed that they experienced extreme forms of pain during the surrogacy pregnancy as compared to their regular pregnancy. (Refer section 5)

Many surrogate mothers said they were experiencing health problems post surrogacy leaving them with a lowered capability of even doing regular chores (SM 2, 8, 5 and many more). (Refer Case Studies) Mercy (SM 8) expressed that her body is wasted post-surrogacy,

One surrogate mother (SM 28) thinks she won`t live long because of the two surrogacies she was involved in and that she won`t be alive to see her children growing up. But she says that she has done her duty by earning money for their future use.

16. Financial impact

It is portrayed in popular media, IVF clinics and also some researchers emphasise that surrogacy is a win-win situation, that it brings poor households out of poverty while providing babies for the infertile. This study reveals that women from very poor households have to repeat surrogacy at least two times to bring the family out of poverty. This is at the cost of a very high physical and psychological well-being. (Refer section 9 and 10) Women from very poor households who have done surrogacy only once, have slipped back into abject poverty. Several poor households (12/45 27%) have slipped back into abject povertyy or bare subsistence level after one surrogacy. For the very poor, surrogacy money brings in a sudden influx of money which many spent on household expenses such as TV, fridge, scooter, bike or spent it on their daughter`s marriage or health care treatment. This sudden influx of money did more harm to many of their lives of the very poor than any good, unless they go for another surrogacy to make up for this loss.

Those living in abject poverty have only been able to buy some basic needs or pay off debts after the first surrogacy (SM 20, 29, 30, 31, 45). These women didn't repeat surrogacy because of its adverse effects on their physical and emotional health and moral considerations. (Refer sections 9 and 10)

None of the poor surrogate mothers have been able to buy or a build a house after the first surrogacy. Many became a surrogate mother to buy/build a house but could not do so after one surrogacy and hence repeated the process (SM 4. 5, 6, 7, 12, 13, 19, 22, 25, 28, 32, 42).

The land/house owning households have been able to buy better means of income source such as; an autorickshaw, tempo, sewing machine, an extra piece of agricultural land or livestock (cows, buffaloes) with the surrogacy money (SM 15, 16, 17, 18, 33, 37, 38, 44).

Banu (SM 5) did two surrogacies but her husband got into a habit of spending the money that his wife earned and started taking loans regularly. He sends the money lenders to her to claim the amount and to repay this she went again for surrogacy, egg donation and clinical trials. She built a house and rented out a shop and also bought an autorickshaw and yet she is in deep financial crises.

For some women, surrogacy has pushed them further into the vicious circle of selling their body at the cost of their life, health and psychological well-being (SM 1,3,4,5,9.13, 14, 22,32,

39,40,41,42). Despite repeating surrogacy, Kinjal (SM6) did not have enough money to buy/build a house. She spent the money from her first surrogacy on buying household items.

One surrogate mother (SM 31) experienced a misfortune, her husband met with an accident on the day her embryo transfer came out as positive and she spent all the surrogacy money on his treatment. She didn't repeat surrogacy because she felt this was a sinful act and hence she experienced this misfortune. Nargisa (SM 14) was involved in surrogacy and donation of her eggs for eight times, four before and four after surrogacy and she had to sell the house she bought and is now in abject poverty and deep debt. After seeing the huge influx of money through surrogacy and egg donations, her husband has become greedy and has got into a habit of lending money from anyone.

Another surrogate mother experienced a severe health problem, obstetric fistula in her pregnancy following the surrogacy. She spent all her money on this treatment. Mercy (SM8) was a popular surrogate agent in 2009, but now she has lost that source of earning and has slipped back into abject poverty because she has no other sustainable source of income. Madhuri (SM1) and Sarala (SM3) are likely to follow the same pattern as they are both dependent on money earned as an agent in surrogacy, egg donation and clinical trials which is not a sustainable source of income. Kalpika (SM 32) is also an agent but she now works in a hospital as a cleaner and hence can sustain her household income. Saadia (SM 30) slipped back into poverty because she was very poor and bought a house with her first surrogacy, her mother-in-law fell sick, they fell into debt and she had to sell the house. Now they are living in a shanty close to the railway line.

Only one surrogate mother from a poor household, who stopped after one surrogacy could build a house. And this household was already above subsistence level and with a sustainable income.

Madhuri (SM 1) is a seasoned agent and is somewhat stabilised after three surrogacies, several egg donations and the commissions she has earned as an agent in the body market. Mercy (SM 8) was a similar agent in her younger days, but now she has slipped back into abject poverty because this was not a sustainable form of earning.

Gracy (SM 2) spent all the money in trying to go to Israel after her first surrogacy and did not repeat because she felt that surrogacy is not only painful but also a sinful act.

Sarala (SM 3) has got into the vicious circle of selling her body to the body market.

Those living in abject poverty have had to do another surrogacy to be able buy an autorickshaw, a tempo or a tailoring machine, as a source of income or built a house with the second surrogacy (SM 6).

It is only those households who are already living above subsistence level have been able to some sort of a means of sustainable earning in the first surrogacy that is; if they could use the money effectively or didn't face any health or other incidents in the family.

Land owners and the households having a source of income have been able to make good use of the surrogacy money (SM 7, 11, 15, 16, 17, 18, 23, 33, 43, 44, 45). Dimpy (SM 15) already owned agricultural land and bought an extra piece of land with the first surrogacy; with the second surrogacy they bought buffaloes.

For most of the households living on subsistence, one surrogacy only brings in the basic necessities. Women have to go for a second surrogacy for the money to have any financial impact. For the very poor, the first surrogacy brings in a sudden inflow of a huge amount of money into the household. The second surrogacy stabilises the income and it is the third surrogacy that brings some form of sustainability.

17. Conclusion

This report reveals certain findings that reconfirmed many of my previous research findings, filled some gaps and some new evidence that emerged about; severe forms of violation of medical ethics, some financial advantage at the cost of severe adverse impact on surrogate mother`s physical and emotional wellbeing and on their family`s lives. Their relationship with the clinic, commissioning parents and the children born were completed controlled by the clinic and according to the whims and desires of the commissioning parents. The Muslim women were trafficked into surrogacy from Ahmedabad to Kerala because their bodies were pawned with conditions that they were not informed about, their fundamental human rights were violated and they were mistreated, disrespected and finally paid lesser than what they were promised.

The laws preventing commercial surrogacy in India is having an impact. Clinics around Anand and Ahmedabad have been calling up the surrogate mothers from the database information to ask if they are interested to enroll for surrogacy as the practice is going to be banned soon. Bharatiya Janata Party, having won the 2019 elections, it is expected that they will carry forward the ban on commercial surrogacy into the Rajya Sabha.

This study revealed that; women feel they have been abused, mistreated, manipulated and exploited. They feel their wombs have been rented. The altruistic motive is rarely mentioned by them after years of surrogacy. They carry tremendous feeling of hurt and betrayal towards the commissioning parents and the clinic. They have a craving to see the child and know about their wellbeing. Many women have not been able to build the houses for which they did surrogacy. Some houses have been built with the surrogacy money at the cost of women`s health and well-being. Most surrogate mothers face health problems that have lasted for more than 5 years. They do not have the capacity to work as much after the surrogacy medical treatment, multiple embryo transfer trials, miscarriage and some serious morbidities during pregnancy.

A popular clinic in Anand, continues to transfer five embryos into the surrogate mother's uterus and performs in-utero sex selective abortions of foetuses inside the womb if more than two foetuses survive. This is completely illegal in India. This clinic also continues to keep surrogate mothers compulsorily in surrogate homes against their wishes which is not legal nor illegal by law. Detaining women is a human rights violation. Recently surrogate mothers are detained in the basement of a large clinic building with no windows. Overall, this practice has caused huge adverse psychological problems as well as family problems to surrogate mothers. The surrogate mothers have never been given a copy of the surrogacy contract.
There was a death of a surrogate mother in Asha clinic in Anand Sangeeta died in 2012 during surrogacy and this never came out in news, it was all hushed up. Many women are facing near death situations and or their uterus have to be removed due to haemorrhage but this never

comes out in news. Some other clinics in Gujarat are engaging in some unethical practices such as; one smaller clinic in Anand was using the surrogate mother's egg for surrogacy. Poor Muslim women from Ahmedabad were being transported to one Gift clinic, Athani, Ernakulam in Kerala to become a surrogate mother for couples coming from Dubai. They are kept in hiding in Aluva and forced into selective in-utero abortions, are paid lesser than what they are promised and not given a copy of the contract.

It is important to note that; it is generally thought that surrogacy is just another natural birth, but there is nothing natural about surrogate motherhood. When a woman becomes pregnant naturally her entire body and brain prepares itself for the pregnancy, but in surrogacy, her body has to be made ready artificially. This is done by pumping hormones into her body; right from increasing the uterus lining that hosts the embryo to maintaining the pregnancy until childbirth, as this is a foreign body. To maintain this foreign body (embryos created externally), she is given hormones injections throughout the pregnancy that are extremely painful with several and some serious side effects. Every successful pregnancy involves on an average, three embryo transfer trials. Many surrogate mothers whom I have met again after 5 to 10 years are now facing serious health problems after surrogacy.

Women's bodies are being used like a money-making object by the clinics, the family members and also women themselves who prefer to sacrifice themselves for the sake of their children`s and family`s well-being. This study reveals that give the complexity of medical practices and its physical and psychological impact on the surrogate mothers and their families, there cannot be an ethical form of surrogacy. Apart from passing the present Surrogacy Bill at the Rajya Sabha, I hope the Government of India gives a serious thought to these harms and calls for a complete ban on surrogacy in India. It would also be a suggestion that ex-surrogate mothers be included in the Pradhan Mantri Shram Yogi Maandhan (PMSYM) scheme which entails a minimum of Rs 3000 pension for the unorganised sector workers.

There is a need to implement a strict control on all IVF clinics to monitor their activities. If nothing else, they are all involved in sex selective abortions and inhuman use of women's bodies for their own benefit. People need to be made aware of the inhuman procedure involved in surrogacy and the violations of human rights, because what is generally being published in popular media is nowhere near the reality of the surrogacy practices.

India banned commercial surrogacy on reported deaths of surrogate mothers and egg donors, custody battles for children, abandonment of disabled and undesired children and exploitation of women, apart from trafficking for surrogacy. The illegal networks trafficking young girls into prostitution and domestic work from poor localities in India were also being used for surrogacy. This study also revealed Muslim women being moved to Kerala to cater for surrogacy demand from the Middle- East. The surrogacy practice maintains patriarchy through familial persuasion and contracts that controls and exploits women's bodies and triple-alienation; from the children born, from their own body and physical alienation. Applying the reproductive justice framework, I argue that surrogacy is likely to put the surrogate mother through multiple forms of indignity and injustice along with physical, psychological and life risk and hence cannot be considered to be the intended parent's reproductive right. Although India banned commercial surrogacy, altruistic surrogacy is allowed and there are several loopholes left in this practice that is exploitative and a violation of human and child rights. Surrogacy hence needs to be included in declaration of universal human rights violation, from a reproductive justice perspective.

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PHOTOS

Photo 1: Ujwala, her husband and Dr. Sheela

Photo 2: New IVF Clinic Complex in Anand

Photo 3: Sneha and her Children

Photo 4: Parul and her Son

Photo 5: Mercy and Dr. Sheela

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