AROGYAM Reproductive Loss and Bereavement Conference

30 March to 02 April 2015

Habichtswald-Klinik, Kassel-Wilhelmshöhe, Germany

Organisers: Professor Harish Naraindas & Dr. Karin Polit

The conference had 6 sessions spread over 3 days.

Day 1 was dedicated to the arrivals of the participants and invitees from the partner institutions.

The main program began on Day 2 of the conference with introductory remarks by Dr Harish Naraindas, Jawaharlal Nehru University, India, India and Dr Karin Polit, University of Heidelberg followed by the keynote address by Julie Pearce on '*The Perinatal Journey- Honouring those who have never "lived" and those who have lost them'.*

The keynote address was chaired by Professor Roger Jeffery, University of Edinburgh and the discussant was Dr Harish Naraindas.

The first session of the day began post lunch and was chaired by Professor William Sax and Julie Pearce was the discussant. The session was entitled '*Perinatal Death, Bereavement and Memorialisation'* and had two parts.

In the first part Dr Harish Naraindas presented his paper on '*Sacraments for the dead? Reflections on the emergence of perinatal bereavement'.*

The second part of the session saw Alicia Finger, Dr Harish Naraindas and Dr Karin Polit present a paper on '*Reproductive Technology, the Value of Reproduction and Pregnancy Loss in Germany'.*

The second session of the day entitled '*Mourned and Non-Memorialised Deaths'* began post tea break and was chaired by Dr Karin Polit and discussed by Dr Dina Sidhva, University of Edinburgh. In this session, Professor Ramila Bisht, Jawaharlal Nehru University, India, spoke on *The Unheard Silence: Reproductive Loss among Urban Poor Women of Mumbai, India* in the first part. She was followed by Professor Sanghamitra Acharya, Jawaharlal Nehru University, India, who spoke on '*Socio-economic correlates of grief and bereavement – Evolving a Typology with Illustrations from Live Data'.*

Day 3 had 3 sessions. The first of these was entitled '*the Role of Doctors and Nurses in articulating and making sense of pre-term death'.* The session was chaired by Professor William Sax and the discussant was Dr George Palattiyil, University of Edinburgh. The session had Pallabi Roy, Jawaharlal Nehru University, India, New Delhi speaking on '*Understanding Reproductive Loss: The Role of Medical Practitioners'* and Dr Ananda Samir Chopra, Kassel/Heidelberg, speaking on '*To die before being born: Death and Bereavement in the Neonatal Intensive Care Unit (NICU)'.*

The second session of the day titled '*Reproductive Imperatives: Legal, Professional and Social'* was chaired by Professor Roger Jeffery and the discussant was Dr Ananda Samir Chopra. Dr Mathangi Krishnamurthy spoke on '*Assisted Reproductive Technology: The Re-imagining of Loss as Failure'* and in the second part of the session Nupur Barua and Dr Harish Naraindas spoke on '*The Imperative of Reproductive Success: The Illegitimacy of Pain and the Legitimacy of Fertility'.*

The third and final session of the day entitled '*Reproductive Technologies, Markets and Hope'* began post lunch and was chaired by Professor Dr Professor Dr Silke Schicktanz. The discussant was Dr Mathangi Krishnamurthy. This session had Professor Rama Baru speak on '*Fertility markets, IVF technologies and bereavement',* followed by Dr Harish Naraindas, Dr Dina Sidhva, Nupur Barua, Dr George Palattiyil, Patricia Cantarell and Josep Roca presenting their paper on '*Confessions of Reproductive Loss: Infertility, Assisted Conception and Adoption'.*

The final day had one session titled '*Reproductive Failure, Surrogacy and Care'* chaired by Professor Rama Baru, Jawaharlal Nehru University, India. The discussant was Professor Ramila Bisht. In the session, Dr Sunita Reddy, Jawaharlal Nehru University, India and Tulsi Patel, University of Delhi presented a paper on *'You have failed': Surrogates' Experiences of Loss and Bereavemen't* and Sayani Mitra and Professor Dr Silke Schicktanz presented their paper on '*Failed Surrogate Conceptions and an Ethics of Care'.* The day ended with the Rapporteur's remarks given by Professor Roger Jeffery and Professor William Sax followed by an Open house discussion moderated by Dr Harish Naraindas, who also held a discussion of the future prospects along with Dr Karin Polit.

ABSTRACTS

1. ***The Perinatal Journey - Honouring those who have never "lived" and those who have lost them***
   By: Julie Pearce, Melbourne

Julie's knowledge, understanding and decades of experience have been gained by working intimately with couples ravaged by the loss of their baby or babies.

Julie touches upon 20th century Australia – old fashioned and ill-thought practices associated with belief systems of the time, resulting in lifelong disenfranchised grief issues experienced by these parents.

A snapshot of Australia in the 1980's is given - a time of radical change in regulations governing the recognition of those born still. The ensuing gradual altering of considered responses in medical and nursing practices is discussed, as well as changing attitudes and expectations within society itself.

The 1990's saw Julie's career in the Funeral Industry begin - this fuelled a passion and determination to eradicate the perceived reputation of Funeral Directors as that of a "necessary evil," both with clients and within the hospital system. This role has now largely evolved to that of a welcome and valued extension of the holistic professional care giving team.

Julie provides insight into the pioneering changes she and others have been able to create and nurture, to empower parents to be parents in the tiny window of opportunity available to them, whilst honouring the reality of precious infants whose lives were seemingly snuffed out before they had the chance to truly begin. Babies deemed legally to have never lived, in reality live forever within the hearts of parents and extended family.

2. ***Sacraments for the dead? Reflections on the emergence of perinatal bereavement***
   By: Dr Harish Naraindas, Jawaharlal Nehru University, New Delhi

This paper is based on a retrospective narrative of a young person's early pregnancy loss in a large teaching hospital in the United States. It recounts her story of an intended home birth gone astray due to eclampsia, resulting in an hospital admission and her subsequent grappling with religious, moral, scientific and pragmatic dilemmas with life threatening consequences for her and her foetus/unborn child. It follows the twists and turns in the narrative as she first contemplates abortion, then makes life-threatening moves against medical advise to hold on to her pregnancy from 22 to 24 weeks to "make the foetus into a child". She is enabled in this quest by her pious protestant father and by an evangelical pro-life/anti-abortion group whose

personnel regularly appear to do hands on praying for those two weeks in the hospital. She succeeds in making the foetus into her baby and is delivered of it by a vertical caesarean, only to lose it in a matter of hours the same day. This perinatal loss brings into play at least three institutional forms that this paper will dwell on at some length: the "touching hearts programme" instituted by the American nursing profession to address perinatal loss through a variety of means including modes of memorialising the dead and creating what may be called secular ritual; the hospital chaplaincy that is called upon to sometimes administer "sacraments for the dead", and their co-creation with the sufferers of forms of memorialising the dead; and finally the instauration of "baby cemeteries" as the culmination of acknowledging and memorialising perinatal loss. In the bargain the paper will hope to raise questions about perinatal loss, grief, and bereavement practices in the Euro-American world by situating the emergence of this "new perinatal bereavement complex" within a larger canvas of reproductive technology, a changing demographic profile, the pro-life and pro-choice divide, and the notion of personhood, in an attempt to reflect on the continuing interpenetration of science, religion, and spirituality in a modern hospital setting.

3. ***Reproductive technology, The Value of Reproduction and Pregnancy Loss in Germany***
   By: Alicia Finger, Dr Harish Naraindas and Dr Karin Polit, South Asia Institute, University of Heidelberg

In this paper we will address reproductive loss, in particular pregnancy loss in Germany. We are interested in the institutionalized support for mourning parents, in the effects of reproductive technology on the perceived value of offspring in early phases of pregnancy and the individual coping strategies of women and couples who have experienced pregnancy loss.

We assume that the high trust in medical technologies has resulted in paradigm shifts in expectations of child survival among contemporary global middle classes, including German middle class families. As middle class couples become increasingly individualized and reproductive technology has become part of standard family planning practices in couples in all age ranges in Germany, trust in biomedicine is high. We ask how this has impacted the value of a foetus in the womb and an infant? We will specifically ask how biomedical technologies of reproduction and childbirth have impacted on people's expectations of their own and their children's health and life expectancy and link these to changing patterns of childbirth practices (hospitalized birth) as well as to changing attitudes towards stillborn children, or so called medically- subscribed abortion. In this context we will present a case study of a woman who has experienced spontaneous pregnancy loss. How has she experienced this loss especially in relation to the perceived value of her unborn child? We will trace the responses to her loss by medical staff, nurses and hospital chaplains as well as her family and report on her own individualized mourning rituals that eventually helped her to get over the pain of losing her

child. We will put this in context with institutionalized funeral rituals organized by the university hospital in Heidelberg, their rationale and history. We will also present cases of failed In-Vitro-Fertilisation and discuss these cases especially in the context of perceived value.

4. ***The Unheard Silence: Reproductive Loss among Urban Poor Women of Mumbai, India***
   By: Professor Ramila Bisht, Jawaharlal Nehru University, New Delhi

Attention on over-population and high fertility rates in India has meant medicalising the experience of reproductive loss by focusing on averting miscarriages, stillbirth, perinatal or neonatal death through narrow, programme-centric approach, reducing it to merely a physical problem, needing better medical and managerial interventions. Yet, experiences of reproduction are mediated by a wide range of social (and other) factors with poverty and social exclusion emerging as most significant in determining women's reproductive health. Located in Mumbai, the megalopolis which represents Indian cities with its huge disparities in economic development and in the quality and quantity of healthcare, the paper focuses on reproductive loss as a critical phenomenon within poor women's daily social lives. Yet poor women often find their loss invalidated, with little social and emotional space to grieve. This painful social silence of the poorest and most marginalised women is further aggravated by the medicalisation and responsibilisation of pregnant body through the state-run RCH programmatic approaches. Further sequestering childbirth within hospital walls through institutional birth movement has created new environments where grief is denied but blame is foisted on the mother often amounting to ill-treatment. Drawing on six ethnographic case studies, the paper highlights the immense physical hardship, emotional trauma, indignity and humiliation experienced by these poor women. It also places these experiences within intersecting social, relational and macro-developmental context. The reproductive health debates and policy the paper argues, needs to be concerned not only with techno- medical approaches to averting this loss, but also with understanding reproductive bodies in context- an approach which integrates structural inequalities and social processes and dynamics into dominantly medicalised notions of reproductive loss.

5. ***Socio-economic correlates of Grief and Bereavement - Evolving a Typology with Illustrations from Live Data***
   By: Sanghamitra Acharya, Jawaharlal Nehru University, New Delhi

Death brings in sadness and melancholy of different kinds. Some could be laden with helplessness while other could be with angst. Loss of an infant or child invokes different grief than that due to the demise of an earning adult or an elderly person. In a country which has been obsessed with the population control during the 1970s and through the 1980s, mortality has been an assessment of events feeding into policy formulations. Experiential narratives of

the events of death and loss of life have become relevant gradually as injuries leading to death have emerged as one of the major cause of death. A literature review was done to study people who are grieving due to loss of life– because they are care-takers, have experienced a death, or are balancing their own illness and old age. Using a range of search terms, relevant literature was reviewed over a span of time. Despite illness and death occurring at any stage of a person's life, there is little research that identifies issues associated with grief and bereavement due to pregnancy loss, including induced abortion. In many parts of the country, there are instances of forceful termination of pregnancy due to reasons as varied as sex composition of children in the family to sexual assault leading to rape. Another area of scant research is related to the persons engaged in conservancy work. Although issues related to workplace legislation allow for minimal supports, there is evidence that some works including conservancy, have remained neglected to offer any respite for work life balance. Particularly when most of the workers are in the young adult ages and family is dependent on them beyond economic support. Considering the work conditions, workers are very vulnerable and the death makes their families more susceptible. Loss of life of these young adults is often assumed to accrue damages beyond those that are caused due to loss of pregnancy or child death or death of an elderly. While expectant mother is considered to be the most obvious bereaved party due to pregnancy loss; death of a conservancy worker is likely to bring in loss and grief to the whole family.

The present paper endeavours to evolve a typology of grief and bereavement based on the age of the deceased and the social, demographic and economic relationship which the deceased had with those left behind. Special emphasis will be given to the bereavement caused due to pregnancy loss; and death among children and those engaged in conservancy works. The paper draws from the National Family and Health Surveys and the primary data collected in the selected villages of Gujarat and Rajasthan.

The findings suggest that the pregnancy loss due to induced abortion is highly correlated with the number of female children in the household. Bereavement experienced ranges from extreme grief (mostly reported by the mother) to fatalist view of 'God's will' (mostly reported by other members of the family). Loss caused due to death of conservancy workers has strong positive correlation with the bereavement experienced by the mother and the spouse followed by the father and other male members.

6. Understanding Reproductive Loss: The Role of Medical Practitioners

By: Pallabi Roy, Jawaharlal Nehru University, New Delhi

The developments in science and medical technology have assured that the rapid medicalization of human fertility reckons with an illusion of omnipotence within the domain of

reproductive healthcare. This omnipotence is however, shattered and difficult to reconcile with when it is confronted by its own failure in assuring 'reproductive success'. In the pursuit of the 'elusive embryo', many actors such as the 'patients' and medical practitioners are involved in the enactment of the reproductive technologies and are responsible for the consequent success or failure. The failure of these varied technologies includes not only a lost attempt (or multiple attempts) at pregnancy, but also financial, emotional, psychological, physical and confidence loss. The 'multiple loss(es)' experienced by these women and men manifest in various forms as they try and reconcile with the failure of the treatment(s).

Over the last three decades, there has been an unprecedented proliferation of assisted reproductive technology (ART) clinics in India where these technologies are seen as offering 'hope' to those women and men who have been unable to experience reproductive success. It is within such medical spaces where not only do these technologies get enacted but also the (intended) conception, (unintended) failure, subsequent loss(es) and grief is enacted. Through a broad exploration of the understanding and management of 'reproductive loss' as an outcome of the failure of the reproductive technologies, the paper focuses on identifying the role of the medical practitioners. The assumption is that their role in managing these 'losses' has the potential to reduce the trauma of such events and the potential psychological sequelae, as the medical practitioners are not only responsible for providing reproductive healthcare and administering the technology, but, they are also involved in defining what constitutes experiences of such 'losses'. This sociological study was conducted in one of the most well-known fertility clinics in Kolkata (and in India) which claims to specialise in – In-Vitro Fertilization (IVF); artificial insemination [both Intra-Uterine Insemination (IUI) and Donor Insemination (DI)]; and surrogacy.

7. To die before being born - Death and Bereavement in the Neonatal Intensive Care Unit (NICU)

By: Ananda Samir Chopra, Kassel/Heidelberg

In a modern industrialized country like Germany most infant deaths take place in the hospital, especially in Newborn intensive care units (NICU). Though neonatal medicine initially mainly dealt with infants born after a full term-pregnancy, in recent decades the focus has shifted to the care of preterm-infants. The enormous advances of neonatal medicine have made it possible to ensure the survival of preterm-infants of a gestational age as low as 22 to 25 weeks of gestation. It can be argued that neonatal care has thus created a whole new phase of human life, that of the preterm-infant living outside the maternal womb. The death of such a preterm-infant can hence be described as "death before birth". But though a preterm-infant might biologically not be supposed to have been born yet, it is very often an object of exceptionally intense hopes and aspirations. One of the reasons for this might be that many if not most

preterm births follow after from some kind of assisted reproduction. Apart from this one has to realize that the death of an infant in the NICU very often involves decisions about withholding or withdrawing medical care. So the NICU is a sight of complex interactions and disputes between doctors, medical staff and parents; in addition social and religious aspects have a palpable impact, too. In this paper a research-project on the subject of death in the NICU is outlined.

8. Assisted Reproductive Technology: The Re-imagining of Loss as Failure

By: Mathangi Krishnamurthy, Indian Institute of Technology, Madras

The 2010 draft of the Indian Assisted Reproductive Technology Bill begins with a preamble that infers infertility to be one of the most "highly prevalent medical problems". It further posits the right of "every couple to have a child" and speculates on the nature of infertility and its social stigma within India. The work of assisted reproductive technology in this Bill is therefore predicated upon a presumed will to reproduce, the originary absence or loss of ability, and the concurrent loss of the subject to be fully realized in society.

In keeping with the revolutionary solutions that assisted reproductive technology offers, the word "loss" does not appear in the bill. Instead, we see the prevalence of terminology positing "limitations", "advantages", and "disadvantages", "risk", and "implications and chances of success". In this paper, I examine three sets of discourses; one produced by doctors and consultants in Chennai involved in the gestational surrogacy process; two, stories proliferating across popular non-fiction accounts of the surrogacy industry; and three, a close reading of the Assisted Reproductive Technology Bill, in order to ask questions about reproductive loss.

Conversing across these discourses, I argue that loss is re-imagined in a classically late capitalist scenario as individual failure. The societal future of infertility as manifested through a woman's body, is now taken up by a neoliberal re-imagining. Reproductive loss is now seen as reproductive failure, whether on the part of an unwilling body, a conservative society, intervening technology, or a corrupt industry. In the process, the original assumption of the will to reproduce is re-iterated, as well as produced as newly normal.

9. The Imperative of Reproductive Success: The Illegitimacy of Pain and the Legitimacy of fertility

By: Nupur Barua (DFID) and Dr Harish Naraindas, JNU, New Delhi

This paper is an ethnography of a form of shadow-boxing. Through a retrospective narrative of a patient with severe endometriosis, it will show that the pain of endometriosis – terrible and debilitating by most accounts - is forever deferred if not denied as it is seen as an unfortunate index of that other *mortal* pain: the pain of infertility. Potential infertility and incipient

reproductive loss arising from endometriosis is mortal insofar as it may lead to a woman's social death and cast her, like all mortal sins, into a place of no return and without redemption. The fallout of such a script is that it is blasphemous for a woman to claim that her endometrial pain is primary and the infertility is secondary or of no consequence. In the narrative here, we will see how the medical establishment, reproductive technologies, and gynaecologists, are often impregnated by this hegemonic script: a script where a woman is allowed to make claims for the relief of her endometrial pain only for the legitimate purpose of conceiving and avoiding infertility and not for the illegitimate purpose of solely addressing her pain without any desire for conception. And how the doctor-patient consultation, or medical interventions in the form of surgery, is ontologically rigged and turns into a shadow-boxing where, instead of addressing the physical pain of endometriosis, the therapy is encoded to achieve reproductive success and prevent reproductive failure.

10. Fertility markets, IVF technologies and bereavement

By: Professor Rama Baru, Jawaharlal Nehru University, New Delhi

It is estimated that globally, around 2-5 percent of persons in the reproductive age group are infertile. It varies within this range in most countries. Using the NFHS data, Jeejebhoy estimated that close to six percent of the Indian population have been unable to conceive. Although the proportions maybe small, in pro-natalist societies the consequences of infertility are severe for women. It has negative consequences at the psychological, social and cultural aspects of a woman's life leading to discrimination and stigmatisation. During the last four decades IVF technologies have been marketed as 'hope' for those who are unable to conceive. Zoll calls IVF technologies as the 'hope technologies' that has spurned the growth of fertility markets across the globe. The growth of transnational networks of the fertility market has led to a disproportionate rise of clinics and hospitals in the developed and developing countries for the treatment of infertility. The range of IVF technologies has widened but their success rates, ranging from 30 to 50 percent, is not shared with the persons seeking treatment. Thus the economic viability and profitability of fertility markets is dependent on the 'hype' and 'hope' of the inflated success of IVF technologies. The hype surrounding the IVF technologies has received exaggerated importance in the promotional and academic literature. However, the experience of technology failure of these technologies resulting in bereavement of women has not been adequately addressed in academic writing.

The paper explores the relationship between fertility markets, IVF technologies and bereavement. While each of these has received attention of researchers, the relationship between them has not been adequately conceptualised. The IVF technology is seen as hope for those who are infertile and is seen to assuage the grief that women experience due to childlessness. However, there is considerable debate around the success rates of IVF and the

procedure itself that requires numerous interventions with a variety of hormones and other drugs, to ensure a positive outcome.

In a recent study of fertility markets in relation to surrogacy in Hyderabad, interviews with gynaecologists revealed that a positive outcome that is assisted by IVF is usually around 30 percent. Doctors are unable to predict how many cycles a woman needs to undergo before she is able to carry the pregnancy to full term. This is supported by Zoll's research in the US which shows that almost 70 percent of IVF assisted pregnancies end as failures. The clinics promoting IVF in India and abroad often claim that they get 70 percent if not 100 percent success! The uncertainty around success rates of IVF, there are a number of testimonies of women who share the emotional fall out of the process. Much of this is based on blogs and related websites of individuals or those who are a part of networks dealing with grief and bereavement during the IVF process. We would be accessing these testimonies and in the Indian context will interview select gynaecologists and women who have experienced failure with IVF.

11. Confessions of Reproductive Loss: Infertility, Assisted Conception and Adoption

By: Dr Harish Naraindas (Delhi), Dr Dina Sidhva (Edinburgh), Nupur Barua (Delhi), Dr George Palattiyil (Edinburgh), Patricia Cantarell (Barcelona) and Josep Roca (Barcelona)

This paper attempts a possible innovation in method. It brings together three couples to explore and widen the ambit of what constitutes reproductive loss to include that grey zone between voluntary and involuntary childlessness and the sense of loss and grief this brings in its wake; the attempted surmounting of this by IVF technology and the grief that follows in merely attempting to traverse it; and the possible failure to conceive through IVF or other means leading towards adoption and whether the possible joy of adoption plugs the grief of reproductive loss, or whether it is experienced in part as a continuous reminder of loss. Conceived as a narrative that straddles the divide between autobiography and biography, it is an ethnographic experiment in the making, where three couples will converse with each other as couples, as three men, as three women, as men in pairs, women in pairs, and as men and women in pairs, to see whether this produces confessional moments that lead to epiphanies other than what may surface through mutual interviewing, or through a group discussion. Apart from the possible methodological novelty, the intended thematic novelty was to cover ground from childlessness to failed IVF, failed surrogacy, to perinatal loss, and finally to adoption, the last of which seems to be completely missing from the reproductive loss scholarly canvas. Given the impossibility of covering the entire gamut from failed conception to perinatal death, we came up with three cardinal moments of the reproductive journey, partly based on willingness to confess, to widen the scope of what constitutes reproductive loss and to see whether an auto/biography of mutual confessions produces ethnographic and theoretical surprises.

12. 'You have failed': Surrogates' Experiences of Loss and Bereavement

By: Sunita Reddy, Jawaharlal Nehru University, New Delhi (and Tulsi Patel, University of Delhi)

Bodies are not just individual bodies, but social and bio-political. Women's bodies have always been under surveillance and control in the patriarchal societies since long, more so with development of biotechnologies and new reproductive technologies. Childbirth, which is supposed to be natural and normal, has been medicalized and with commencement of ARTs, birthing has gone beyond body boundaries. Surrogate babies are 'produced' crossing the body boundaries of maximum of three individuals. In case of surrogacy, the birthing becomes even more medicalized, ranging from screening, to hormonal injections, constant monitoring, fetal reduction, termination in case of abnormal growth and if successful, ending with C-section deliveries. In order to see that these 'precious' pregnancies' are successful, the surrogates' pregnancy is constantly monitored, medicalized and controlled.

While for a surrogate coming from a lower economic class, bearing her own biological child is a matter of joy, bearing for 'others' has an added advantage of economic value, and is seen as reproductive labour. While for bearing their own children, the surrogate mother might not have enjoyed the privileges of good food, care, and rest, for bearing a 'precious baby' as a surrogate is ensured of all medical check-ups, nutritious food, ceremonies, rest and additional care, though under constant medical screening and strict surveillance. While the surrogate embark on to provide this service, as 'mutual exchange' between those who have children but no money and those who have money and no children, makes a conscious decision to be a surrogate with a purpose and being a 'mother-worker' as Pande puts in.

It then becomes all the more important for a surrogate to successfully conceive and deliver the baby. What happens if the surrogate cannot conceive successfully or is aborted mid-way. How does the surrogate feel about this loss, what kind of bereavement she undergoes? What are the coping strategies they employ? Based on our studies in Hyderabad and Delhi, this paper addresses the important issue of loss, where it is not just personal, but very much economical. The study shows the process of surrogacy is like a litmus test for her to prove her fertility and carrying capacity despite that she has born her own children, naturally without any technological assistance. Elimination process starts from day one, where the clinicians make decisions seeing at general health of the intended surrogate. Further initial screening tests, cleaning of uterus, checking the condition of endometrium, preparing uterus for conception through hormonal injections and embryo transfers are done. For the surrogate the most important test is to have 'successful conception' which they celebrate. When they fail to conceive, the clinics blame the surrogate…. '*you have failed*', for the failure, leaving them shattered, disappointed and cursing their own self as 'worthless'. Even more serious concern

and unethical practice, in two of the Delhi IVF clinics, is to prepare more than one surrogate for a couple, for 100% success, choose the best one and abort the rest, in clear violation of ICMR guidelines. Are these surrogates aware of such a misuse of their bodies, shattering their dreams and aspirations?

13. Failed Surrogate Conceptions and an Ethics of Care

By: Sayani Mitra and Professor Dr Silke Schicktanz, University Medical Centre, Göttingen

During a gestational surrogacy arrangement, the event of embryo transfer (ET) officially inducts the surrogate mother into a surrogacy arrangement. However, it is extremely common to get a negative beta hCG test (pregnancy confirmation test) result for the surrogate after 12-14 days of ET. It was found that the surrogates and the intended parents (IP) often experience a failure in their attempts to conceive after their first round of ET. This raises an important question as to whether such failures or unsuccessful attempts to pregnancies after a successful embryo transfer can be called 'pregnancy losses'? In this article, we try to answer this question by discussing how technology involved during the process of IVF causes a feeling of loss both for the surrogate and the IP. Based on a sociological study conducted in Delhi and Kolkata, we reconstruct the perceptions and affects of surrogates and IPs. While on the one hand, the surrogate grieves the non-arrival of 'good news' or a 'new entity' that she was eagerly hoping for, she also experiences a sense of loss at having lost out on an opportunity to earn a secure future. The intended parents, on the other hand, experience yet another sense of failure in their journey towards becoming parents. However, unlike their previous attempts at an own In Vitro-Fertilization (IVF) or Intrauterine insemination (IUI), they now experience a 'disembodied pregnancy loss' whereas the surrogate 'embodies a loss' in the quest to achieve social mobility for herself and her family. Her body becomes a site of 'a lost opportunity'. In the discourse of the fertility experts, such failed attempts or loses get normalized as non-events. Their narrative of assisting a successful pregnancy neglects the impact of these failures on the actors concerned. Therefore, it raises questions about professional ethics, as to whether mentioning such a "risk of failure" is needed and how the disclosure or non-disclosure of a particular failure is always appropriate. While all the actors have logic of their respective practices in place, we would like to question along the lines of an approach of 'ethics of care' - the relationality of all the actors to assisted reproductive technology (ART) and the role of fertility specialists. Therefore by moving out of the oppressor-oppressed dichotomy common in the exploitation narrative of surrogacy, this paper wants to discuss how agency of each of the actors during the process of surrogacy is not fixed but is relational, being spatio-temporally embedded in the technology ridden procedure of surrogacy. As a result, agency of the surrogates and the intended parents on matters of screening, ovum pickup, embryo transfer etc. becomes a process that is 'in its making' based on their ongoing interaction with technology and the fertility specialists.