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"I am the baby's real mother": Reproductive tourism, race, and the transnational construction of kinship

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SYNOPSIS

This essay examines what I call "crossracial gestational surrogacy," a practice in which prospective parents of one race contract with a woman of another race to carry their child. I situate surrogacy within transnational circuits of reproductive labor, particularly "reproductive tourism" from the United States to India. This essay examines how Western notions of race and genetic determinism are mapped uneasily onto surrogacy in India, including the ways in which Indian surrogates resist or complicate these discourses in creating their own narratives of surrogacy. The essay also interrogates the question of agency; while many critique reproductive tourism in India as yet another example of the wealthy elite exploiting the labor of poor women of color, or celebrate it as an empowering transnational example of women-helping-women, the reality is far more complicated. Moreover, intended parents benefit from the racial and economic "differences" between themselves and Indian surrogates.

Introduction

Reproductive tourism—international travel for fertility and reproductive services—is an increasingly common phenomenon. Also known as "fertility outsourcing," "rent-a-womb," and "procreation vacations," reproductive tourism encompasses a range of practices that occur globally, including egg donation, in vitro fertilization, preimplantation genetic diagnosis, and commercial surrogacy. While many service providers and consumers build a pseudo-philanthropic discourse around the practice that focuses on the trope of "women helping women," these processes naturalize and justify an economic arrangement that is fraught with inequality. Reproductive tourism is often a deeply racialized endeavor that relies on class disparities between those who provide reproductive services and those who consume them in order to create a family built around genetic ties. One illuminating example of this inequality is in the practice of what I call "crossracial gestational surrogacy," in which intended parents commission a surrogate of a different racial background than their own. The surrogate, then, has no genetic connection to the developing fetus (Ragoné, 2000, p. 65).[1] This essay focuses on crossracial gestational surrogacy in India; here I analyze the discursive and cultural construction of this specific form of reproductive tourism. I connect socially constructed notions of race and genetic essentialism that travel alongside the reproductive tourist with the more benign discursive trope of "women helping women."

Crossracial gestational surrogacy has proliferated in recent decades due to technological advancements in the reproductive technology industry, as well as prevailing popular discourses of race. Many intended parents do not hesitate to choose a gestational surrogate of a different race because consumers of reproductive technologies are encouraged by popular scientific discourse to compartmentalize gestation and genetics, believing that the qualities that determine the identity of their future child are locked into their genes. This genetic essentialism, in which cultural meanings of the gene conflate with the scientific or biological, "reduces the self to a molecular entity, equating human beings, in all their social, historical, and moral complexity, with their genes" (Nelkin & Lindee, 1995, p. 2). The role of the surrogate is minimized when DNA is framed as the sole arbiter of the "true self," (Nelkin &

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Lindee, 1995) as reflected by the term "gestational carrier," which is often used in the ART industry as a synonym for "gestational surrogate." According to Melinda Cooper and Catherine Waldby (2014), this logic makes (comparatively) low-cost gestational surrogacy in India particularly appealing for U.S. clients, "because the surrogate makes no *genetic* contribution, hence her ethnicity leaves no trace on the child" (p. 64). In crossracial surrogacy arrangements, whiteness can be "commercially reproduced" at an appealing price (Cooper & Waldby, 2014, p. 65). Genetic essentialism also raises questions for how race is defined; when intended parents, surrogates, donors, fertility clinics, and others all play their parts in the fiction that race is reproduced genetically, then these actors and institutions are reinforcing a social "truth" about race rather than a scientific one. In other words, ART use has the potential to reify cultural attitudes about the biological basis for racial difference, while scientific and academic arguments to the contrary largely fail to trickle down into the popular consciousness. Analyzing the racialization of surrogacy, particularly when racial difference correlates with massive disparities in economic privilege, points to how ideologies of race and kinship travel alongside the reproductive tourist. It also marks the strategies used to naturalize and justify an economic arrangement that is fraught with inequality.

ARTs in a global context

With the commercialization of ARTs in the late twentieth century came varied levels of regulation among industrialized nations, as well as limitations on open access to these technologies. What has remained consistent is the reliance upon people of color and low socioeconomic status to meet the reproductive demands of the dominant classes. Technological advancements in the ART industry routinely outpace attempts to address their ethical and moral implications. What is legal and even state-subsidized in one nation may be banned entirely in another, or carry a price tag that few but the wealthy can hope to afford. Despite these barriers, the "end result" of ART treatments is for many such a precious commodity (to use a loaded term) that individuals are willing to cross borders of nationality, language, class, race, and even legality to achieve their goals.

Individuals who would be categorized as reproductive tourists have expressed discomfort with this term when interviewed by researchers. They describe the experience as costly, stressful, and motivated by desperation to have a child; nearly all research participants reported that they would prefer to access services in their home countries if the same procedures were available legally, safely, and at an affordable price. Restrictions come in a variety of guises: moral codes (such as barring unmarried people and gays and lesbians from ARTs), religious prohibitions, long waiting lists, prohibitive costs, and banning certain practices (most commonly sex selection, surrogacy, preimplantation genetic diagnosis, and gamete donation) (Ferrareti, Pennings, Gianaroli, Natali, & Magli, 2010). As a result, developing nations with lax (or nonexistent) regulations and cheap labor have increasingly become popular destinations for fertility services (Points, 2009). The emergence of such "global reproscapes" ties the commodification of gametes and wombs to a globalized landscape in which technologies, people, money, and beliefs about blood and family flow in multiple directions (Inhorn, 2011, p. 90).

Some countries that are now magnets for reproductive services were already popular destinations for a broader base of medical tourism such as heart, cosmetic, and joint-replacement surgery, as well as sex reassignment surgery (Pande, 2010). India, for example, attracts a high volume of medical tourists because of its advanced medical technologies, low costs, popular tourist destinations, and highly skilled and trained English-speaking doctors (Points, 2009). Like in the United States, where intended parents often "shop around" for the most favorable pricing and regulatory environment, international consumers also seek out countries that are conducive to their reproductive goals. This has led some theorists to speculate that the restrictions placed on ARTs by individual nations do little but further stratify access to such treatments; those who can afford to travel will seek services elsewhere (Spar, 2006). For example, after Britain's Human Fertility and Embryology Authority banned anonymous egg and sperm donation in the United Kingdom, the supply of gametes quickly shrank, and the number of British citizens traveling abroad for these products increased significantly (Martin, 2011).

India is comparable to the United States in that it is one of the "friendliest" countries in the world for intended parents seeking gestational surrogacy, which is reflected in the skyrocketing availability of medical services. The Indian women's organization Sama estimates that about 3000 clinics in India offer surrogacy services (Sama Resource Group for Women and Health, 2012). Surrogacy was legalized in India in 2002, and is expected to add an annual 2.3 billion dollars to the nation's gross domestic product from the year 2012 on (Hochschild, 2012). While estimates range and costs vary due to the variety of necessary procedures and choice of clinic, surrogacy costs in India are roughly $20–$60,000, as compared to $80–$150,000 in the United States (Kirby, 2013). Reports vary on how much of this money goes to the surrogates themselves, and some sources claim that surrogates are paid less than what intended parents or reporters are told. Dr. Nayna Patel, the owner of the most well-known surrogacy clinic in India, reports that she pays surrogates $6500 (Bhalla & Thapliyal, 2013). India's surrogacy industry is similar to that of the United States in that it follows a commercial, for-profit model. This stands in contrast to other nations such as Israel, in which surrogacy is heavily regulated and controlled by the state (Pande, 2010).

Because of the significantly lower prices associated with surrogacy in India, agencies are able to offer deals and packages that are extremely attractive to intended parents. The agency Proactive Family Solutions, for example, offers a "surrogacy guarantee" that promises a full refund to couples whose surrogate has not become pregnant or given birth within twenty-seven months (Surrogacy/Egg Donation Guaranty, 2014). As journalist Henry Chu (2006) writes in the *Los Angeles Times*, some see surrogacy in India as "a logical outgrowth of India's fast-paced economic growth and liberalization of the last 15 years, a perfect meeting of supply and demand in a globalized marketplace" (p. 1A). Others are critical of what they perceive as abuse of the desperately poor.

A bill meant to regulate surrogacy in India has spent years making its way through government ministries and departments, yet what is now titled the Assisted Reproductive