DOING SURROGACY: SURROGATES' AND INTENDED PARENTS' NEGOTIATION OF PREGNANCY AND CHILDBIRTH

A dissertation submitted

to Kent State University in partial fulfillment

of the requirements for the

degree of Doctor of Philosophy

by

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December 2024

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ACKNOWLEDGEMENTS

First, to my mom and dad, Anna and John, thank you for always prioritizing my future through your hard work and commitment to my education. You were there for me when I needed you the most during this process. You kept me going when I did not think I could and assured me that everything would work out, no matter the outcome. For that I will be forever grateful. To my brother, Danny, I greatly appreciate the countless walks and talks that kept me on an even keel and the advice you gave along the way. Dave, my partner and best friend, thanks for constantly reminding me that "I got this," and for taking care of our home and Charlie when I was not able to pitch in. To all four of you, I could not have done this without your endless love and encouragement. Thank you for believing in me when I did not always believe in myself.

I would also like to express my gratitude to my advisor, Clare Stacey. I appreciate all the feedback you gave and the countless meetings we had throughout this process and my graduate career at Kent. Though you have always graciously praised my writing skills, your detailed edits of this paper have helped me to continue to grow and improve. I am especially grateful for the emotional support and the words of wisdom you provided. Thank you to all those who served on my dissertation committee throughout the years as well: Tiffany Taylor, Susan Roxburgh, Deborah Barnbaum, Mary Himmelstein, and Adriene Frech. Your feedback and comments were also invaluable.

I would also like to thank my friends and colleagues, Struther, Mazen, and Paige. Struther, you have been a great friend since we started the Ph.D. journey together and have continued to be there for me no matter where the years have taken us since. I hope our friendship continues to thrive for many more years to come. To Mazen, I appreciate the many hours toiling away together in the library and elsewhere, and for the laughs and breaks when they were

needed. Paige, thanks for being a dissertation buddy from afar, and congratulations on completing your degree this year as well. We did it!

Finally, I am deeply indebted to the surrogates and intended parents who took time out of their lives to share their stories, tears, and joys with me. Without your help and honesty, this dissertation truly would not be possible.

CHAPTER I: INTRODUCTION

After the first contractual surrogacy agreement in 1976, and especially the landmark case of Baby M in the 1980s, public and political debates about surrogacy began to proliferate (Markens 2007). Some of surrogacy's earliest critics included feminists who expressed their concerns about the control of surrogates' bodies and health (Corea 1985; Oliver 1989; Rothman 1989). The contested nature of surrogacy has not dissipated much since then. In early 2024, Pope Francis called for a global ban on the "deplorable" practice of commercial surrogacy, claiming that surrogacy "represents a grave violation of the dignity of the woman and the child" (De Guzman 2024). Despite its ongoing contested nature, surrogacy seems destined to continue, at least in the United States. Just months after the Pope's declaration, the governor of Michigan signed a bill that decriminalized surrogacy, leaving one less "unfriendly" surrogacy state (Executive Office of the Governor 2024).

Though there are no official or complete statistics documenting the use of surrogacy in the United States, according to the CDC, "Over the last decade, the number of embryo transfer cycles that used a gestational carrier [surrogate] increased, from 3,202 in 2012 to 8,862 in 2021,

with a high of 9,195 in 2019" (CDC 2023).[1][2] Given the clear rise in the use of surrogacy in the U.S., it is as important as ever to understand the experiences of surrogates and the intended parents who utilize them. In this dissertation, I explore surrogates' and intended parents' expectations for, negotiation, and experiences of control and autonomy over medical decisions throughout the surrogacy process. For the purpose of this paper, autonomy is defined as "self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding" (Beauchamp and Childress 2013:101).

Despite the barrage of public, legislative, and feminist responses to surrogacy that emerged in the 1980s, comprehensive empirical research on surrogacy has been slow to follow. Ragoné's (1994) examination of surrogates, intended parents (commonly referred to as IPs within the industry), and the small number of established surrogacy agencies that existed in the late 1980s and early 1990s was the first ethnography to explore surrogacy in the U.S. Her work, however, mainly focuses on traditional surrogates, or those who are biologically related to the children they carry, given the development and use of IVF had not yet grown to the scale it has today. Smaller scale studies published around that time also began to examine the experiences

[1] Gestational surrogates are not biologically related to the children they carry, and the embryos used for conception are created via an IVF procedure. One or more embryos are then transferred into the surrogate. It is possible that a single gestational surrogate may go through multiple embryo transfer cycles before a viable pregnancy is achieved, so these numbers do not reflect the actual number of gestational surrogates used. These statistics also do not include instances of traditional surrogacy, where the surrogate donates her own egg used for conception and it is fertilized through intrauterine insemination (IUI), for instance.

[2] The peak in 2019 can likely be attributed to the COVID pandemic and a subsequent drop or pause on surrogacy arrangements in 2020. Though not yet reaching the 2019 high, gestational surrogacy began to rise again in 2021.

and motivations of both traditional and gestational surrogates, IPs, and the psychological effects of surrogacy in the context of both Britain and the U.S. (Blyth 1994, 1995; Ciccarelli and Beckman 2005; Edelmann 2004; Hohman and Hagan 2001; Kleinpeter 2002; Van den Akker 2003).

Jacobson's (2016) and Berend's (2016) ethnographic examinations of surrogacy in the United States helped fill the gap in knowledge left after Ragoné's (1994) pioneering study. Jacobson's (2016) work explores how and why surrogates' labor is obscured in the U.S., while Berend (2016) collected data from a large surrogacy website to examine how surrogates come together to create meaning around and understand their work. Since then, Ziff (2017, 2019, 2021) has added to our understanding of U.S. surrogacy arrangements through her work with military spouses who engage in surrogacy. There has also been a growing body of literature within the last decade and or so that specifically examines gay men's experiences of surrogacy. These studies focus on various topics, from how gay men view and negotiate biogenetic paternity (Dempsey 2013; Murphy 2013; Riggs 2018), their path to and motivations for using surrogacy (Blake et al. 2017; Murphy 2013), their experiences with transnational surrogacy arrangements (Carone, Baiocco, and Lingiardi 2017; Maya and Ben-Ari 2023; Riggs, Due, and Power 2015; Ziv and Freund-Eschar 2015), as well as their experiences with surrogacy within the context of the United States (Blake et al. 2016; Smietana 2017). Other scholars have also examined gay men's experiences of parenthood after surrogacy (Bergman et al. 2010; Tuazon-McCheyne 2010). Finally, Jacobson (2018) recently explored how those in the surrogacy industry recruit gay men as clients.

Ziff's 2021 paper examines surrogates' experiences of autonomy and power in the early stages of the surrogacy process, mainly IVF. Jacobson (2016) and Berend (2016) also discuss

some findings about surrogates' experiences of control and medical negotiation within specific contexts of the surrogacy experience, though it is not the focus of their larger work. To date, there has not been a U.S. study that focuses on issues of medical control, negotiation, and autonomy throughout the entirety of the surrogacy arrangement (i.e., from IVF to birth) that includes equally represented perspectives of surrogates and intended parents, including both heterosexual and gay individuals. Much of what we do know about surrogates' experiences of control and agency comes from the large body of literature that examines surrogacy in countries other than in the U.S., such as in India (Deomampo 2016; Majumdar 2014; Pande 2010, 2014; Rudrappa 2015), Mexico (Hovav 2020), and Israel (Teman 2003, 2010) where the context of surrogacy is much different. Again, given that many of these studies focus on transnational surrogacy experiences, the direct influence and experiences of IPs is largely absent from this work. My study seeks to fill this gap in U.S. surrogacy literature.

SURROGACY LITERATURE REVIEW

In the following literature review, I begin by exploring some common critiques of surrogacy argued by second wave feminists who wrote on the topic. It is important to note that these critiques are more akin to ethical treatises on the subject, rather than empirically informed research studies that incorporate the lived perspectives of surrogates or intended parents themselves. Still, reviewing their arguments are pertinent, as many subsequent studies of surrogacy sought to investigate the validity of these claims. This includes not only my own research, but much of the research I include in the rest of the literature review. I then examine what we know about surrogates' and IPs' motivations for engaging in surrogacy. Next, I review the literature on the respective feelings of surrogates and IPs in terms of their relationship to the surrogate child, as well as to one another. It is important to understand these motivations and

relationships, as they can have a direct and indirect effect on the surrogacy medical negotiation process. Finally, I explore previous scholarship on common mechanisms of control that surrogates outside of the U.S. may experience, as well as how they may experience agency. Though much of this literature focuses on transnational surrogacy arrangements, it is possible that some of these mechanisms of control or experiences of agency may be present within domestic arrangements in the U.S. Though there is a gap in U.S. literature, I also attempt to supplement the transnational findings with some of the limited information we have about control and agency on U.S. surrogacy (Berend 2016; Jacobson 2016; Ziff 2021), as well the case of domestic surrogacy in Israel (Teman 2003, 2010).

Relevant Critiques of Surrogacy

Early feminists who are critical of the practice of surrogacy share several common concerns (Anderson 1990; Corea 1985; Oliver 1989; Rothman 1989). For one, they argue against what they see as the commodification and exploitation of women and children. They warned that the lower economic status of women may propel them into surrogacy, especially if surrogacy expanded to the use of cheaper, poor, uneducated women of color in the United States or in "third world" countries (Corea 1985; Oliver 1989; Rothman 1989). Some also believe that the altruistic motivations of surrogates can be used as a coercive tool (Anderson 1990; Corea 1985). Further, feminist critics of surrogacy argue that surrogates are, in fact, the natural mothers of the children they bear, even in the case of gestational surrogacy where surrogates are not biologically related to the child (Anderson 1990; Corea 1985; Oliver 1989; Rothman 1989). As a result, they maintain that surrogates are treated merely as a vessel (Corea 1985), a container (Rothman 1989), or as a fragment of a person or a machine (Oliver 1989). Because the surrogate is the "natural" mother, they posit that surrogates are likely to form a bond with or become attached to

the child, but that this connection is not acknowledge or allowed, which compromises surrogate autonomy (Anderson 1990; Corea 1985; Oliver 1989; Rothman 1989).

Relatedly, many critique the potential medical control of surrogates' bodies and their inability to contribute to the medical decision-making process (Corea 1985; Oliver 1989; Rothman 1989). Finally, because of their concerns, these feminist scholars either implicitly or explicitly call for the practice of surrogacy to end (Anderson 1990; Corea 1985; Oliver 1989; Rothman 1989). Anderson (1990), for instance, goes as far as to say that surrogacy contracts should not be enforceable, and that any parties that arrange such contracts should be subject to criminal penalties.

Surrogates' Motivations for Engaging in Surrogacy

Surrogates report having a variety of motivations for engaging in surrogacy. For one, surrogates point to their enjoyment of and ease in which they experience pregnancy and childbirth (Blyth 1994; Jacobson 2016; Ragoné 1994). While they want to experience pregnancy and birth again, they also do not want (or other circumstances prevent them from) more children of their own (Jacobson 2016; Ragoné 1994). Surrogacy, therefore, allows them to enjoy pregnancy without having more children. Surrogates are also motivated by feelings of altruism and a desire to help others have a child, and report having either general compassion for or personal experiences with others who have experienced infertility (Blyth 1994; Hohman and Hagan 2001; Jacobson 2016; Ragoné 1994; Van den Akker 2003). Surrogates are often inspired by their feelings of love for their own children and their experiences of motherhood and want others to experience the same (Jacobson 2016; Ragoné 1994). While commercial surrogates accept money for their work and believe they are deserving of some sort of compensation, they also often minimize, deny, or denounce financial renumeration as a primary motivation for

engaging in surrogacy (Berend 2012, 2016; Hohman and Hagan 2001; Johnson 2016; Ragoné 1994, 1996).

The Work of Surrogacy

As Zelizer (2000) explains, intimate relationships, such as those between a surrogate and the child she bears or the intended parents she works for, are often thought to be "hostile" to or should be separate from the transfer of money. Any contact between the two is argued to give rise to "moral contamination and degradation" and can ultimately lead to coercion (Zelizer 2000:818). Given the criticisms surrounding the commodification of motherhood (Anderson 1990; Corea 1985; Oliver 1989; Rothman 1989), it is not surprising that surrogacy has become what Johnson (2016) calls an obscured form of labor. As a result of this obscurity, the skills that surrogates bring to pregnancy and birth and the health risks they undertake often go unacknowledged (Jacobson 2016).

Similarly, Pande (2014) argues that surrogacy is a form of embodied labor. As Pande (2014:106) explains, "Surrogacy is an extreme manifestation of worker embodiment, where the body is the ultimate site of labor, where the resources, skills, and the ultimate project are derived primarily from the body of the laborer." As a result, the surrogate's body is "both appraised and monitored at each stage of the surrogacy process" (Pande 2014:104). At the same time, the body can also be a "space of resistance for the surrogates and a place for them to claim a sense of control" (Pande 2014:104). Commercial surrogacy can also be considered a form of intimate labor, where the intimate realms of pregnancy, childbirth, and the creation of family are performed in the service of others in the context of a paid exchange. Scholars of intimate labor point to the interaction of market forces, gender, race, ethnicity, and other structural constraints that define and shape intimate labor. They also, however, argue against the view that intimate

labor is fully or always exploitive, and therefore seek to explore how individuals may negotiate and resist such inequalities and exhibit agency within their work (Boris and Parreñas 2010:8).

Intended Parents' Motivations for Using Surrogacy

Intended parents are clearly drawn to surrogacy because they want to have a child. For heterosexual IPs, infertility issues are often what makes surrogacy one of the only viable options for parenthood (Blyth 1995; Jacobson 2016; Kleinpeter 2002; Ragoné 1994). The path to parenthood before surrogacy often involves unsuccessful attempts at starting a family through conventional means, experiences of loss, and intended parents' own attempts at using infertility treatments, including IVF (Blyth 1995; Jacobson 2016; Kleinpeter 2002; Ragoné 1994). Surrogacy also provides benefits that other options do not. Both heterosexual and same sex couples are drawn to the fact that surrogacy can provide a possible genetic link to the child for at least one half of the couple (Blake et al. 2017; Jacobson 2016; Kleinpeter 2002; Ragoné 1994). Heterosexual and same sex intended parents also report that they pursue surrogacy to avoid the pitfalls associated with adoption (Blake et al. 2017; Kleinpeter 2002; Ragoné 1994). Gay men also may be or were previously barred from adoption in some locations, leaving surrogacy as the more viable option (Blake et al. 2017).

Surrogates' and Intended Parents' Relationship to the Surrogate Child

Both gestational and traditional surrogates consistently reiterate that they do not believe that the child is theirs and that it is instead the child of the intended parents (Berend 2012, 2016; Jacobson 2016; Ragoné 1994, 1996; Teman 2010; Teman and Berend 2018). Ragoné (1994:75) argues, "The perception that the child is not her own tends to shape a surrogate's entire experience of surrogacy." Surrogates use various metaphors to describe their relationship to the

child, including “hotel,” “innkeeper,” “vehicle,” “cow,” “babysitter,” “incubator,” and “oven” (Berend 2016; Ragoné 1994; Teman 2010; Teman and Berend 2018). Though they are not maternally bonded with the baby, surrogates do often feel a sense of obligation to care for it while in utero (Jacobson 2016).

Gestational surrogates often point to their lack of genetic relatedness as the reason they do not feel that it is their child (Berend 2016; Jacobson 2016; Teman 2010). Traditional surrogates, on the other hand, tend to deemphasize their genetic link (Berend 2016; Ragoné 1994, 1996). In Ragoné’s (1994, 1996) study of traditional surrogates, she found that surrogates believe it is the social role of motherhood and one’s role as a nurturer that makes someone a parent. Berend (2016) similarly reports that both gestational and traditional surrogates believe it is the act of parenting and the intent to become parents, as well as surrogates’ intent to help facilitate parenthood, which defines surrogates’ and the IPs’ relationship to the child. Similarly, intended mothers who are not genetically related to the child may also focus on the intentionality of parenthood (Ragoné 1994, 1996).

Surrogates’ separation from the child and feelings of motherhood, as well as intended mothers work to establish their material identity, is also a process that is facilitated through their close relationship (Ragoné 1994, 1996; Teman 2009, 2010). Teman (2009:66) describes the process as one of “joint identity-work” through what she calls a “dyadic body-project.” Surrogates work to “distance, detach from, and disembody” the pregnancy, which enables intended mothers to “encompass, attach, and embody what the surrogate has distanced” (Teman 2009:49). One way that this may be accomplished is through the intended mother’s involvement in medical aspects of the pregnancy, such as by attending appointments with the surrogate (Ragoné 1994, 1996; Teman 2009, 2010). Medical professionals may also support the intended

mother's maternal identity by waiting for them before starting an appointment, or by using language that acknowledges their status as the mother (Teman 2009, 2010).

Conversely, gay men who have engaged in transnational surrogacy arrangements in India report feeling alienated and detached from the pregnancy, especially in the absence of being able to engage with the embodied experience of the mother. This, in turn, impacted their ability to connect with the child and develop a parental identity (Ziv and Freund-Eschar 2015). Similarly, Maya and Ben-Ari (2023) found that geographical distance and linguistic and cultural differences increased gay men's reliance on medical knowledge to relate to the pregnancy and fetus early in the transnational surrogacy process, which resulted in feelings of alienation and detachment. Eventually, however, they embraced medicalization as a way to connect with the surrogate, fetus, and create a parental identity. Finally, gay fathers who *were* able to interact with their transnational surrogates living in the United States and Canada report that, over time, their surrogates helped facilitate their connection with their child (Carone et al. 2017).

The Relationship Between Surrogates and Intended Parents

In the case of domestic surrogacy, the surrogate and IP relationship is a fundamental aspect of the surrogacy experience, where surrogates and intended parents often develop a deep bond (Berend 2016; Jacobson 2016; Teman 2010, 2019). Surrogates often report bonding more with their IPs than with the child (Berend 2012, 2016). For surrogates who work with heterosexual couples, bonding is typically between the surrogate and intended mother, though husbands may be peripherally involved as well (Berend 2012, 2016; Blyth 1994; Ragoné 1994, 1996; Teman 2010, 2019). Surrogates who work with gay men, however, do bond with male intended parents (Berend 2016). Although surrogates and IPs in the U.S. may live in different states, they often still interact with each other through phone calls, emails, and texts, and see

each other during attendance at appointments and of course, the birth. They may also meet during more casual encounters, such as by going to lunch or at mutual family get togethers (Berend 2016; Jacobson 2016). When surrogates do not feel a level of connection that they desire with their IPs, when it feels like or turns into more of a "business relationship" than what was expected, or similarly, when there is a connection that suddenly ceases after the arrangement is finished, it can often result in negative feelings for the surrogate (Berend 2012, 2016; Jacobson 2016; Teman 2010, 2019).

The surrogate and intended parent relationship is often framed using gift-rhetoric or as one of mutual gift giving (Berend 2016, Jacobson 2016; Pande 2011, 2014; Ragoné 1994, 1996; Teman 2010). In the United States, surrogates report receiving both tangible and intangible gifts from their intended parents. Intangible gifts include time and attention, appreciation, care, respect, friendship, and importantly, the trust that they receive from IPs by choosing them to carry their children. In return, surrogates provide counter gifts, one of which is their facilitation of IPs' involvement in what surrogates believe is "their [the IPs'] pregnancy." This can include welcoming IPs to or reports about medical appointments, sharing symptoms or "firsts" during the pregnancy, and making sure that IPs and even their families can be involved in the birth. Many IPs desire "gifts" like these to feel included (Berend 2016). Here again the reality of surrogacy as an intimate labor emerges, as the line between formal labor and informal friendship blurs considerably (Boris and Parreñas 2010).

Jacobson (2016) also speaks about the issue of trust and its importance in surrogacy relationships. As she explains, though surrogates tend to view their contracts as legally binding, contracts either lack enforceability or have not been tested for enforceability in many states. There is no federal law that addresses surrogacy in the U.S. Therefore, surrogacy laws vary from

state to state, with legality or illegality established either through state statutes or more often, case law. At the time of this writing, fourteen states lack any legislation or case law regarding surrogacy (Creative Family Connections, n.d.). While surrogacy is practiced in these states since there is no law that prohibits it, the legality of contracts has not been tested. Even among states that permit surrogacy in some form through statutes or case law, most do not regulate surrogacy arrangements or have provisions for enforcing surrogacy contracts (Jacobson 2016). In Arizona, Nebraska, and Indiana, surrogacy contracts are considered void and unenforceable, though the practice of surrogacy is not subject to criminal penalties. Surrogacy is therefore still practiced in these states as well. Finally, Louisiana has explicitly banned and criminalized commercial surrogacy, though certain altruistic arrangements are permissible, and in Virginia, compensation is limited to reasonable medical and ancillary expenses (Creative Family Connections, n.d.).

Surrogates and IPs, therefore, must trust that each member will fulfill their end of the agreement, a reality that is negotiated through interaction over time (Jacobson 2016). Jacobson (2016:96) found that surrogates "work hard" to appear trustworthy and understand the trust that is placed in them when carrying someone else's child. They also sympathize with IPs' struggles to have a child and understand the emotional and financial stakes that are at play. As a result, the surrogates in her study reported that they treated the surrogate pregnancy with greater care than they did when carrying their own children.

Surrogates' Experiences of Control: Lessons from Transnational Surrogacy

Surrogates can experience control over their bodies and health in a variety of ways throughout the surrogacy process, from decisions about the embryo transfer and the regimented medical protocol required during IVF, to the requirements and restrictions on health behaviors and practices during the pregnancy, to decisions made about prenatal testing, abortion, medical

care, intrauterine surgery, or childbirth (Berend 2016; Deomampo 2016; Hovav 2020; Jacobson 2016; Lozanski and Shankar 2019; Majumdar 2014; Pande 2010, 2014; Rudrappa 2015; Teman 2003, 2010; Ziff 2021). Surrogates may also encounter a variety of mechanisms of control.

Surrogates can be controlled via the institutions involved in surrogacy (Deomampo 2016; Lozanski and Shankar 2019; Majumdar 2014; Pande 2010, 2014; Rudrappa 2015). For example, before the 2021 law that banned commercial arrangements in the state, many Indian surrogates lived in dormitories where their daily activities and behaviors were monitored and controlled (Deomampo 2016; Pande 2010, 2014; Rudrappa 2015). This surveillance could be quite literal, as Rudrappa (2015) noted the presence of closed-circuit cameras in the dormitories she studied, used to ensure that surrogates were not engaging in sexual relations with their male companions who visited. Pande (2010, 2014) describes how the surrogates in her study were subjected to "timetables," where their days were divided into periods of rest, fixed meals, visits from doctors, and routine administration of vitamins and medicines. Pande (2010, 2014) also discusses how the differential ranking and placement of surrogates in the dormitory system was used to encourage self-surveillance. In her study, surrogates who were further along in their pregnancies and repeat surrogates had more freedom in their assigned living spaces and were expected to self-monitor their IVF injections, medicines, diet, and rest.

Surrogates, however, need not be kept in dormitories to be surveilled. In Mexico and Ukraine (Lozanski and Shankar 2019) and for surrogates who lived at home in India (Majumdar 2014), agencies performed in-home visits throughout the pregnancy to check surrogates' living conditions and whether they were following proper health behaviors and practices. These visits may be documented and then made available to transnational intended parents (Lozanski and Shankar 2019). Lozanski and Shankar (2019) argue that surrogates are subjected to this kind of

surveillance because the larger structural risks that intended parents encounter when engaging in transnational surrogacy are not as easily managed at the individual level. Therefore, surrogates become the focus of a more "localized" risk management (Lozanski and Shankar 2019:46).

Notions of surrogate risk may also be used by medical professionals as a mechanism of control. For instance, Deomampo (2016) found doctors justified their high use of C-sections by referencing racialized stereotypes about Indian women's small size and their incapability of vaginally delivering "larger" Western babies or carrying them to term. Alternatively, Hovav (2020) reports that the especially high rate of C-sections among Mexican surrogates is partially attributed to fact that medical professionals viewed poor, Mexican women as incapable of properly managing the risks of pregnancy by following prenatal guidelines. C-sections were therefore used, or rather "abused," as one doctor explained, "to give a better result in terms of the baby" (Hovav 2020:5). The doctors in Hovav's (2020) study also believed that the emotional experience of vaginal birth would make it more likely for surrogates to attach to and bond with the child, which could jeopardize relinquishment. Pande (2014) also found evidence that similar beliefs about maternal bonding affected C-section decisions among doctors in India.

A surrogate's class or gender may contribute to control in other ways. For instance, in Israel, surrogacy contracts are approved by a government committee and are valid in a court of law (Teman 2010). Under the contract, surrogates must agree to doctor recommended procedures such as abortions or Cesarean sections. While they cannot be forced to comply, refusal is considered a breach of contract. Doing so would therefore require surrogates to repay any of the money received by intended parents until that point, in addition to possibly paying a fine to their IPs. This is particularly coercive considering that most of Teman's sample was either lower class or very poor. Her surrogates also reported that making money through surrogacy was one of their

primary motivations. Deomampo (2016:185) similarly found that "surrogates' payment is linked directly to their bodies' performance." In her study, Indian surrogates reported that their payments were reduced if the child they were carrying was underweight, and doctors reported cutting surrogates' payments if they delivered babies preterm. Finally, Indian surrogates were also controlled through gendered notions of "good" motherhood (Majumdar 2014; Pande 2010, 2014). Surrogates were encouraged to be nurturing and take care of the children they carry, though at the same time they were frequently reminded that the child is not theirs.

As many of the above studies show, the needs and interests of intended parents and the health of their child can become paramount in the surrogacy arrangement. The power that IPs have in the surrogacy arrangement, therefore, can indirectly contribute to the control of surrogates, even when their relationship is separated by a large geographical distance. For instance, for surrogates in Mexico and India, C-sections were used to accommodate the scheduling needs of IPs, especially when they were travelling internationally to attend the birth (Deomampo 2016; Hovav 2020, Pande 2014; Rudrappa 2015). Even when IPs did make it on time, the doctors in Deomampo's (2016) study admitted to using inductions or C-sections so intended parents did not have to spend too much time waiting around for their child to be born. Some intended parents in her study also referenced the convenience afforded by C-sections (Deomampo 2016).

Alternatively, Hovav (2020:2) found that her IP participants believed in a neoliberal choice model "wherein birthing women are assumed to be autonomous agents with the right and responsibility to make informed (consumer) choices about childbirth." However, IPs failed to recognize how their powerful role within the surrogacy arrangement and eagerness to attend encouraged doctors and agencies to use C-sections. They also were not cognizant of how their

own experiences with the medical system differed from the power dynamics between Mexican surrogates and the doctors who delivered them. Indeed, while many surrogates report desiring a vaginal birth, they often do not have enough power to change the practice (Deomampo 2016; Hovav 2020; Pande 2014).

Jacobson's (2016) work points to the possibility that similar issues of control may be present in the lives of U.S. surrogates. For instance, she explains that IPs may attempt to mitigate feelings of risk by cultivating a sense of control through "micromanagement" of the surrogate pregnancy, such as through frequent check-ins and discussions regarding surrogates' health behaviors and practices. Most surrogates in her study felt sympathetic and understood intended parents' need to feel in control. However, they also desired a level of trust and autonomy since they believed they possessed a unique set of skills, expertise, and experiential knowledge, especially when compared to their IPs who may have not experienced pregnancy themselves. While in most cases, surrogates took attempts at control in stride, some had to involve their agency to help manage the situation. Conversely, other surrogates did report receiving trust from their IPs and noted a lack of "micromanagement."

Surrogates' Cultivation of Agency

Though surrogates can and do certainly experience issues of control, several scholars have argued that surrogates are also able to carve out opportunities for agency and empowerment (Deomampo 2016; Pande 2010, 2014; Rudrappa 2015; Teman 2003, 2010; Ziff 2021). For example, population control systems and propaganda in India often present lower-class women's fertility as "recklessly reproductive," and Indian women are often encouraged to partake in sterilization procedures (Pande 2014:108). Irresponsible reproduction is also posited as an explanation for Indian women's poverty. Yet, by partaking in surrogacy, some Indian surrogates

engaged in what they felt was a form of "productive motherhood." Surrogacy allowed them to earn money for themselves and their families, thereby exerting control over their own reproductive capacities while subverting these narratives (Pande 2014:109). Similarly, Rudrappa (2015) found that the Indian surrogates she studied viewed their work as more meaningful and valuable than their previous work as garment workers. Both Pande (2014) and Deomampo (2016) also found that surrogates negotiated control over their bodies with their husbands and other family members, sometimes in the face of opposition to their becoming a surrogate.

The dormitory systems in India also provided avenues for agency and feelings of empowerment (Pande 2010, 2014; Rudrappa 2015). For instance, dormitories served as networks for future employment or as a place to collectively negotiate wages (Pande 2010, 2014). Though the dormitories restricted their behaviors, surrogates also felt it freed them from having to engage in household duties and childcare (Pande 2014; Rudrappa 2015). Finally, Pande (2014) found that while surrogates were rarely able to negotiate the C-sections that were imposed on them, some were able to negotiate a level of post-natal care that allowed them to rest, recuperate, and spend money on themselves. Finally, viewed within the context of a stratified reproduction system, it is not surprising that some Indian surrogates felt more in control of the bodies than they did during their own pregnancies, especially due to the high level of medicalized and technological care they received. Yet, Pande (2014) notes this was only temporary and in the interest of producing a child for another woman.

Other scholars have also examined how medicalization may be used as a "tool" for agency and empowerment (Teman 2003, 2010; Ziff 2021). In her study of surrogates in the U.S., Ziff (2021) argues that through their research about and execution of the strict IVF regimen that is required of them, surrogates developed an embodied expertise that allowed them to feel in

control of the IVF process and their own bodies. Similarly, in her examination of Israeli surrogates, Teman (2003, 2010) found that surrogates used medicalized rhetoric and practices to create distance between themselves and the fetus. Israeli surrogates' detachment from the fetus is important within the context of a pronatalist state like Israel, where motherhood is seen as a "national mission," thereby positioning surrogacy as a possible transgressive act (Teman 2003:80).

Teman (2010) also argues that detachment allowed Israeli surrogates to protect themselves from feeling controlled. Since they did not view the baby as theirs, they believed that certain decisions should rightly be made by their IPs. At the same time, surrogates demarcated parts of their body that they felt were more intimate, private, and belonged to them. Israeli surrogates, therefore, had to find ways to maintain a boundary around the personalized parts of their body and private self, while also allowing for intended parents' involvement and a connection to their child. For instance, a surrogate may cover her intimate body parts while also allowing both her intended parents to attend a vaginal ultrasound.

Similarly, Berend (2016) found that U.S. surrogates often must navigate between their own bodily, health, and moral self-interest, their interest of achieving a pregnancy, and the interests of their IPs when making embryo transfer and abortion decisions. While she found that surrogates were able to separate gestation from feelings of motherhood, much like the surrogate's in Teman's (2010) study, this did not always result in a clear-cut division about who should ultimately make baby-related decisions in the area of abortion (Berend 2016).

Taken together, the preceding studies illuminate how surrogates may experience medical control over their bodies and health. They also point to opportunities for agency and autonomy during the surrogacy experience. Other than the findings of Jacobson (2016), Ziff (2021), and

Berend (2016), however, this literature focuses on transnational surrogacy experiences and contexts that are much different than in the United States. These differing contexts include specific surrogacy, medical, cultural and social systems that affect surrogates' experiences of control, agency, and autonomy. While the mechanisms of control and experiences of agency and autonomy described above may be present within surrogacy in the United States, empirical research on this is fairly thin. Furthermore, transnational surrogates are often separated by greater geographic distance and language barriers that limit their interaction with their IPs, which explains why experiences of direct control on the part of IPs is largely missing from most of these studies. In fact, evidence suggests that agencies or medical professionals involved in transnational surrogacy may discourage communication between surrogates and their clients (Deomampo 2016; Majumdar 2014).

While Berend (2016) and Jacobson (2016) do occasionally supplement their data the views of intended parents, the IP viewpoint and lived experience is largely missing from their respective examinations of medical negotiation, especially in terms of the perspective of male IPs that engage in surrogacy. To date, there has not been a comprehensive study of how surrogates and intended parents in the U.S. understand and negotiate control over medical decisions throughout the entire life course of the surrogacy experience, from the embryo transfer process all the way to decisions about childbirth. Through this study, I seek to fill this gap in the U.S. surrogacy literature. To do this, I utilize Neiterman's (2012) concept of "doing pregnancy" as a theoretical framework.

"DOING PREGNANCY"

Borrowing from the concept of "doing gender" (West and Zimmerman 1987), Neiterman (2012) suggests a similar process specific to reproduction which she refers to as "doing

pregnancy." The embodied experience of "doing pregnancy" involves three interrelated processes: learning, adapting, and performing. Learning involves acquiring the knowledge of appropriate pregnancy norms by reading relevant literature and listening to the advice of others, such as medical professionals, family members, and friends. Adapting involves mastering daily routines of self-care such as eating, drinking, exercising, walking, and sleeping. Finally, performing means ensuring that the way one does pregnancy is acknowledged and approved by others (Neiterman 2012:373). As Neiterman (2012) argues, how one does pregnancy affects whether one is viewed as a "good" or "bad" mother, thereby affecting their placement on what she calls the "social ladder of motherhood," or "an array of social perceptions that we have about 'good' and 'bad' mothers" (Neiterman 2012:373).

At the same time, one's position on the social ladder of motherhood may affect how actively one feels the need to perform the norms of pregnancy, as well as how closely one's performance is monitored and how it may be sanctioned. Those who are customarily assumed to be "good" mothers, such women who are white, married, financially secure, or experienced mothers, already have a secure place on the social ladder of motherhood. As a result, Neiterman (2012) found that experienced mothers were often critical of and challenged prenatal guidelines, and instead relied on their previous experiences of pregnancy to determine the proper way to do pregnancy. Furthermore, Neiterman (2012) argues that a "good" mother's performance of pregnancy may not be as diligently monitored, and occasional nonadherence to pregnancy norms may not be as negatively sanctioned.

Neiterman (2012) also points to the importance of social context in determining the "rights" and "wrongs" or pregnancy. Social context can include, for one, the larger culture from which pregnancy norms are drawn from. Neiterman (2012) explains that pregnancy norms not

only vary between cultures, but within cultures as well. Norms can differ based on social class or religion, for instance. Given that the "rights" and "wrongs" of pregnancy are not universally established across or within different cultures, the audience that one is interacting with also matters. As she explains, "It is possible that two groups of audiences may share different, if not conflicting, beliefs about social norms on mothering and the same action or behavior of a pregnant woman may position her at the bottom or at the top of the social ladder of motherhood" (Neiterman 2012:381).

Given that pregnancy norms are not always firmly established, Neiterman (2012) argues that the "rights" and "wrongs" of "doing pregnancy" can also be negotiated in social interaction. For instance, immigrant mothers in Neiterman's (2012) study who tended to interact with their own communities drew their pregnancy knowledge from these interactions and in turn, sometimes rejected advice from medical professionals. Pregnant women, therefore, may be selective in terms of the audiences that they choose to interact with to preserve their own norms of "doing pregnancy," as was the case with the immigrant women in Neiterman's (2012) study. Relatedly then, different audiences may evaluate one's performance of pregnancy differently. Furthermore, those who "do pregnancy" may disregard the assessment of their performance depending on the audience. For instance, teen mothers sought to minimize interaction with "unintended audiences" such as strangers who tended to judge their performance negatively, instead choosing to interact with family and friends who had more knowledge about their positive pregnancy work (Neiterman 2012:380).

In this dissertation, I plan to utilize Neiterman's concept of "doing pregnancy" to analyze not only how surrogates and IPs negotiate the "rights" and "wrongs" or pregnancy, but also other medical decisions that arise during the surrogacy process as well. As such, I refer to entirety of

the medical negotiation process as one of "doing surrogacy." When applied to the context of surrogacy, Neiterman's (2012) concept raises several important questions.

For one, how does the unique context of surrogacy affect medical negotiation? More specifically, how is medical decision making affected by the fact that those who are interacting have differing claims to the baby and the body that is carrying it? What happens when surrogates and IPs disagree on how to "do surrogacy?" How might the surrogacy matching process, where surrogates and IPs choose to work together based on their preferences for the experience, be used to circumvent possible disagreements about medical decisions? Given that surrogates are required to have birthed a child before engaging in surrogacy, how might their status as an experienced "good" mother affect their adherence to norms, as well as the monitoring and sanctioning of their pregnancy performance? Furthermore, how might intended parents' possible *inexperience* with pregnancy, including due to their gender, affect their reactions to their surrogates' performance or how they choose to "do surrogacy" overall? Finally, how are agencies, medical professionals, or others that mediate the relationship between surrogates and intended involved in the negotiation of "doing surrogacy"? This dissertation represents an attempt to address these important questions and to paint a richer picture of how—in the process of negotiating medical and health decisions during surrogacy—IPs and surrogates co-create the social reality of "doing surrogacy."

OVERVIEW OF THE DISSERTATION

The purpose of this dissertation is to explore surrogates' and intended parents' expectations for, negotiation, and experiences of control and autonomy while making medical decision throughout the surrogacy experience. In short, I examine how they "do surrogacy." To answer this research question, I conducted semi-structured interviews with 18 surrogates (17

females and one who identified as a trans male) and 15 intended parents, seven of whom were female, seven who were male, and one who identified as transfeminine. In Chapter II, "Methods," I describe my sampling and interview procedures, my data analysis approach, and the demographics and characteristics of the sample. I end the chapter with a statement on my positionality as a researcher.

In Chapter III, "Doing IVF, Selective Reduction, and Termination," I begin by describing how surrogates and intended parents tend to delineate control based on their mutual understandings of ownership over the IPs' child and the surrogate's body. I then move on to explore how this mutual understanding becomes complicated when trying to negotiate decisions about embryo transfers, selective reduction, and termination (both of which are decisions related to aborting one or more fetuses), as well as how surrogates and IPs navigate this complication.

In Chapter IV, "Doing Pregnancy," I first describe the health behaviors and practices that surrogates were required to engage in during the pregnancy. I then move on to describe surrogates' expectations about and actual experiences of control over their health behaviors and practices, especially in light of their embodied expertise that they bring to the pregnancy. I then examine intended parents' expectations about controlling their surrogate's health behaviors and practices, and conversely, how this is affected by their lack of pregnancy expertise and experience, especially when the IP is male. The issue of trust is also a major theme throughout this chapter, including how IP trust contributes to the autonomy of surrogates. I also explore how IPs sometimes find it hard to give trust, as well as how trust can be broken during the surrogacy arrangement.

In Chapter V, "Doing Childbirth," I discuss how surrogates and intended parents must navigate not only medical decisions related to childbirth, but also their mutual desire to share in

the birth experience. I discuss how medical decisions can be used to ensure as well as complicate IPs attendance at birth. I also explore how medical professionals were involved in facilitating IPs' birth involvement. I end by describing surrogates' desire for space during birth, and how this was navigated in light of surrogates' as well as intended parents' desire to experience the birth together.

In the final chapter, Chapter VI: "Summary and Conclusion," I begin by summarizing the major findings from each of the three empirical chapters of the dissertation. I then revisit the concept of "doing pregnancy" and how this concept must be viewed differently when applied to the unique context of surrogacy, as well as how my work both confirms Neiterman's (2012) findings but also expands on the concept. I then review how my work fits within the surrogacy literature overall, especially in terms of surrogacy literature specific to the United States. I end the final chapter with a discussion of the limitations of this study as well as with suggestions for future research.

CHAPTER II: METHODS

I first proposed this research project in early 2017 (Kent State University IRB Log Number 17-344, see Appendix A) to explore surrogates' and intended parents' expectations for, negotiation, and experiences of control and autonomy over medical decisions during the surrogacy experience. I designed an inductive, in-depth qualitative interview study that allowed participants to describe their experiences in their own words. In this chapter, I describe my sampling and interview procedures, my data analysis approach, and the demographics and characteristics of the sample. I end the chapter with a statement on my positionality as a researcher.

SAMPLING PROCEDURES

I recruited participants for this project using a purposive sampling method. My goal was to collect interviews from an equal number of surrogates and IPs. In terms of intended parents, I wanted to talk to both intended mothers and fathers. I also wanted to speak to participants that did and did not use a surrogacy agency. To begin the recruitment process, I started by utilizing my own social network to connect with three surrogates and one intended parent. One of these participants, a surrogate, also connected with me with her IP, a male in a gay relationship. After I utilized my network connections, I recruited the remaining participants via the internet and through subsequent snowball sampling.

I chose to use an internet recruitment approach for a variety of reasons. For one, people who engage in surrogacy are a part of a relatively small group that could be hard to find,

especially if searching locally. Each state also has their own specific surrogacy law—or a lack thereof—which could affect the surrogacy experience. By using the web, I could expand my search to all over the United States. I also recruited two participants who resided and engaged in surrogacy outside of the U.S., though my primary focus is on U.S. based surrogacy. While another option was to contact surrogacy agencies to help with recruitment, agencies are involved in the surrogacy negotiation process, including when it comes to medical decisions. It is possible that an agency may have a specific "style" of negotiation, such as leaning more towards the interests of surrogates or IPs, which could create bias if too many people came from a single agency. Furthermore, I was also interested in participants who did not utilize an agency and therefore had to negotiate medical decisions independently. Using the internet would allow me to include participants that did not use an agency, as well as participants who used a variety of surrogacy agencies.

To find participants through the web, I first posted about my study on four private Facebook groups that require administrator approval to join and participate. Two of the Facebook groups focused on helping surrogates, intended parents, and egg donors match with one other without an agency, though the site was also a space to discuss surrogacy and other related processes such as IVF. One of these groups also allowed industry professionals such as agency owners to advertise on the site, so although the group focused on independent matching, I also hoped to and did recruit people that had used an agency as well. Both groups had thousands of members. Another group I posted on was an IVF discussion and connection group that included surrogacy as part of its focus, though it only had a few hundred members. (Ultimately, though, I did not end up successfully recruiting from this group, likely because of its small membership and broader focus.)

Since I wanted to speak to both intended mothers and fathers, I also purposefully looked for a group for gay men who may have utilized surrogacy, although there were men who were members of the three groups I just described. (Although I did not have access to the exact group demographics, a quick scroll through the membership roster made it clear that there were likely many more female members than males.) While I could ask to speak to the partners of the women I recruited in my study, I wanted to interview the person who did most of the negotiating during the surrogacy experience. Among heterosexual couples that use surrogacy, it is typical that the surrogacy relationship mainly involves the surrogate and intended mother (Berend 2012, 2016; Blyth 1994; Ragoné 1994, 1996; Teman 2010, 2019). Alternatively, for men in gay and other non-heterosexual relationships, at least one of the interned parents must negotiate the surrogacy process. Furthermore, I was specifically interested in how being a biological male who had not dealt with infertility and had limited experience with the reproductive process before engaging in surrogacy affected negotiation. Heterosexual partners of intended mothers may have already attempted IVF or even experienced their partner's own pregnancy before using surrogacy. I therefore found a Facebook group focusing on gay families in a single city, which had close to one thousand members.

To access these four private Facebook groups, I introduced myself to the page administrators, described my study and shared my study flier (see Appendix B), and then asked for permission to enter and post on their page. Though I could see member posts once I had permission to enter the group, I promised to and did not utilize any of the information I saw as data for this project. I posted my study flier and a brief description about myself and the study and asked interested members to contact me privately via Facebook messenger or e-mail. I planned to continue posting and collecting interviews until I had an equal number of participants

from each sub-group (e.g., surrogates and IPs) and reached saturation. Saturation is reached when gathering additional data is not revealing any additional themes or insights (Hennink and Kaiser 2022). Through a systematic research review, Hennink and Kaiser (2022) found that saturation is typically reached between nine to 17 qualitative interviews, which was also largely true for my study. While my recruitment approach was mostly successful in terms of reaching saturation and securing interviews with surrogates and female intended parents, I was still having trouble finding intended fathers. Unfortunately, the initial gay male group that I attempted to recruit from did not result in any participants.

Luckily, an intended father I had successfully recruited told me about a surrogacy Facebook group for gay men that I had not yet posted on. This group had thousands of members. Since I was not having much success recruiting intended fathers with my own posts in the general surrogacy groups, nor the city-based gay family group, I asked if he could make a post on my behalf and share my flier since he was a member. This strategy yielded four additional male participants and one that identified as transfeminine.

THE HELPING MEN HAVE CHILDREN ORGANIZATION

Three of the IPs in same-sex relationships worked with a non-profit organization called Helping Men Have Children (HMHC) (a pseudonym), in addition to other organizations and individuals they worked with throughout their journey. The Helping Men Have Children organization began on the east coast but has since expanded its work throughout the US and internationally. HMHC offers seminars, workshops, and other educational and practical information to assist prospective parents who are gay, trans, queer, or bisexual men achieve biological parenting. They also promote ethical surrogacy practices, raise awareness around surrogacy, and encourage and support medical and social science surrogacy research. They

advocate for the affordability of surrogacy related services and provide financial assistance through grants, discounted, and free services. In addition, they provide a directory with reviews and ratings of surrogacy agencies and clinics that they can help connect their clients with. Finally, they also run a community forum on Facebook, which is where I was able to recruit five of my participants via my gatekeeper's post. The three participants that worked with HMHC utilized various HMHC services including seminars and workshops, financial assistance, review information, and referrals to other surrogacy organizations and individuals.

INTERVIEW PROCEDURES

So that participants could describe their experiences in detail and in their own words, I developed an open-ended interview guide that allowed them to describe their expectations for, negotiations, and experiences of medical decision making throughout the surrogacy process. Before any interviews, participants provided verbal and written consent (see Appendices C and D). As part of this process, I told participants their identities would be kept confidential, including through the assignment of pseudonyms, and that any other identifying information would be generalized. I also stressed the voluntary nature of the research by letting participants know that they could choose not to answer certain questions or could stop the interview at any time. I did not compensate respondents for their participation.

I began the interview with a brief demographic and surrogacy experience questionnaire. The main interview guide was split into four main sections: 1) motivations for engaging in surrogacy and early expectations about medical control and involvement (e.g., expectations about sharing symptoms or attendance at pregnancy appointments or birth); 2) pregnancy expectations, negotiation, and experiences; 3) childbirth expectations, negotiation, and experiences; and 4) feelings about the experience once the surrogacy process was complete. On

the interview guide, I also included possible probing questions to illicit more information (see Appendix E). At the end of the interview, all participants were asked to share my study and contact information with any other surrogates or intended parents who may be interested in the study.

Since this was an inductive study, I also asked about topics that were not on the initial interview guide (e.g., about the hospital experience during childbirth) as it became clear that these were important topics as the interview process moved along. One regrettable aspect of the initial interview guide is that I did not include specific questions about the IVF process which is, of course, an important component of the surrogacy experience since most participants in this study were gestational surrogates. I also did not have questions about abortion decisions. Luckily, participants I interviewed early in the process brought these topics up on their own given their importance, so I began asking more specific questions about IVF and abortion in subsequent interviews.

I allowed surrogates and intended parents that were in any stage of the surrogacy process to participate. Participants who had already completed at least one surrogacy journey offered a retrospective account of each part of the process. Some of these respondents were also engaging in a subsequent ongoing journey when our interview took place. We therefore also spoke about any completed phases of their current journey. (For example, if they already completed the IVF process in the subsequent journey, we discussed how that went.) I also asked them about their expectations for any future events that had not yet been completed, such as the childbirth. For any participant who had engaged in multiple journeys (whether they were all completed or currently ongoing), I inquired about how their expectations and experiences may have changed over time.

Other respondents were engaging in their first journey and had *not* completed a full surrogacy experience yet. The process for these interviews was similar for those engaging in an ongoing journey that I described just above. We first completed an initial interview where I asked any questions that were relevant to their place in the process (e.g., matching), and then also discussed any expectations for future uncompleted events (e.g., childbirth). I made every attempt to reinterview participants who were in the middle of completing a journey (either as their first or a subsequent journey) after childbirth when the journey was complete. During any follow-up interviews, we first returned to the previous experience to reflect on how expectations changed over time. I also asked respondents to talk about their experiences for phases of the process that happened after the initial interview.

Of the 33 respondents, 28 completed a single interview. Five participants (three surrogates and two IPs) completed an initial interview and then a follow-up interview for a total of 38 interviews. Four of the follow-ups were post-surrogacy interviews and one was at 25 weeks of pregnancy. One participant, Laura, was a six-time surrogate that I interviewed twice a week apart, although I count it as a single interview since it was not technically a follow-up but more of a continuation. Six respondents (three surrogates and three IPs) did not complete at least one full surrogacy experience by the time of our (final) interview, but speaking with them allowed me to dive deeper into specific parts of the surrogacy process such as matching, the IVF process, or pregnancy. Some participants also communicated or followed up with me informally, such as through e-mail or Facebook messages.

While data collection began in late 2017, the bulk of interviews took place in late Spring 2018. I completed almost all interviews by the end of 2019, though there were three additional follow-up interviews in early 2020. I conducted most interviews with participants via the

telephone (or via other audio call options, like on Facebook) or video chat, although I met two local participants in-person at a location of their choice. One was at a coffee shop, and another was at the participant's residence. I audio-recorded all the participants' interviews with their permission. Single or initial interviews lasted from 26 to 155 minutes, with Laura's interview being the longest. (The next longest lasted 144 minutes). Twenty-six of these interviews lasted about an hour or more, with 12 of those lasting more than 90 minutes. The average length of single or initial interviews was about 81 minutes. Follow-up interviews lasted between 22 and 41 minutes. The average length was around 34 minutes.

ANALYSIS

Most interviews were transcribed using two transcription services, *Rev* and *GoTranscript*. One interview was transcribed by an undergraduate student that I worked with as part of an instructor-student mentorship program in the Kent State Sociology and Criminology Department. After the interviews were transcribed, I corrected any discrepancies or sections labeled as inaudible (if possible) in the interviews manually. Once interviews were properly transcribed, I proceeded to code my data using the coding software *Dedoose*.

Although I had done a previous literature review on surrogacy and had some initial themes in mind, my goal was to allow the final themes for this paper to arise from the participants' own stories. Therefore, I followed an inductive coding approach. I began this inductive process using an "open-coding" method, meaning I went through each interview, line-by-line, and was open to any all topics as potential codes (Lofland et al. 2006). Using *Dedoose*, I was able to highlight specific sections of a participant's interview and organize them into various folders that were labeled with short phrases (a code) that represented what was happening in that section of text.

To start, codes were very generalized and typically represented the questions I had developed for my study. I attempted to not let code folders get too large, so question topics that had multiple themes, like childbirth, were split into more specific open codes such as "childbirth complications," "labor induction," or "natural vs. medical approach." I also made code folders for topics such as "agency help" or "gender and sexuality," which did not pertain to a specific question, but could help me to understand how those specific elements of the surrogacy experience came into play. The same sections of an interview, therefore, could be labeled with multiple codes, for example, when males talked about how their gender impacted their expectations about control. Finally, any new topics that I did not specifically ask about that arose from my interviews also had a code, such as "experiences of pregnancy loss."

After open-coding all interviews, I moved to a more "focused" coding approach that was more interpretive than the previous open-coding round (Lofland et al. 2006). To do this, I recoded my original open codes into more specific topics. For instance, I broke the code "medical control experiences" down into more specific topic codes such as "receiving trust" or "lack of control." In some instances, this was sufficient. However, if a recoded topic was too large or needed more interpretation and analysis, I repeated the process again. I continued this process until all focused codes were broken into several smaller themes. While coding, I also utilized the "memoing" method, meaning I wrote "memos" or notes about my ideas for the final paper, such as about how codes were connected, connections to literature, or which codes I felt would be most relevant in terms of the final story (Lofland et al. 2006). After the coding process was complete, I identified focused codes and specific themes that recurred in the data that described surrogates' and intended parents' expectations for, negotiations, and experiences of medical control throughout the surrogacy process.

PARTICIPANT DEMOGRAPHICS AND CHARACTERISTICS

Of the 33 participants in this study, 18 are surrogates, and 15 are intended parents. Two surrogates and two IPs were "matched," meaning they worked directly with one another through the surrogacy process. All the surrogates were assigned female sex at birth. One surrogate identified as a transgender male, although he had not yet transitioned when he served as a surrogate. Of the intended parents, seven were female and eight were assigned male biology at birth, though one, Robert, identified as transfeminine, including during the time he was using surrogacy. Since Robert uses both she/her and he/him pronouns, I use both when referring to Robert throughout this document. Surrogates' ages at the time of our interview ranged from 24 to 52, though only two were in their 20s and one, the "retired" six-time surrogate in this study, was in her 50s. The majority (n = 12) of surrogates were in their mid-to-late 30s to early 40s, and three were in the early 30s. Intended parents were between 35 and 56 years of age. Eight were in their mid-to-late 30s to early 40s, six were in their mid-to-late 40s to early 50s, and one was the 56-year-old.

Fifteen of the surrogates in this study identified as white, one identified as black, one as Hispanic, and one, the surrogate from Canada, as "mixed culture." As for the 15 intended parents, 11 identified as white. The four remaining IPs identified as black, Hispanic, Middle Eastern, and Korean, respectively. In terms of surrogates' highest level of education, two had a high school degree, four had completed some college (one of which also attended a vocational school), seven had a bachelor's degree, and five had an advanced degree. Intended parents had a slightly higher average level of education. One IP had an associate degree and pursued a bachelor's degree but had not finished yet, four had a bachelor's degree, and 10 IPs had an advanced degree. As for surrogates' relationship status, two surrogates were single, two were

partnered in different sex relationships, 12 were married to different sex partners, one was in a same sex marriage, and one, the trans male, was in a same gender marriage. All female IPs (n = 7) were married to different sex partners. One male IP was in a same sex partnership and the remaining male IPs (n = 6) were married to same sex individuals. The transfeminine IP was also married and identified as queer. Finally, four surrogates also worked with six sets of same sex IP couples during their various experiences (not including one surrogate who was matched with an intended father in a same sex relationship that was also interviewed for this study, as he was included in the IP count above). (See Table 1 on page 36 for a summary of the demographics I just previously described.)

All but two participants, one surrogate from Australia and one from Canada, completed their surrogacy experiences in the United States. Participants' experiences took place in over a dozen U.S. states, ranging from the west to the east coast. When including the location of participants' surrogates and IPs, the various experiences in this study took place in at least 20 different states. Three U.S. surrogates also worked with IPs that lived outside of the United States, in Canada, Taiwan, and Israel, though two of them also participated in domestic surrogacy experiences during their tenure as surrogates. The two surrogates from abroad had domestic experiences in their respective countries. One IP, the owner of an U.S. surrogacy agency that utilizes surrogates in Mexico, planned to use her own agency and therefore possibly a Mexican surrogate, though she had not yet officially started that journey. Given the characteristics of the sample, the focus of this research is on the U.S. domestic surrogacy experience, though I do provide examples of non-U.S. and transnational experiences where relevant throughout this document.

Table 1: Participant Demographics Summary (Gender, Age, Race, Education, Relationship Status)

		Surrogates	IPs
Gender			
	Cisgender Female	17	7
	Cisgender Male	X	7
	Transgender Male	1	X
	Transfeminine	X	1
Age			
	21-24	1	X
	25-34	4	X
	35-44	12	8
	45-54	1	6
	55+	X	1
Race			
	White	15	11
	Black	1	1
	Hispanic	1	1
	Other	1	2
Education			
	High School	2	X
	Some College/Vocational School/Associate's	4	1
	Bachelor's	7	4
	Advanced Degree	5	10
Relationship Status			
	Single	2	X
	Partnered Different Sex/Gender	2	X
	Partnered Same Sex/Gender	X	1
	Married Different Sex/Gender	12	7
	Married Same Sex/Gender or Queer	2	7
Total		18	15

Almost all surrogates (either in this study or IPs' surrogates) were or were going to be compensated for their work, above and beyond any reasonable expenses incurred during the surrogacy process, and therefore were considered "commercial" surrogates. Although surrogates

who are not compensated beyond reimbursement are considered "altruistic" surrogates, most commercial surrogates in this study also reported altruistic motivations. In some countries, commercial surrogacy and therefore direct compensation beyond reasonable reimbursement is prohibited by law, which was the case for the two surrogates located in Canada and Australia. Finally, two IPs in this study reported that their three surrogates were not or were not going to be directly compensated, meaning that those journeys were or were going to be fully altruistic. In one case an IP had altruistic arrangements with his sister and then a friend of a friend, and in another an IP had planned a future altruistic arrangement with a friend.

The participants' surrogacy experiences took place or were taking place (if not completed yet) between 2007 and 2020. The total number of surrogacy experiences represented by participants in this study is 51, since 11 participants (5 surrogates and 6 IPs) engaged in two or more surrogacy experiences (eight had two experiences, one had three, one had four, and one had six). Twenty-two, therefore, had engaged in surrogacy only once. Of all the experiences, 41 were completed at the time of our single (or final) interview, though three completed journeys did not result in a viable pregnancy. Since two sets of participants were matched with each other, this represents 36 total births when not counting births that were reported to me twice by matched participants.

Of the ten experiences that were not completed at the time of our single or final interview, three were among participants who had already completed at least one journey and were engaging in a subsequent journey at the time of our interview (one surrogate was at the matching stage, one surrogate had matched but had not yet done an embryo transfer, and one IP was working with a surrogate that was five weeks pregnant). The remaining seven incomplete journeys were represented by six participants. Twenty-seven participants, therefore, completed at

least one journey (15 surrogates and 12 IPs). Three of the six participants with incomplete journeys (one surrogate and two IPs) were at the matching stage. One of the six was a surrogate that had matched but had not yet done an embryo transfer, and one was a surrogate that was 25 weeks pregnant. Finally, one IP had two incomplete experiences, one with a surrogate that had transferred, lost the pregnancy, and was going to try to transfer again, and one with a surrogate that was going to transfer in the next year.

As is typical of surrogacy since the development and rise of invitro fertilization (IVF), 40 of the 44 surrogacy experiences in this study that had reached the embryo transfer stage were considered gestational, meaning that a surrogate carries the child or children but is not genetically related to them. The remaining four experiences were traditional, meaning the surrogate also provided the eggs to be used during surrogacy. Two were surrogates that had one traditional surrogacy experience each, but they also served as gestational surrogates during other experiences. One additional surrogate's experience began as gestational, but after unsuccessful attempts at getting pregnant she ended up donating her eggs to her IPs and therefore served as a traditional surrogate in the end. Only one male IP attempted traditional surrogacy when his sister served as his surrogate and provided her egg, although that attempt was unsuccessful. In his remaining two surrogacy experiences, one of which was successful and one of which was not, the surrogacy experiences were gestational. The seven remaining experiences (of 51 total) that had not yet reached the transfer stage were to be gestational as well.

Fifteen of the participants, eight surrogates and seven IPs, used an agency at least once during their surrogacy journeys. Two IPs were also agency owners themselves (both operated in the US, though one of them utilized surrogates in Mexico) and were using their own agencies for at least one of their experiences, for a total of 17 participants. In total, 24 of the 51 experiences in

this study involved an agency. Johnson (2016) reports that the cost for intended parents to use an agency can range from $10,000 to $20,000. However, more recent estimates indicate that prices have risen to somewhere between $20,000 and $40,000 dollars or more (Circle Surrogacy 2024). (Unlike intended parents, surrogates do not have to pay to sign on with an agency.) The price of using an agency varies since it largely depends on the services that the agency provides as part of their fee. Some agencies are very large and have many employees as part of their team, such as lawyers and accountants, and may include these services within the cost of using their agency. Other agencies are smaller, consisting of an owner and perhaps a few key employees, and only offer basic services as part of their price. Intended parents must then pay for legal and other needed services that are not included in the agency fee out of pocket.

Though the kinds of services agencies provide vary, they all typically help navigate a surrogate journey from start to finish. One of the most basic services that agencies provide is to prescreen and then match intended parents and surrogates. Before matching, both surrogates and IPs may have to complete criminal and background checks, individual interviews, in-home assessments, and psychological evaluations or consultations. Surrogates are much more likely to be required to complete most if not all these procedures before signing up with an agency. Whether intended parents are required to complete one or more of these steps depends on the agency or is determined on a case-by-case basis. Agencies also require that surrogates have at least one successful past pregnancy and an uncomplicated past pregnancy history. They also must typically have no more than five previous pregnancies and three Cesarean sections, although these numbers can vary slightly from agency to agency. Agencies also look for surrogates that do not use drugs, smoke, or abuse alcohol. They must be at least 21 years old and are no longer accepted after reaching their early 40s, though again, the cutoff age can vary.

Agencies tend to prefer to work with intended parents who are utilizing surrogacy because of infertility issues or the inability to physically carry a child, rather than as a matter of convenience. Finally, agencies often ensure that IPs have the financial means to pay for their services and the overall cost of surrogacy, while surrogates are typically excluded if they are not financially stable and are currently receiving government assistance. Jacobson (2016:32) reports that agencies may also screen IPs for "anticipated problematic behavior or attitudes," such as being "overly controlling or unrealistically demanding." Similarly, agencies will often look for surrogates who will be compliant and appropriately follow the agreed upon medical protocol that is required of them (Jacobson 2016).

Once screened, agencies help match surrogates and intended parents based on their various requirements and preferences. These can include preferences for frequency of communication and attendance at medical appointments and birth, the number of embryos that are to be transferred, whether both parties agree on the issue of abortion, and expectations around diet, health behaviors, or the plan for childbirth. Keeping in mind that some surrogates and IPs in the study had more than one surrogacy experience, 23 of the 51 total experiences (or all but one of the 24 experiences that involved an agency) were or were going to be matched through an agency. In the one instance where the participant worked with an agency but was not matched through them, the surrogate first utilized a professional surrogacy matching service that brought together Jewish egg donors, surrogates, and intended parents. When a surrogate and IP has already matched before working with an agency, which is sometimes the case, the matching portion of the agency fee may be waived. Agencies may also help match intended parents with eggs donors. Finally, they can refer IPs and surrogates to other needed individuals and institutions such as reproductive endocrinologists (REs) and fertility clinics, obstetricians and

hospitals, mental health professionals, or lawyers if not already provided through in-house services.

Agencies also typically provide general case management and help to coordinate information between the various parties and institutions involved in the surrogacy process. They are there to answer any questions during the surrogacy experience and ensure that all necessary steps are being completed during the process. They may also assist with scheduling and coordinating medical appointments and making travel arrangements. After matching, agencies also typically help to facilitate and mediate communication and foster the relationship between surrogates and IPs. They may also help negotiate any disputes between them if needed, including those pertaining to the contract. Agencies also often provide ongoing counseling and emotional support to surrogates and intended parents. As stated earlier, some agencies provide legal services as part of their fee, which can include helping to craft the surrogacy contract or establish legal parenthood. Finally, since IPs typically must put the funds needed for surrogacy in an escrow account, agencies may also help manage the trust and can help distribute payments, such as to the surrogate.

Alternatively, 27 of the 51 experiences in this study were considered "independent" journeys. (See pages 42-43 for Tables 2 and 3, which list demographics and characteristics for each participant.) During an independent journey, surrogates and IPs navigate their journey without the help of an agency and therefore take on much more responsibility of managing and coordinating their own experience. Not using an agency may help lower the overall cost of surrogacy, though the cost of paying out of pocket for services that an agency may provide can add up quickly. One of the first steps that surrogates and intended parents must complete is finding and vetting needed surrogacy institutions and individuals (e.g., fertility clinics, lawyers)

DEMOGRAPHICS AND CHARACTERISTICS OF EACH PARTICIPANT

Table 2: Surrogates - Demographics and Characteristics

Pseudonym	*Gender*[1]	*Age Range*	*Race/Ethnicity*	*Relationship Status*[2]	*Level of Education*[3]	*Number of Experiences*	*Number of Interviews*	*Gestational*[4]	*Traditional*[5]	*Agency Journey*[6]	*Independent Journey*[7]
Jacqueline	Female	35-44	Black	Single	SC/V	1	1	1	0	0	1
Elizabeth	Female	34-44	White	DSM	AD	1	1	1	0	0	1
Drew	TM	35-44	White	SGM	AD	2	1	1	1	0	2
Kathleen	Female	35-44	White	DSM	HS	1	1	1	0	0	1
*Amanda***	Female	35-44	Other	DSP	BA	1	1	0	1	0	1
Susan	Female	35-44	White	DSM	BA	4	2	3	1	4	0
*Joyce****	Female	35-44	White	SSM	AD	1	1	1*	0	0	1
Kim	Female	35-44	White	DSM	BA	1	2	1	0	0	1
Emily	Female	25-34	White	DSM	BA	1	2	1	0	0	1
Mary	Female	21-24	White	DSP	SC	1	1	1*	0	1	0
Cynthia	Female	25-34	White	DSM	BA	1	1	1	0	0	1
Laura	Female	45-54	White	DSM	BA	6	1	6	0	3	3
Heather	Female	35-44	White	DSM	BA	1	1	1	0	0	1
Amy	Female	35-44	White	DSM	AD	2	1	1, 1*	0	1	1
Megan	Female	35-44	Hispanic	DSM	SC	1	1	1	0	1	0
Olivia	Female	25-34	White	Single	SC	1	1	1	0	1	0
Amber	Female	25-34	White	DSM	AD	2	1	1, 1*	0	2	0
Rachel	Female	35-44	White	DSM	HS	1	1	1	0	1	0

[1]**Gender:** TM = Transgender Male

[2]**Relatinship Status:** DSM = Different Sex Marriage, SGM = Same Gender Marriage, DSP = Different Sex Partnership, SSM = Same Sex Marriage

[3]**Level of Education:** HS = High School, SC = Some College, V = Vocational School, BA = Bachelor's Degree, AD = Advanced Degree

[4]**Gestational:** Indicates total number of experiences that were gestational, *Indicates plan for transfer that had not yet been completed

[5]**Traditional:** Indicates total number of experiences that were traditional, *Indicates plan for transfer that had not yet been completed

[6]**Agency Journey:** Indicates total number of experiences using an agency

[7]**Independent Journey:** Indicates total number of experiences that were independent

**Amanda is the surrogate from Candana, ***Joyce is the surrogate from Australia

Table 3: Independent Parents - Demographics and Characteristics

Pseudonym	*Gender*[1]	*Age Range*	*Race/Ethnicity*	*Relationship Status*[2]	*Level of Education*[3]	*Number of Experiences*	*Number of Interviews*	*Gestational*[4]	*Traditional*[5]	*Agency Journey*[6]	*Independent Journey*[7]
Nicole	Female	35-44	Black	DSM	AD	1	1	1	0	0	1
Emma	Female	35-44	White	DSM	SC	1	1	1	0	0	1
Sarah	Female	35-44	White	DSM	AD	1	2	1	0	0	1
Hannah	Female	45-54	White	DSM	AD	1	1	1*	0	1	0
Diane	Female	45-54	White	DSM	AD	1	1	1	0	0	1
Stephanie	Female	35-44	White	DSM	BA	2	1	2	0	1	1
Samantha	Female	35-44	White	DSM	AD	2	2	2	0	0	2
John	Male	45-54	White	SSM	BA	2	1	2	0	0	2
Tom	Male	35-44	White	SSM	BA	3	1	2	1	1	2
Ben	Male	45-54	Other	SSM	AD	1	1	1	0	1	0
James	Male	35-44	White	SSM	AD	1	1	1*	0	1	0
Christopher	Male	45-54	White	SSM	BA	1	1	1	0	1	0
Will	Male	55-64	Hispanic	SSP	AD	1	1	1	0	1	0
Henry	Male	45-54	White	SSM	AD	2	1	2	0	2	0
Robert	TF	35-44	Korean	QM	AD	2	1	1, 1*	0	1	1

[1]**Gender:** TF = Trans Feminine
[2]**Relatinship Status:** DSM = Different Sex Marriage, SSM = Same Sex Marriage, SSP = Same Sex Partnership, QM = Queer Marriage
[3]**Level of Education:** SC = Some College, BA = Bachelor's Degree, AD = Advanced Degree
[4]**Gestational:** Indicates total number of experiences that were gestational, *Indicates plan for transfer that had not yet been completed
[5]**Traditional:** Indicates total number of experiences that were traditional, *Indicates plan for transfer that had not yet been completed
[6]**Agency Journey:** Indicates total number of experiences using an agency
[7]**Independent Journey:** Indicates total number of experiences that were independent

if not already connected with them, including the surrogate or IP they plan to match with. Of the 27 (out of 51) independent, non-agency matched or led experiences, five were matches with a friend or acquittance. Two experiences were with family members and in one case, a "god-sister." In four experiences, participants were introduced to their match through a friend or family member. Another four matches were through Facebook and four were through a website. Alternatively, in three experiences participants were matched by lawyers, and in four experiences participants were matched through clinics or a medical professional.

Whether or not an agency is involved, surrogates must still be medically approved by a fertility clinic before moving ahead with surrogacy. Both agencies and fertility clinics tend to follow the recommendations of the American Society of Reproductive Medicine (ASRM) when screening and approving a surrogate, and therefore have many of the same requirements (ASRM 2022) in terms of age, having a successful past pregnancy, and limitations around any previous pregnancy complications, number of pregnancies, and Cesarean sections. To approve a surrogate, REs will review the surrogate's medical records, complete a physical examination, and run various tests. Fertility clinics also often require the surrogate, and sometimes intended parents, to complete a psychological evaluation and receive initial counseling as is recommended by the ASRM (2022). IPs can also pay for ongoing counseling and support for themselves or their surrogate out of pocket.

Those who engage in independent journeys also receive guidance from a lawyer or lawyers. The ASRM (2022) recommends that IPs and surrogates each have their own separate legal counsel. Since surrogates are not expected to cover the costs of surrogacy, IPs must pay for their own and the surrogate's legal representation. Once hired, lawyers will help craft the surrogacy contract, establish legal parenthood for the IPs, and can help interpret and enforce any

contract stipulations during the journey. Contracts typically outline financial obligations and compensation schedules, as well as expectations for during and post-surrogacy communication and medical involvement. They also usually include transfer, abortion, medical, health behavior, and decision-making expectations, any birth or contingency plans (such as if the surrogate faces medical complications), and will cover the issue of parental rights.

POSITIONALITY STATEMENT

I am a person who has not given birth, nor have I served as or utilized a surrogate. By Dwyer and Buckle's (2009) definition, I was, at least at the outset of my work on surrogacy, somewhat of an "outsider" in terms of the larger surrogacy community. Being an "insider" versus "outsider" can result in both benefits and disadvantages during the research process (Dwyer and Buckle 2009). For one, insider status can allow for easier access to the research population that one wants to study. While this may be true, I was largely able to overcome that obstacle, at least in terms of recruiting surrogates and intended mothers, by utilizing gatekeepers such as the administrators of the general surrogacy Facebook groups. Being a female also likely helped, since I believe it would have been particularly difficult for a male researcher to gain access to those groups and recruit female participants from them. Conversely, gay males who are pursing surrogacy have differing experiences and challenges compared to females or heterosexual couples who are doing so, which may explain why their membership on more general surrogacy groups was more limited. Recruiting these participants not only required access to a specialized gay male surrogacy group, but a direct endorsement and post on my behalf from a gay male participant was also likely helpful.

Being an insider can also help create participant acceptance and trust, which may make them more willing to share their experiences because of an "assumption of understanding and

shared distinctiveness" (Dwyer and Buckle 2009:58). This, in turn, can result in better data. Alternatively, participants may not fully explain their experiences since they may assume that an insider may already know and understand what it is like to be a part of that group. In that way, being an outsider can be beneficial. I also propose that a third, related option may also be possible. Insiders may be accustomed to speaking to other insiders, and therefore utilize insider language or assume common knowledge when speaking to others, even when that person is a known outsider. Finally, I also argue that the depth of an interview depends not only on the status of the interviewer, but the personality of the participant as well. Some participants are natural teachers or simply like talking about themselves. Others may prefer talking to someone who is more knowledgeable or who shares their experience, and some just tend to be briefer when answering questions during an interview.

Though Dwyer and Buckle (2009) point out these common advantages and disadvantages of researcher status, they also argue against the simplistic dichotomy of insider versus outsider. Though one may lean more towards one or the other, they contend that researchers often exist in a space in between the two. For instance, as someone who has strived to become an expert in surrogacy, I have read a lot of literature on the topic. While I am not truly an insider in terms of actual experience, I am somewhat in the sense of the knowledge I have gained. The nature of qualitative research also means that I am deeply immersed in my data and the experiences of my participants and therefore gain knowledge from them as well. My approach to interviewing involved strategically utilizing this space in between.

Participants often assumed, rightly so, that I was not a surrogate or IP, given that I did not state as much in my general introduction on my recruitment posts or during our interviews. Rather, I initially presented myself as an outsider researcher who wanted to learn more about

surrogates' and IPs' own experiences, particularly in relation to the medical negotiation process. This approach worked well for the most part, and many participants were willing to describe both the positive and negative aspects of their experience in detail. Sometimes, participants asked whether I had ever given birth, and when I stated that I had not, they proceeded to explain a procedure or experience with that in mind. Acting like an interested outsider who wants to learn can also be particularly beneficial when speaking to participants that like to teach or speak about themselves. In those cases, being a good listener works well.

On the other hand, I did occasionally experience participants using insider language or assumed knowledge that I was not familiar with, or participants that were simply not as responsive or detailed when I asked them questions. Regardless of the reason why participants may not fully explain themselves, it could usually be rectified by employing good interviewing practices. When I needed more information, I was not hesitant to continue to act like an outsider and ask participants to explain what they meant or why they felt a certain way. That is why "probing" questions are an important aspect of qualitative interviewing. Of course, there were some participants who were still brief, no matter the amount of interest I conveyed or probing questions I asked. I could and did, however, utilize the more talkative and detailed participants to fill in any "gaps" from these interviews during my analysis.

Other times, either with a certain participant or during certain moments during an interview, it seemed more beneficial to utilize the insider knowledge I had gained. For instance, I made use of what I had learned through the surrogacy literature and previous interviews and took that with me going forward in subsequent interviews. I began to utilize the language of pregnancy, birth, and surrogacy. For instance, I used the shorthand "IP" (instead of intended parents) or referred to their experiences as "journeys" as participants often did. This likely

resulted in some participants sharing more because of my familiarity with their experience. It also allowed the interviews to flow better without frustrating participants by having them stop and explain every medication name or procedure, for example. Instead, they could concentrate on describing how they felt about the experience itself. As Acker (2001:5) suggests, while taking the approach of the "naïve observer… does have the effect of stimulating the participant to give a layperson's explanation," it can also possibly "[distract] from other exchanges that might have been of greater relevance to the project."

Insider versus outsider status and the space in between is also relevant in terms of analysis. First, since a certain level of subjectivity and connection to one's participants and their feelings is helpful and encouraged in inductive analysis (Adler and Adler 1987), being an insider can be beneficial. Yet, according to Dwyer and Buckle (2009), an insider researcher can also suffer from a lack of objectivity that can be detrimental to the study. For instance, they may focus too much on shared experiences, either during an interview or analysis. Insiders may also project their own personal interpretation of an event which may be different than what the participant intended or meant. Both issues can be further complicated by the fact that not all members of a community group share the same intersecting identity statuses or experience. Although surrogates and IPs are members of a larger group, for instance, they also have differing identities and experiences as individuals on opposite ends of the surrogacy relationship, and as a result, sometimes have competing interests.

While being a surrogate or IP may have helped me to understand respondent experiences more fully, it could have also created the types of bias described above. As Dwyer and Buckle (2009:59) explain, "…The core ingredient is not insider or outsider status but an ability to be open, authentic, honest, deeply interested in the experience of one's research participants, and

committed to accurately and adequately representing their experience." Being in a "neutral" position between the two groups did not mean, however, that I was not critical in my analysis. For instance, I attempted to accurately describe when surrogates experienced a loss of autonomy during the medical negotiation process. To put this into context, however, also means understanding the feelings, motivations, interests, and implications for intended parents, in addition to those of surrogates. At the same time, as a researcher who has moved more towards an insider status, I am also aware of the many critiques and potential negative aspects of the surrogacy process present within the surrogacy literature. I attempted not to let this bias my analysis either. As a result, I also attempted to highlight the positive aspects of surrogacy, such as when surrogates did have autonomy, including when it was facilitated and supported by intended parents.

CHAPTER III: DOING IVF, SELECTIVE REDUCTION, AND TERMINATION

Neiterman (2012) argues that pregnancy is an embodied experience where the "rights" and "wrongs" of "doing pregnancy" are negotiated in interaction with others based on larger social norms. In the first part of this chapter, I briefly explore surrogates' and IPs' expectations about control over medical decisions, or who gets to determine the "right" and "wrong" ways of "doing surrogacy." Many surrogates reported that they generally expected IPs to have the power to make medical decisions, especially because they believed it is the IPs' child and pregnancy. As I will show throughout the chapter, however, surrogates also wanted to have control over decisions that they believed could affect their bodies and their health. Similarly, IPs also described wanting to make decisions, while also respecting surrogates' right to bodily autonomy and their concerns for their own health.

Neiterman (2012) states that the social context in which the negotiation of "doing pregnancy" takes place can define what is expected of pregnant women. Within the specific context of surrogacy, the negotiation process is unique in that surrogates and IPs have differing, yet seemingly agreed upon, claims to the pregnant body and the child inside of it. Furthermore, although participants tended to separate the two, decisions pertaining to the surrogate's body and health can affect intended parents and their children, while decisions made in the interest of intended parents and their children can affect surrogates' bodies and health. How then, do surrogates and intended parents go about making decisions when intended parents' children and surrogates' bodies and health are so deeply intertwined? After describing how surrogates and IPs

general expectations for control over decisions, I explore this issue in more detail in the remainder of the chapter.

First, I examine decisions about the embryos transfer process and how the bodily autonomy and health of the surrogate was considered against the wishes and hopes of intended parents who want to have a child, as well as the aspirations of the surrogates themselves who wanted to accomplish a pregnancy for them. Next, I explore how decisions about the reduction or selective termination of one or more fetuses in a multifetal pregnancy and pregnancy termination (all of which are essentially decisions about whether to abort one or more fetuses or end the pregnancy) created a complex scenario where the values, bodily autonomy, and health of the surrogate was interlaced with the values, autonomy, and possible real and lasting effects for intended parents in terms of their life and the life of their children. In each section, I explore how surrogates and IPs negotiated decisions in these areas where this line between the surrogate's body, health, and implications for the intended parents and their children was blurred, while also examining how others such as medical professionals and agency employees were involved in the negotiation process.

To shed light on this empirical story, I draw on Neiterman's (2012) argument that different audiences can have divergent or even conflicting opinions on the "right" and "wrong" ways of "doing pregnancy." When negotiating decisions about reduction and termination, this is especially true since the debate over whether it is "right" or "wrong" to abort a child is so deeply contested in the United States. In Neiterman's (2012) study, participants sometimes sought out receptive audiences that affirmed their views on the proper ways to "do pregnancy." Similarly, negotiation on how to "do surrogacy" starts before the surrogacy process even begins, during the matching phase, when surrogates and intended parents decided if they wanted to ultimately work

together. Finding the proper match, or "audience," is especially pertinent in the section on reduction and termination since it was one way that surrogates and IPs were able to navigate such a debated topic that also involved the indistinct line between surrogates' own values, bodies, and health and the values and effects on IPs and their children.

THE DELINEATION OF CONTROL OVER MEDICAL DECISIONS

Although both surrogates and intended parents expected to make medical decisions during the pregnancy, some participants tended to separate decisions between those that should be made by intended parents and those that should be made by surrogates. For example, a little over a third of surrogates reported to me that they generally expected intended parents to make medical decisions. For instance, when I asked Elizabeth how much control she envisioned to have during her surrogacy experience, she told me, "When it comes to tests like invasive tests like an amnio or something, that would be their choice. If they wanted to know any results from an amino, that's not, I don't feel like it's my choice whether they find out if their child has a genetic disorder." Elizabeth's IPs did not choose for her get an amnio, but she was willing to give them the option to do so since it pertained to "their child." Like Elizabeth, Cynthia was also a surrogate who talked about the fact that it was "their [the IPs'] baby." She went even further by saying that she wanted it to be like "their pregnancy." She explained,

> As far as medical decisions, ultimately it's their baby and so I'm not going to force them to have to do something that they wouldn't do for themselves. When I said I wanted it to be like their pregnancy, that meant that if something came up and they had to make a decision, then I didn't necessarily want them to worry about how I felt about that decision. It was their baby, their decision to make type thing. (Cynthia – Female Surrogate)

Though many surrogates made it clear that they would allow their IPs to make certain baby-based decisions as Elizabeth and Cynthia did above, surrogates in this group also expressed that they wanted to be able to make decisions that involved their own body and health.

For example, Heather was another surrogate that also used the language of "their pregnancy" and added that it would be "their delivery" as well. In addition to giving control to her intended parents, she also said that they would follow doctor's recommendations. Yet, Heather also said she also wanted to have control over certain decisions. She said, "I think almost 100% was their guidance, however, there has to be something that is up to me. Obviously, we followed a doctor's recommendation. I really wanted them to have the most control that they could possibly, as if it was their own pregnancy and delivery." When I asked what decisions would be up to her, she elaborated by saying,

> Yeah, just more like my own input. You know, and it could be just as silly as like whether or not I got an epidural. That's not your decision, that is my decision. I would even say like if someone said to me, "You have to choose between a vaginal or a C-section," like that would obviously be up to my doctor. I wouldn't make that decision. But yeah, I would say the majority of the decisions I wanted them to make regarding the process. (Heather – Female Surrogate)

For Heather, having some autonomy involved deciding whether she would get an epidural, despite her saying that it was "their [the IP's] delivery."

Jacqueline also said that she wanted to make decisions about her body while also allowing her intended parents to make decisions about their baby. She also talked about

establishing that her health was most important early in the surrogacy process, even above that of her IPs' child. She explained,

> Yeah, so we talked about it, in the beginning, that my health was more important than anything else. There's no point in trying to move forward with surrogacy if it was going to affect my health, because I also have a child that I have to take care of. So, if it was going to be my health versus the baby, it was always going to be my health. That was something that we established at the very beginning. That's how everything moved forward when it came to medical decisions. Medical decisions for the child would always be up to them, but medical decisions for the person carrying the child was always my choice. There was no compromising on what I needed, medically. (Jacqueline – Female Surrogate)

Later in the interview, Jacqueline told me how the importance of her health was reinforced in a one-on-one interview with a doctor at the fertility clinic that she and her IP used. She told me, "The fertility clinic doctor said, 'You're just as much my patient as hers… Your health matters in this too. If this is something you want to not do anymore, you let me know, and you don't have to be the bad guy. I'll be the bad guy for you'." Jacqueline's doctor reassured her that he would come up with a medical reason to not continue with the surrogacy arrangement if that was something that she did not want to pursue anymore. She explained, "Knowing that… was extremely helpful."

Many intended parents seemed to have similar thoughts on the delineation of decision making as the surrogates did above. Slightly less than two-thirds of intended parents told me that they generally expected surrogates to make decisions about their health and body, or similarly, that the surrogate's body and health were more important, even more so than their own child.

Most of these IPs also simultaneously expressed that they expected or wanted to make decisions, especially those that they believed pertained to their children. For instance, Nicole, an intended parent who was matched with Jacqueline, spoke about how she and Jacqueline were on the same page about Nicole's ability to have control over decisions. At the same time, Nicole also let Jacqueline have control over decisions if it affected her health. It was even stipulated in their contract together. Nicole explained,

> She was pretty cool with me making the decisions. We drafted a contract in the beginning that we went through [with] lawyers. We both went through what we wanted. There was no concern there. The contract stated that I would make all the medical decisions unless it was life threatening to her… We never had any issues with that. It never got that serious. (Nicole – Female IP)

For example, Nicole told me that Jacqueline was "open to…whatever I wanted to do as far as testing the health of the baby."

Samantha, who was also an IP, had a very similar contract stipulation as Nicole that established that "the parents make the decisions unless it has to do with the life of the carrier." She also told me that she was grateful that her surrogates gave her the power to make baby decisions. She said,

> I think as far as medical stuff, we've been very blessed with both [surrogates]. I know I've read some horror stories. But, with both of our surrogates they have just deferred the questions to us. When we're sitting there if they try to ask her about, say the genetics screens. We just went through that. She's like, "That's not my decision. That's up to her.

> She's the mom." … We had no issues with that thankfully, because, like I said, I've heard a few stories. (Samantha – Female IP)

Samantha's use of the words "blessed" and "thankfully," along with the comparison to "horror stories," implied that it was important for her to be able to make certain decisions. Yet, she also told me that she was "pretty laid back" during both of her surrogacy experiences and that she did not have "extensive expectations" for her surrogates because "they're giving us this gift and it's her body." Finally, James, another intended parent said,

> I would like to be involved, for sure. I would like to be involved in decision-making. Ultimately, it's going to be her decision if that affects her health in a negative way. I'll try to be open-minded and just supportive because it's really her that's going through the physical part of this journey. (James – Male IP)

After that statement, I asked James if it is hard to separate the health of the baby from that of the surrogate. He replied, "It's one and the same, for the most part."

Ben was an IP who talked about having the power to make certain decisions, as well as letting his surrogate control decisions that affected her body, using the example of decisions about childbirth. He said,

> I think we wanted control over major decisions, things like whether she was going to use a midwife versus a hospital setting for birthing the child. Those were, of course, decided upfront… Obviously, to the extent of the things that involved her body and needing stuff, obviously, whatever she needed. We were also very upfront, we said we don't limit pain meds for birthing, we don't believe in making you suffer through the pain. Do what you need to do. I know some people are very particular. (Ben – Male IP)

Additionally, John, an intended parent in my study who was matched with Elizabeth, the surrogate quoted earlier who said she wanted her IPs to decide about getting an amnio because it was "their baby," told me that he expected his surrogates to be involved in decision making because "it's her body." He explained,

> Just a quick example. With our second surrogate, she determined that she would not take two embryos, when the first surrogate said yes, she would accept to have two embryos, and see if either one would take, but that was... I felt strongly that was her decision, and I supported her decision. (John – Male IP)

In addition to allowing surrogates to make decisions about their health and bodies, three intended parents also spoke about how the importance of the surrogate's health and body was a priority, sometimes even above the health of their child.

For instance, Emma told me, "The risk we put in another woman's body was my biggest concern. So, for us, it was always the surrogate comes first. Her health comes first, then our children." John, quoted in the previous paragraph, was one also one of those IPs. He said, "If there was a major thing that came up, like god forbid, there was a miscarriage, or there was some bleeding or something… our concern would have been foremost for the surrogate." Elizabeth the surrogate that was John's match, also confirmed that John cared about her health, although what that meant or how it would be applied was not necessarily clearly established. She explained,

> They did say that my health came first. We didn't define necessarily what that meant but if I were to come in danger, my health came before the health of the baby. There are so many scenarios, they just made it clear, we care about your health. You got to do what you need to do to maintain your health, so once we got to a stage [during the pregnancy]

> where we knew the baby was viable, everybody kind of breathed a sigh of relief... Even if something did go terribly wrong with me, we got a viable baby now (Elizabeth – Female Surrogate)

These quotes from John and Elizabeth also illuminate how the surrogate's and baby's health can be "one in the same" or intertwined, as James said earlier. For example, Elizabeth implied that a decision may have had to be made about her health that could affect the baby until it was "viable" and able to live outside of the womb, away from the effects of decisions about her body and health.

As is clear from the quotes above, both surrogates and intended parents tended to separate decisions that affected the intended parents' pregnancy and their child and the surrogate's body and health, with each of them respecting the other's ability to make decisions that pertained to their own domain. Yet, where the separation lies between the surrogate's body and health and IPs' decisions about their baby may not always be clear, as some of the quotes above indicate. This issue became more apparent when surrogates and IP spoke about decisions regarding the embryo transfers, reduction, and termination.

EMBRYO TRANSFER DECISIONS

Gestational surrogates are not genetically related to the child that they carry. The embryos used to achieve pregnancy are created in a lab through a process known as in vitro fertilization, or IVF. One or both intended parents may provide the genetic material needed for the process, or a donor egg and/or sperm may be used. Once fertilized, one or more resulting embryos are then transferred into the surrogate. Alternatively, traditional surrogates both carry the baby and

provide the egg. The egg is fertilized using either an intended parent's or donor sperm, usually through artificial (intrauterine) insemination.

Of all participants that had reached the embryo transfer stage, only three served as traditional surrogates during at least one of their surrogacy experiences. All of them, however, also went through the IVF process at least once during their time as a surrogate. One intended parent also attempted a traditional surrogacy experience, although that experience did not result in a successful pregnancy. This ultimately led him to pursue gestational surrogacy with another surrogate instead. All participants that had not yet reached the transfer stage planned to pursue gestational surrogacy. All participants, therefore, had to or were considering how many embryos to transfer during at least one IVF process.

Decisions about how many embryos to transfer was one area where the line was obscured between the interests and autonomy of intended parents and the surrogate's bodily autonomy and health. Although some surrogates can certainly become pregnant when transferring one embryo, sometimes participants in this study had to decide whether to transfer multiple embryos to potentially increase the chances of the surrogate becoming pregnant. This was especially true if the embryo quality was low or if initial transfer attempts failed. For instance, Stephanie, an intended parent, talked about her decision to transfer more than one embryo after following the recommendation of her reproductive endocrinologist.

> Our physician, our RE recommended transferring two…They basically said, "Listen you all have four kind of crap embryos... They have less than a ten percent chance of implanting into the uterine walls successfully, so we recommend you transfer two." And dumb dumb us ... So, we had less than a ten percent chance of either of them taking and of course they both took. So, [my surrogate and I] did talk about it, but we basically

> trusted our physician that if we transferred two that was going to be pretty much the best chance for us to actually even successfully get pregnant. (Stephanie – Female IP)

At least a few intended parents also considered or did transfer more than one embryo to increase their chances of twins. Transfer decisions, therefore, clearly had implications for intended parents who desired to have a child or even more than one child.

Whether or not intended parents desire to have twins, transferring more than one embryo increases the chance of a multifetal pregnancy, which is what happened to Stephanie and her surrogate. Multifetal pregnancies increase health risks for both the babies and the surrogate. Risks to the children can include the potential for miscarriage, birth defects, twin-to-twin transfusion syndrome (TTTS) (a condition where twins who share a placenta have an uneven balance of blood between them, with one receiving too much blood and the other too little, which puts both babies at risk for death), and preterm labor and birth (John Hopkins Medicine, "Complications of Multiple Pregnancy," n.d.; John Hopkins Medicine, "Twin-to-Twin Transfusion Syndrome [TTTS]," n.d.). Increased risks to the children can also affect the surrogate's body. For example, a surrogate may have to be put on bed rest to prevent preterm labor.

Multifetal pregnancies put surrogates at personal risk for bodily and health complications as well, from heartburn and lower back pain, to high blood pressure, anemia, gestational diabetes, and an increased chance of having a C-section or postpartum hemorrhage (Brigham and Women's Hospital, n.d.; John Hopkins Medicine, "Complications of Multiple Pregnancy," n.d.; Stanford Medicine Children's Health, n.d.). IPs and surrogates, therefore, had to navigate their individual interests in a scenario where decisions that affect the IPs and their children and the surrogates' bodies and health are not absolutely clear. Megan and Amy are two surrogates who

transferred more than one embryo at the request of their IPs. Their stories shed light on some of the issues discussed above.

After two failed transfer attempts, Megan became pregnant with twins. When I asked her if she and her IP had originally agreed to transfer two embryos, she explained,

> No, we contractually agreed to one. I was not going to have twins, but again, my IM was masterful at doing things outside of a contract. Our first cycle ended up with me in a chemical pregnancy and the second cycle, my body rejected the med a week before transfer and I shut everything out. By the third time, which was contractually our third and last time, we were going balls to the wall, basically… By the time that we were deciding would we go through the third and final cycle, she asked me, "Do you want to go all in?" … At that point, it became a little bit of a moral decision where we had invested so much time in each other and we genuinely liked each other and became friends that I felt okay. I put my own reservations aside. I had no real medical reason why I couldn't carry twins, but I'm 5'3" and I was 119 pounds. I'm pretty petite and I didn't think I would be a great vessel to carry twins. I usually carry big babies. Both my own kids have been over eight pounds… My fear was, is this going to take a toll on me? I put that aside and I said, "You know what? This is our last shot, we're going to go with all we got," and I said, "Sure." Sure enough, both babies stuck. (Megan – Female Surrogate)

In the above case, Megan changed her decision about a single embryo transfer, which was stipulated in their contract, because of her IP's suggestion to go "all in" on their last attempt at getting pregnant. The investment of time and the development of a friendship between the two of them were also clear factors. At the same time, she knew she did not want to carry twins at the

outset of her experience and continued to worry about the effects it would have on her when she was faced with the decision to change her initial plans.

When I inquired if she thought that twins were a possibly, even after she agreed to the double embryo transfer, she told me,

> [My intended mother and I] knew that it could happen, but we were like, "Look, the way that things have happened, there's a likelihood that one sticks." That's the truth. My neighbor, she transferred a couple of weeks ago two as well, and I'm like, "Brace yourself for twins. This is not easy," and yesterday she got a confirmation and it's only one. I'm like, "Look, not for nothing, good for you," because I wouldn't do multiple. I have other friends who have had multiples, and then after, they just go singleton all the way. They're like the money's not worth it for all the trouble that it is to carry multiples. (Megan – Female Surrogate)

Later in our interview, Megan told me that the twin pregnancy did affect her body, as she initially feared. She said,

> I was short out of breath… I had a lot of swelling. It was frankly just taking a toll on me. Also, where I live, it's Northern San Diego, in the summer, we'll get to a hundred degrees and dry heat, zero humidity, so it's hard. It's taxing to be pregnant with twins that time of year. It became harder by the week… (Megan – Female Surrogate)

Megan was put on modified bed rest to prevent preterm labor and to help mitigate her symptoms. She was also subject to increased medical interventions because of the high-risk pregnancy. She explained, "They gave me like EKGs, they did a stress test, they did all these things just to make

sure that I was okay, that there wouldn't have to be some emergency intervention." She had to take her blood pressure multiple times a day and report it back to her doctor.

Towards the end of her pregnancy, Megan had to go to weekly and then bi-weekly doctor appointments, including with a perinatologist. She lived over 60 miles away from the hospital, which also added a significant amount of travel time. At 34 weeks, her doctor had her stay at a hotel near the hospital so that she could more easily attend appointments and get to the hospital quickly if she went into labor. In the last week of her pregnancy, Megan developed preeclampsia, a serious high blood pressure condition, and therefore had to have an emergency C-section at 35 weeks (Cleveland Clinic 2024). It seemed that, given the advice to her neighbor, Megan would not risk another twin pregnancy.

Unlike Megan, Amy did not have a clear stipulation about the transfer number in her contract during. She explained,

> So, the number of embryos transferred was not clearly put into my contract the first time around, which is something I learned about. So, I was kind of open… So, both the IVF coordinator and the IP's doctor were like, "Oh, well, they'd like to transfer two. And I was like, "What?" They almost acted like they would break the match with me if I didn't transfer two. I really felt kind of like pushed to do it. (Amy – Female Surrogate)

Although she said she felt "pushed to do it" because her IPs might "break the match," Amy also told me she felt guilty that they "wasted" two embryos after the first transfer resulted a chemical pregnancy, or a very early miscarriage (Cleveland Clinic 2021). Yet, after that, she decided she was okay with transferring two again. She said, "I was kind of like, 'Eh, if twins happen, whatever.' I'm a twin, my mom carried twins full term when she was 37, so I'm like, 'I guess I

could be up for the challenge'." Although she was "up for the challenge," Amy only ended up getting pregnant with one baby after the two transfers of two embryos.

It was clearly important for Amy to get pregnant for her IPs. For her second journey, Amy made sure to look for a couple who had more than one or two embryos. She explained, "I was looking at couples with more embryos already because it took four embryos this last time to get one. She got one healthy baby." When we talked more about her second journey, which had just started when we had our interview, Amy had not finished the contract with her IPs but was in the process of discussing the transfer number. She told me she was willing to transfer up to four embryos since the fertility doctor believed it provided the best chance for a successful pregnancy, though she was not sure how many would be able to be transferred once the embryos were thawed and their viability was assessed. She told me, "[The intended mother] was surprised the doctor hadn't talked to me about transferring all four at once. So, I was like oh like, 'Oh, I don't know about that'." Again, she seemed to have some initial reservations about the transfer number, although it was not clear if this was related to "wasting" all four embryos at once if the transfer did not take, the "challenge" of carrying multiples if that happened during her second surrogacy experience, or a combination of both. For example, she explained, "Because they want to transfer all four embryos, I'm kind of like this is a one-shot deal. I'm hoping it will work." At the same time, she also briefly spoke about the potential health risks that can come with carrying multiples and the possibility of reduction if that was the case.

Regardless of where her initial reservations stemmed from, she also said that she "understands the reasoning" and was willing to go forward with the option of transferring all four. She went on, "Because the doctor's like, 'With these variables, I mean, who's to say…' He said at that age [of the intended mother] and [the embryos] not being [genetically] tested, one…

might stick." In a follow up message after our interview was complete, Amy let me know that they ended up transferring three embryos, but the transfer did not result in her becoming pregnant for her IPs. Her and her IPs tried one last time with a transfer of one embryo from a donor, but again, it did not result in a successful pregnancy. Ultimately, her IPs cancelled their contract and decided to work with another surrogate.

In terms of transferring more than one embryo, the stories of Megan and Amy were somewhat unique in that they had initial reservations about transferring multiple embryos but ultimately agreed. One additional surrogate, Laura, also reported having reservations about a multi embryo transfer that she ultimately agreed to during one of her journeys, though I will discuss her story in more detail later in this chapter. Megan and Amy had to weigh their bodily autonomy, concerns for their own health, desires to get pregnant, and even their friendship with their IPs against the ambitions of their intended parents and, in the case of Amy, the suggestions of a medical professional. In her study of an online surrogacy website, Berend (2016) similarly found that surrogates often felt pressured to transfer more than one embryo in the interest of becoming pregnant for their IPs. Some of the surrogates in her study even changed their mind after agreeing to a lower number in their contract, just as Megan did.

Alternatively, seven other surrogates in my study did or were willing to transfer more than one embryo but did not report any reservations to me. Kathleen even described getting pregnant with twins after a double embryo transfer as a "double bonus." Three surrogates let their IPs know that they were willing to transfer more than one embryo when matching. For example, Mary said,

> So that also went into my profile because that's something some parents want to know because some surrogates I found only want [to transfer one embryo] because of the slight

> chance—It's only like a 5% chance that it can be twins, and 1% [with] one egg. And I'm like, "I will do whatever the parents want or the doctor suggest." Because like some people I know, they don't have very good eggs, but they still want to attempt with their own, so I would be open to [transferring] more. If they wanted just one, and that's fine too. (Mary – Female Surrogate)

Olivia also allowed for a double embryo transfer since her intended parents wanted twins. She explained, "They transferred two. They had mentioned in their match interview that they wanted twins. In my original document for my [matching] profile, I had said that I would carry twins."

Megan was not unique, however, in her worry that carrying more than one baby could "take a toll on her" or that it "is not easy." Nor was Amy when she said that twins could be a "challenge." Six surrogates that I did not yet report on above told to me that they were only willing to transfer one embryo at the time of our interview, since for some of them, the decision to only transfer one changed as they pursued new surrogacy journeys. For at least two surrogates, their desire to only transfer one embryo was supported by the fact that the medical professional or clinic the IPs were working with strongly recommended or had a requirement that they only transfer one as well. Jacqueline also had a transfer of only one embryo per her doctor's recommendation. Although she did not say if she was personally adamant about only transferring one, she did talk about the irresponsibility of some doctors who transfer too many embryos. She explained,

> I see all the time, like with octo-mom, that doctor was just completely and totally irresponsible. You should not put that many in at one time. But, especially for the first try, you don't. You have a better chance of success, of getting pregnant, and having a healthy pregnancy, which is what's most important. (Jacqueline – Female Surrogate)

Finally, one additional surrogate also had a single embryo transfer, although again, it was not clear whether that was her personal preference, totaling the eight remaining surrogates in this study.

Although embryo transfer choices may directly affect the IPs and whether the surrogate becomes pregnant with a baby, or even multiple babies at the IPs request, transfer decisions may also affect the surrogate and their body and health as was clear from Megan's story. In addition to Megan and Amy who cited reservations and possible risks to their health but did transfer more than one embryo, four surrogates who were personally adamant about a single embryo transfer also spoke about the increased risks that can come with carrying multiples. Three of them specifically cited the risks to their own body and health as influencing their decision. For instance, Amber told me how her views on transfer number changed from one experience to the next.

> I am now firmly single embryo transfer. But at the time, I was kind of wishy washy. I was like, "Well, I'm really leaning toward single embryo transfer, but if you really want a double embryo, I'll totally do it." Now looking back, I'm like, nope, single embryo transfer all the way… Even if they only have two embryos, I'm only transferring one. (Amber – Female Surrogate)

When I asked what influenced that decision, she explained,

> We had two women at our agency who ended up having triplets. Not necessarily at the same time I did, but I heard those stories, eventually... There was like three or four people in my transfer group, where twins split and either they survived or they didn't, or there were major complications. There's a woman who is on blood clot medication for the rest

> of her life because the twins split, twin-to-twin transfusion syndrome. She had multiple surgeries. I'm just looking at that, I'm like, you know what? That split. That was one embryo that split. Why would I up my chances of a complicated pregnancy? ... I'm only getting older, which means my pregnancies are only potentially getting more complicated. Plus, this will be my fifth pregnancy, which again, only gets more complicated with subsequent pregnancies. Why would I add a risk to that? Now if it split, I would tolerate twins, but I'm not going to play the odds… There is no doctor who is going to talk me into that. (Amber – Female Surrogate)

During Amber's first experience, although she was "leaning toward" a single embryo transfer, she was open to transferring two if her intended parents wanted to. As she was about the enter her second experience, however, Amber was willing to express her agency over the transfer decision in the interest of her own body and health, even if that decision could affect her future intended parents, as she implied with her comment "even if they only have two embryos." She was also clearly willing to resist the influence of a medial professional.

Similarly, Susan, another surrogate, also told me that she changed her requirements to single embryo transfer after her first journey where she transferred two. She also heard "stories" from other women who had twin pregnancies in her agency's support group and "all the complications they went through." Unlike Megan who initially wanted to transfer one embryo but then changed her mind after her intended mother asked her to go "all in," and Amy who was afraid that her IPs would break the match if she did not agree to a double transfer, Susan was unwavering and stuck to her initial plan on her second journey given the risks. She said,

> There was definitely some negotiation with that with my second couple. We had to go back and forth on that quite a bit… We met with the counselor for our match meeting to

> make sure that this was a match, that we wanted to do this. We both agreed… everyone agreed, yes, a single embryo transfer was the way to go to reduce, you know, potential risk to everybody. Probably like a week or so before the transfer, my counselor called me and said, "Oh, well they want to do a double embryo transfer, because they think that would be better for them." I said, "Well, no. I still don't want to do that." I'm like, "Okay, so they're doing this now?" Then she came back, she talked to them, and she said, "Oh well, they still want to do it." And I'm like, "Okay, well I'm still no. They can find somebody else, or you know, agree to a single embryo transfer." So, I guess they finally agreed because I kept saying no, because we only transferred one. (Susan – Female Surrogate)

During this negotiation, Susan asked for advice from a friend, as well as other women in her agency's support group, and they encouraged her to stand her ground. She also reported that she was glad that she had an agency counselor to help negotiate the transfer without having to deal with the couple directly.

Finally, Rachel was an additional surrogate that chose a single embryo transfer and suggested that others do the same given the risks, even if intended parents want to transfer more. She explained,

> I think [surrogacy is] a wonderful thing, but I do think that anybody that goes into it needs to know that the risks are real, and anything can happen. My biggest thing is… I know there are IPs out there that want to do double embryo transfers and stuff, but I just don't think that's safe, especially being as though we were single embryo transfer and it split, you put two in there to split into four or six and it's just… I know there was one surrogate who passed away during the process, but… The statistics aren't that high for

> major complications like that, but things do happen and it's not a normal pregnancy. You just can't compare it. I see a lot of people coming on these Facebook groups that I'm in, like, "Oh, all my pregnancies were perfect." I felt the same way, "Oh, this is going to be great. My pregnancies are perfect." It's just a totally different ballgame when you do IVF. (Rachel – Female Surrogate)

Unfortunately, Rachel's pregnancy was not "perfect" despite her attempt to mitigate the risk of twins by transferring one embryo. The babies ended up developing Twin-to-Twin Transfusion Syndrome (TTTS). Because of the condition, one of the twins passed away, despite Rachel going through a procedure to try and save the baby's life. While Berend (2016) reports that surrogates on the online site she studied often encouraged each other to maintain their bodily autonomy when making transfer decisions, she did not actually discuss cases of surrogates who did do so. I therefore extend on her findings by showing that, while some surrogates feel pressure when making embryo transfer decisions, there are also surrogates that are steadfast in maintaining their bodily autonomy. Some are willing to go against the interests of their IPs or resist the pressure they feel. Furthermore, Berend (2016) did not explore how IPs, like surrogates, must also weigh their own interests against their desire to also protect their surrogate's health.

Two IPs who chose a single embryo transfer talked about the risk of multiples, including for the surrogate. Christopher, an IP, explained, "Carrying multiples for a surrogate is not something that's advised. I think all pregnancies are high risk, but when you start adding multiples, that's when you're really putting them at a risk for some bad stuff." Robert, another IP, initially considered transferring two embryos in the interest of having twins, but then decided against it after considering a fertility doctor's advice. Robert said,

> We were like, "Oh, it'd be really cute to have twins. Financially it would be really nice because we got two kids," right? … Then we started researching more about it and [our clinic] does not recommend double embryo transfers. It's a high-risk pregnancy both for the surrogate and for the babies. A lot of twin pregnancies don't go full term. After reading all of that, and [the Helping Men Have Children Organization] is really explicit that they do not recommend double embryo transfers. There's a lot of people who did double embryo and it split to more… We were just like, let's just do what's best for the baby, and what's best for the surrogate, and for us, that decision was single embryo transfer… Our fertility clinic doctor actually said, "If you really care about your friend, I do not recommend you asking your friend to carry a twin pregnancy." She very explicitly said that. We were just like, no, we care about our friend… Even though our [second surrogate] actually volunteered [to transfer two embryos] … [Our first surrogate] said that she would do it if it was medically advised by our fertility clinic doctor. She was like, "I would prefer not to." She was like, "I really want to deliver a child for you all and if that's what the fertility clinic needs for me, I'm going to do it." (Robert – Transfeminine IP)

Finally, Stephanie, the intended parent who did transfer two embryos at the recommendation of her doctor, as she explained in her quote at the beginning of this section, said she would not do it again given the risks of a multifetal pregnancy. In fact, when pursuing a second journey, Stephanie told me that she did not match with her first surrogate for a second time since the surrogate wanted to transfer two embryos again. She explained, "Obviously she didn't learn anything about how lucky and fortunate we all were." Now that she is an agency owner, she also only works with surrogate who will agree to a single embryos transfer.

REDUCTION AND TERMINATION DECISIONS

In addition to embryo transfer decisions, selective reduction and termination during a multifetal pregnancy and pregnancy termination are also areas where the indistinct line between surrogates' autonomy and health and intended parents' autonomy and the health of their children becomes more apparent. Reduction, selective termination, and pregnancy termination are slightly different but related terms in they all result in the death of one or more fetuses or an end to the entire pregnancy. They all therefore may be considered different forms of abortion.

Multifetal pregnancy reduction (MFPR), or what participants sometimes referred to simply as reduction, is a procedure where otherwise healthy fetuses are reduced in number in a multiple pregnancy. Given the risks of multifetal pregnancies that I discussed earlier in the chapter, the procedure may be used to reduce the risk to the remaining fetus or fetuses and the person carrying the children. MFPR may also be used to reduce the number of children to the desired amount that parents are willing to care for, which, as I will discuss later in the chapter, was the case for at least one surrogate in this study. When a baby in a multifetal pregnancy that has health complications such as a genetic or structural abnormality is aborted, it is called selective termination, although none of the participants in this study used the term "selective" when discussing termination (Kaiser Permanente 2017). Both MFPR and selective termination are usually performed in the same way. The most common method used involves inserting a needle through the abdomen to gain access to the uterus, where one or more fetuses are then injected with a medication that stops the fetal heart. Any fetuses that are reduced or terminated should then be absorbed by the person's body. Some risks of the procedure include infection, miscarriage of unintended fetuses, and preterm labor (Keiser Permanente 2017).

When participants referred to termination, they could also be referring to ending the entire pregnancy, such as when a singleton baby is indicated to have an abnormality or if the life of the surrogate is at risk. Some participants did not use the term reduction or termination at all and simply used the term abortion. Terminating the entire pregnancy may be done either with medication or surgically. Medication induced pregnancy termination is usually done during the first trimester. The pregnant person first takes a medication called mifepristone which stops the growth of the pregnancy. After a day or two, the person then takes a medication called misoprostol which causes the uterus to empty. The process is completed outside of a hospital or health center (such as at home), and patients may be able to request the medications via a telehealth visit, depending on the state. Medication induced termination can cause bleeding that is much heavier than a menstrual period, severe cramping, or nausea, vomiting, fever, and chills (ACOG 2022a). There is also a small risk of infection (UCLA Health, "Medical vs. Surgical Abortion," n.d.).

Sometimes a first trimester pregnancy is terminated using a surgical procedure. During a first trimester surgical abortion, the cervix may need to be dilated. Fetal tissue is then removed using an instrument called a curette (called a Dilation and Curettage or D&C procedure) or through the use of a suction or vacuum (which may be referred to as a Suction Curettage or Vacuum Aspiration procedure, though it may also sometimes be referred to as a D&C) (ACOG 2022a, 2022b). First trimester surgical termination is an outpatient procedure that can be done with local anesthesia or under sedation (UCLA Health, "Surgical Abortion [First Trimester]," n.d.). Risks of a first trimester surgical termination include heavy bleeding, infection, risk of cervical injury, perforation of the uterus, or scar tissue that forms within the uterus which can

lead to infertility (ACOG 2022b; Keiser Permanente 2023a; UCLA Health, "Medical vs. Surgical Abortion," n.d.).

Alternatively, a Dilation and Evacuation (D&E) is the procedure used for a second trimester abortion. It is similar to a D&C in that the cervix is dilated, and then a suction or vacuum is used to remove the pregnancy tissue. Surgical instruments may also be used (Keiser Permanente 2023b). A D&E is also an outpatient procedure but is usually done under sedation (UCLA Health, "Surgical Abortion [Second Trimester]," n.d.). The risks of a D&E are similar to those for a first trimester surgical abortion, although they are higher when the pregnancy is further along. Risks include moderate to severe bleeding, infection, retained pregnancy tissue, injury to the cervix, and perforation of the uterus (Keiser Permanente 2023b; UCLA Health, "Surgical Abortion [Second Trimester]," n.d.).

Reduction and termination have implications for both surrogates and intended parents. For one, choosing reduction or termination may not only go against the values of surrogates, but can also affect their bodily autonomy if they do not wish to have an abortion. Reduction and termination can also affect their health if a complication arises during the procedure. Alternatively, choosing reduction and termination may also help improve a surrogate's health during pregnancy or may even be used to save their life. Their bodily autonomy may also be protected, such as if surrogates do not wish to carry more than a certain number of children.

Reduction and termination can also have clear effects on the intended parents and their child. For example, if multifetal reduction is not chosen, it will affect the number of children that are born. Alternatively, not choosing termination will affect the health status of baby, which can lead to lifelong implications for the child and the intended parents that will have to care for it. If reduction or selective termination are chosen, it may protect the health of the remaining children,

but the intended parents will be faced with one or more losses of life. In the case of terminating a single pregnancy, intended parents may lose the possibility of having any children at all, which is why they pursued surrogacy in the first place. I explore some of these various issues in the following sections.

Limits to Reduction and Termination

Although many surrogates and intended parents agreed that IPs would be the ones that made medical decision that pertained to the child, over a third of surrogates reported to me that they had certain limits in terms of when they would agree to reduction or termination during the surrogate pregnancy. For example, Mary said,

> The important thing to me is no termination. I am completely against it… I know people like, "Oh, what if it has disabilities?" Anything like that, some parents don't want… I'm like, "You're already going to pay for all of this and you're just going to throw that away. You're going to throw the child away." That, to me, doesn't seem like they want to be a parent. I don't know if that makes sense to you, but to me that's how it seems… No matter what, you should be happy that you could even have a child, period… I am religious but I have no care in the world about other people's religions or beliefs or whatever. That's fine, but I'm not going to terminate. (Mary – Female Surrogate)

When I asked Mary if she would agree to a reduction, she also said, "No reductions, nothing, and I made sure that they know I'm very adamant about that." Not all surrogates in this group were as opposed as Mary was to all possibilities of reduction and termination, though the others still had certain restrictions of when they would agree to it.

Although opposition to reduction and termination may stem from the surrogate's own values, at least three surrogates also specifically cited their bodily autonomy as a reason for why they should be allowed to make the final decision. Mary was one of those surrogates. When I asked her about how involved she wanted her intended parents to be in medical and health decisions during the pregnancy and childbirth, she replied,

> As long as they do not try to force me to have an abortion, which I was told by my agency that even if they tell me I need to get one, I am not required only because it is my body still. It is how it is. I can put in the contract that I would do it, but if I decide at last minute I'm not going to, I don't have to. And that's just how it is. Because I mean they can't force me to do anything to my body. (Mary – Female Surrogate)

Similarly, Emily, another surrogate, told me about how her power to make decisions about her own body, including when it comes to termination, was reinforced during her psychological evaluation.

Emily began by saying, "Maybe subconsciously I knew that I had more power than I realized in this whole situation because it's my body. But it wasn't until the psych eval where I was empowered if that makes sense." She continued,

> She asked me a question and I said, "No, I wouldn't terminate," and she said, "Okay," and then she wanted to make sure that that was my answer. I didn't want to change my answer. And I said, "No, I would not terminate," and she said… "You realize this is your body, right, and you have all the choices, right?" (Emily- Female Surrogate)

Although her intended mother told Emily that she—as the surrogate—had the power to make decisions, she felt that it was "on a friend level," and therefore felt more confident when it came from medical professional.

Joyce, a surrogate from Australia, was not one of the surrogates who explicitly said she would not terminate. However, she did say that she wanted to ultimately control decisions about her own body, including when it comes to termination decisions. She explained,

> I guess this was part of the couple that I was talking to. They had to understand that it's my body and they don't get to make decisions about it. I was pretty straight upfront with that. "I'm a feminist, I'm this, I'm this, I'm this, you need to be cool with that." They've gone, "Yep, we are." In terms of decisions about medical care, I expect to have total ability to make decisions about my body. (Joyce – Female Surrogate)

The blurred line between choices that affect intended parents and their child and a surrogate's right to control their own body was illuminated when Joyce explained her thoughts about termination to me. She continued,

> In terms of the baby, so for example if there's trisomy detected or something like that and an abortion or a termination is on the cards… I know that I personally probably wouldn't have a termination for something like that for myself, but at the same time, it's not my baby and I won't be the one caring for it, so I think that's a decision that they need to make a call on. But at the same time, there is definitely an understanding that the final call is mine… Personally, from my experience and from what other people around me are saying from my surrogacy groups, most teams come up with an agreement that they will act on medical advice. For example, if something is wrong with the baby and the quality

> of life would be terrible and the medical advice is to abort, then obviously they'd be going with medical advice. That's generally the understanding. But there's also very much an understanding that it's our bodies and we do get to make the decisions. (Joyce – Female Surrogate)

To avoid disagreements in this area, Joyce said that she and her IPs would have to ultimately agree on their stance on termination in counseling before going ahead with the surrogacy experience.

In addition to the issue of having control over one's own body, Laura's story sheds light on how her intended parent's decision to pursue a reduction impacted her body, health, and emotions. When I asked Laura how involved she expected her IP's to be in terms of medical decisions, she began by telling me, "My thought process with everything was that this was their pregnancy. It may have been in my body, but it wasn't my pregnancy, and because it wasn't my pregnancy there were a lot of decisions I didn't have to make. It could be their decisions." Initially, "their decisions" included allowing her IPs to choose whether to reduce or terminate. For example, she explained, "With the first pregnancy when it came to the point that we realized that this baby wasn't well and they decided to terminate, I was okay with it, because I was open to it even before that need arose."

After her third surrogacy journey, however, Laura changed her stance on reduction after going through a negative experience. During that journey, Laura's IPs requested that they transfer three embryos on their third transfer attempt after the first two transfers of one and then two embryos were not successful. She did, however, have reservations about it based on her experiential knowledge. She explained,

> If I look back, there's like a million things that went wrong, including the fact that the couple never even came to the transfer, they just gave instructions to the doctor of what to transfer, and that's what was done. So, the doctor is trying to explain to me that they're transferring three because they're low-quality embryos. I'm taking a look at these pictures of these embryos with all the knowledge now that I have behind me, and they weren't low quality embryos, but nobody can get in touch with the couple and these embryos were ready to go. So, I kind of shut up and they put three embryos in, and wouldn't you know, three stuck. I think they were really just trying to up their odds, and it didn't work. Well, it did work, but it was not good. (Laura – Female Surrogate)

She continued,

> I wasn't against transferring three embryos per se, especially where we had already transferred three embryos in two different transfers and didn't have very good success, but I do think that they thought that they thought that they had an uneducated surrogate who didn't know what a good quality embryo looked like. (Laura – Female Surrogate)

After Laura became pregnant with triplets, the intended parents decided that they wanted to reduce the number of fetuses because, as Laura put it, "they only wanted one child" and used reduction as a form of "birth control."

After that experience, Laura decided that she would no longer agree to reducing at the request of intended parents. One reason for that decision was because of the effect the double reduction had on her body and health, in addition to the impact the reduction had on her personally. She explained,

> Even up until the point of the reduction, I was still onboard for it. Their pregnancy, their choice, I'm a pro-choice person. It's well within their right to choose this. I've offered them my body... But having lived through the fact that two babies were reduced at 13 plus weeks, and these were babies that I saw frolicking on the ultrasounds. It got to point, when I'd go in for my doctor's appointments prior to the reduction, that the doctors would give me a towel to put over my head, because I didn't want to see the ultrasound… I didn't want to get to know these babies. Even during the ultrasound, I said to them, "Do not talk to me about what you're doing…" Thankfully, for that, the IM sat next to me, and I heard her crying, which in some sense comforted me, because I wasn't the only one agonizing about this. But in the same instance… I wouldn't go through it again. I wound up having some really severe complications as a result of the reduction, and from that standpoint, I wound up in the hospital for 11 weeks. I delivered this baby at 30 weeks, and 11 of those 30 weeks were in the hospital, and 16 of those 30 weeks were on bedrest. So, like it just wasn't going to happen again. One, from the fact that I just couldn't go through it again, but two, because the complications just weren't anything I wanted to have to consider again. Even though they are always possible, I just, under those circumstances, I didn't want to have to consider it. (Laura – Female Surrogate)

She went on,

> To this day, I fully believe that it's their pregnancy and it's their decision. I'm not one of these people who's like, "It's my body, and it may be their pregnancy, but my needs come first." That's not it as well. I wanted each woman to have the pregnancy she couldn't have. I wanted her to like feel it and think about it and make decisions for it as if I wasn't even involved, even though it wasn't in her body. The only time at which that changed

> was when I took reduction off the table for future contracts, and even then I only took it off the table as a form of birth control. I didn't take it off the table if the baby had been sick. (Laura – Female Surrogate)

Although Laura was still willing to let intended parents make decisions about "their pregnancy," she also found a way to protect her own body by only matching with couples who had similar beliefs on reducing from that point on. In that sense, Laura would not be limiting the decisions of intended parents since she would match with couples who she knew would also decide not to reduce themselves.

Berend's (2016) findings on surrogates' feelings about reduction and termination are strikingly similar to those of the surrogates in my study. She too, found that while surrogates can easily separate gestation from feelings of motherhood and fully believe that it "the IPs' child," they have a harder time separating the pregnant body from the "empathetic self that values life" (Berend 2016:126). Surrogates, as she explains, engage in surrogacy to produce children for those that deeply desire them. They therefore find it hard to reconcile that IPs, in turn, can simultaneously choose to end that life. Berend (2016), however, does not discuss IPs' views on abortion, including how they may also find it hard to abort a child that they so desperately wanted. Like some of the surrogates in my study, a little more than a third of IPs also did not wish to reduce, terminate, or both in certain situations. For instance, Tom explained, "For us, we have been trying for so many years, we just wanted the child because I don't care about any of the peripheral… We want what we are going to have regardless of any of the stuff." Emma, who had Crohn's and Lupus, said, "I feel like if there were any issues and the baby wasn't healthy, I consider myself not 100%. I'm not healthy. I didn't have concerns. If an unhealthy baby survived, I would love it all the same."

Navigating the Blurred Line

As was the case with surrogates Joyce and Laura, one of the most common ways that surrogates and IPs avoided possible disagreements about reduction and termination was by discussing these issues very early in the process, such as when matching, so that they could make sure that they all had the same opinion on the matter. That way, the decisions that surrogates made about their body and health, as well as decisions made by intended parents for their children, would be in sync, allowing them to navigate the blurred line between the two. Berend (2016) similarly reported that surrogates found matching with like-minded IPs as the only viable solution for simultaneously honoring their own moral views and IPs' decision-making sovereignty.

Neiterman's (2012) finding that different audiences may have differing opinions on how to "do pregnancy," and that individuals may choose audiences who are receptive to and reaffirm their normative beliefs, can also be applied here. In this case, however, participants choose to work with matches, or "audiences," who agreed with their views on how to "do" reduction and termination. A little less than half of surrogates and a little less than half of IPs talked about discussing termination and reduction early in the surrogate journey, such as when matching. For Will, an intended parent, that meant finding a surrogate that would allow him to terminate. He said,

> The main thing I was interested in was just under what conditions would you terminate? That was very important to me. I did not want to have a child with Down's syndrome. I did not want to have a child with inherited genetic problems, et cetera. I knew that that was just a key thing to… That is probably the most important thing for me… It definitely divides the surrogate population because there are some that are open to it, but there are a

lot that are not. I mean, they just give birth to what they think God put into their body. (Will – Male IP)

Alternatively, Amber, a surrogate, told me that she wanted to find intended parents that agreed that they would not terminate for certain conditions,

> I work with kids with developmental disabilities, so I was like, if it's just a Down Syndrome thing, I'm not going to feel comfortable terminating it. If it's just that, I can't do it. So, I had to find like-minded IPs, who, you know, Down Syndrome wasn't a deal breaker for them… I made it very clear that if it was just a cognitive disability, I don't know… that would really mess me up if I'm… I know it's the parents' choice, but that might really be emotional for me. (Amber – Female Surrogate)

While Amber acknowledged that it was "the parents' choice" in the above quote, she also considered her own values and therefore matched with IPs who had similar values as hers.

Emma, an intended parent, provided an example of how *not* matching with someone who has similar beliefs about reduction and termination can lead to discrepancies between the interests of surrogates and their bodies and health and the interests of intended parents and their children. She explained,

> You'll hear the same thing all over the community of, the most important thing is that your beliefs are the same as far as terminating babies over what reason… [and] how many they'll carry. The only issue… [my surrogate] and I ran into was I would not abort a baby, especially if it's mine, but it's her body. So, if we decide to transfer two embryos, she was hellbent on, "Yes I'll carry twins, but I am not carrying triplets." So, if one of those embryos split and we ended up with triplets, she would absolutely 100% terminate

> one and that was completely out of my control… I knew it wasn't a high possibility, because twins don't run in my family, but that was the biggest concern I had, I guess. It's things like that, your values, your beliefs, and your actions that you plan on taking once you start this process, all of those have to be in sync. So, my big thing was, "Can I transfer two embryos? Are you okay if they both survive carrying twins?" (Emma – Female IP)

Ultimately, Emma chose to transfer two embryos and her surrogate carried and delivered twins. They therefore were able to avoid any difficult decisions.

Christopher's surrogate also had a limitation in terms of how many she would carry and made it clear that she would reduce if she became pregnant with more than two children. In addition to mitigating risks to the surrogate's body, as participants explained above, only transferring one embryo can also help avoid the need for a reduction since the possibility that the surrogate becomes pregnant with more than one child is minimized. Though, of course, there is still a possibility that an egg can split. Christopher chose that approach as a way of navigating the line between his wishes and the wishes of his surrogate. He said,

> …Initially, we said if the first transfer didn't take, then we're going to transfer two. My partner's an anesthesiologist, so he's a physician, and we didn't find this out until I researched it as well. The technique they used to create our embryos in of itself was a high risk for multiples. He put his foot down and said, absolutely not, because technically we could have put one embryo in and still ended up with twins or triplets. In his mind, if we put in two, we could have ended up with like a litter. The possibilities were endless. He wanted to be a little bit more conservative with that. Our surrogate also had a limitation. She was okay if we had multiples, but she did not want three or more… We

> didn't want to have to make a difficult decision because of her wish that she made clear in our contract… We were very conservative with the whole process in terms of just putting in one at a time. (Christopher – Male IP)

Like Emma's and Christopher's surrogates, five surrogates that I interviewed for this study also had limits in terms of how many children they wanted to carry in their bodies. By limiting the number of children to be carried, these surrogates were able to assert bodily autonomy.

Surrogate's Body and Health as a Reason to Reduce and Terminate

Not all surrogates in this study objected to abortion, and even those who had limitations were willing to abort in certain situations. While Berend (2016) explored surrogates' opposition to abortion, she did not examine why they may want to pursue it. For instance, of the five surrogates who had limits in terms of how many children they wished to carry, four said they were willing to let their IPs reduce or they themselves wanted to reduce if they became pregnant with more than twins. Although it was clear that most of these surrogates' IPs agreed to these terms, it was unclear if it was something that all the IPs would choose themselves if their surrogates did not have that stipulation since I did not speak to most of those IPs directly.

Interestingly, just as surrogates cited control over their body and health as a reason for why they would not reduce or terminate, six surrogates also specifically cited their body and health as a reason that they would. Rachel, who was one of the surrogates who spoke about the health risks of transferring more than one egg, also explained why she would allow her intended parents to reduce if she became pregnant with more than two babies, which was the maximum she wanted to carry. "For health issues and for just three it's a lot, and it's a lot for the body. It's a risk for me as well as the pregnancy, so I was willing to do that." Amy, who was willing to

transfer up to four embryos as I described in section on embryo transfers, did not say she had a specific limit in terms of the number of children she would ultimately carry, but did say she would consider reduction if her doctor believed it would be unhealthy for her or the fetuses. The remaining surrogates talked about the possibility of termination more generally if it was going to affect their health.

Four of the six surrogates who said they would reduce or terminate for their own health were also in the group that had additional limits as to when they would allow a reduction or termination. Any, for instance, said she would not reduce simply because her IPs, "changed [their] mind." Kim told me how she and her intended parents agreed to those conditions when matching,

> I told her I'm no-termination. I said the only time I would ever terminate is if my life was at risk, I'm going to die if I don't, and the baby is before viability, it could not survive outside the womb… She was like, "Yes, I'm definitely in agreement with that." … We just had that discussion before we decided to definitely match… I said, "What if the baby has some really bad disorder… and not expected to live long after birth and all that?" She was like, "No, that's the baby that we're meant to have, then we'll love that baby no matter what." I said, "That's perfect." So, we made sure we were on the same page as far as that goes. (Kim – Female Surrogate)

Similarly, Emily who said earlier that her psychologist reinforced her power over her own body when discussing her opposition to termination, also cited her health as a reason she would terminate,

> [Before officially matching] we talked about termination, talked about how as a believer, I can't, no matter what. We did talk about if it was going to obviously take my life, I would want them to deliver the child and try to save it at any expense that they could, but not at [the expense of] my life because I have children and husband. (Emily – Female Surrogate)

Alternatively, Mary was one surrogate that did not want her parents to choose reduction or termination, even if it would affect her health. She said, "For any reason, even my health, I refuse."

Finally, three intended parents who said they would not reduce or terminate, such as if their child had a chromosomal abnormality, reported that they would do so if the surrogate's life was at risk. For instance, Samantha explained how she and her surrogate would not terminate, unless it was for the surrogate's health,

> We are all very much against abortion… The only way any of us would even agree to that would probably be, again, if the baby was literally causing [the surrogate's] health to be in danger, her life to be in danger, which is a very rare situation… But were it to occur, then, you know, we're all like, "Yeah, your life is more important." Not that it's more important. I don't mean it like that, but it is. We're not risking her life. She has two children at home. To have our baby? That's not happening. (Samantha – Female IP)

Samantha was the IP who said that she was "blessed" and "thankful" that her surrogates deferred any questions about the child to her, but also had a stipulation in her contract that the surrogate would make any decisions if it was life threatening to her.

Robert (who identifies as transfeminine) described how her agency helped to negotiate termination decisions with her surrogate.

> The agency's really helpful in that because we didn't even know what would be inappropriate or a reasonable place to start with that. I didn't know even what would feel like a fair thing to ask of the surrogate and it's obviously all spelled out in our legal contract. [Our surrogate] was like, "I'm okay with whatever the intended parents want." In our contract we were like, "We're okay with termination if there is a genetic chromosomal abnormality, or if the surrogate's life is at risk, or if the baby would not be able to survive on its own." Things like that. Later though we have decided, if the baby did have a genetic abnormality like Down Syndrome, that we would not elect to terminate, but we came to that decision after we had agreed, and [our surrogate] knew. [She] was like, "Well it's up to the intended parents. I'm okay with terminating and I'm okay with not terminating, as long as my life is not at risk." That was her concern, obviously, if her life was at risk she would want to terminate, but outside of that she was okay with us making the decisions. (Robert – Transfeminine IP)

As Robert's example indicates, even when both the surrogate and IPs respect the other's ability to make decisions about their own body or child, the two are still not easily separated when the surrogate's life is in danger.

CONCLUSION

Participants in this study tended to separate decisions that should be made by intended parents from those that involved the surrogate's body and health. Embryo transfer, reduction, and termination, however, were areas where the distinction between these two areas became unclear.

Sometimes surrogates were willing to follow the requests of intended parents and their wishes for a multi embryo transfer, especially in the interest of becoming pregnant with a child or multiple children for the IPs. Though a few of these surrogates had reservations about transferring more than one embryo, they ultimately succumbed to their IPs requests. Berend (2016) reported similar experiences of pressure among the surrogates she studied on an online surrogacy website.

Multi embryo transfer, however, may also affect the surrogate's body and health. Therefore, there were also surrogates in my study who were adamant about not transferring more than one embryo, even if intended parents or a doctor suggested it. Some specifically cited the interests of their own body and health as a reason for this decision. Similarly, there were also IPs that chose a single embryo transfer to protect the surrogate's body and health. Berend (2016) did not explore embryo transfer decisions from the perspective of IPs, especially in terms of how their own concerns for the surrogate's health may impact their decisions, something the current study addresses.

In the case of reduction and termination, not reducing or terminating can affect intended parents in terms of the number or health of the child or children they will ultimately have to care for. Alternatively, choosing reduction and termination can lead to the loss of a child or even the entire pregnancy. This not only can impact intended parents, but also surrogates who are opposed to abortion. While surrogates considered the child to be that of the IPs, about a third had limits in terms of when they would allow for reduction or termination. When discussing these limitations, surrogates not only referenced their moral views, but also their right to bodily autonomy. Surrogates' beliefs about their right to bodily autonomy may be used to hold true to their values, as was the case with Mary. As Laura's story revealed, surrogates may also consider the impact

that abortion procedures can have on their health, in addition to the emotional effects. Berend (2016) found strikingly similar sentiments among the surrogates she studied. She did not, however, explore why intended parents may be opposed to abortion as well, which was the case for around a third of IPs in my study. One way that surrogates and intended parents navigated the blurred line between surrogates' views, bodily autonomy, and health and the IPs' ability to make choices about their own children was by matching, or finding an "audience," that agreed with the other's stance on abortion (Neiterman 2012). Berend (2016) also reported that the surrogates she studied utilized this approach.

While Berend (2016) spoke extensively about surrogates who did not want to abort, she largely did not discuss the reasons they may want to. For instance, some surrogates in my study were willing or wanted to reduce because they did not want to carry more than a certain number of children. While a couple of surrogates talked about reducing because of the health risks associated with multifetal pregnancies, others were willing to terminate the pregnancy overall if their health or life was in danger. Interestingly, some of these surrogates were also in the group that said they would limit abortion in other situations, such as if the baby had a disorder. Likewise, a few intended parents who said they would not choose reduction or termination for their own children did agree to pursue abortion to protect their surrogate. Again, Berend (2016) did not explore why IPs may agree to abortion as part of her study. These were stipulations that

surrogates and IPs often agreed upon during the matching phase, just as they did when matching based on abortion restrictions.[1]

Reaching an agreement on abortion or even embryo transfer number, however, did not always mean that larger implications for either surrogates or IPs would not still be present. For instance, surrogates who willingly agreed to transfer more than one embryo to meet their IPs goals of having a baby or even multiple babies could still face the risks of a multifetal pregnancy if it were to happen, though many did not express any pressure or these specific reservations to me during our interviews. Alternatively, IPs who did not want to abort a child but did agree to do so if their surrogate's life was in danger would still have to experience the loss of their in-utero child or children, for example.

In the next chapter, Chapter IV, I continue to explore how surrogates and intended parents negotiate medical decisions by focusing on health behavior and practice decisions while "doing pregnancy." More specifically, I examine intended parents' expectations that surrogates followed doctor's recommendations and certain health behaviors and practices. I then explore how surrogates' and IPs' respective expectations about control, surrogates' previous pregnancy experience, and trust can impact "doing pregnancy."

[1] I conducted participant interviews before the 2022 *Dobbs* decision that eliminated the national right to abortion. In any future studies about surrogacy-based abortion decisions, it would be pertinent to explore how the ideology of *Dobbs* and the navigation of individual state abortion laws affect the abortion negotiation and matching process.

CHAPTER IV: DOING PREGNANCY

In addition to decisions about embryo transfers, reduction, and termination, surrogates and intended parents also negotiated health behaviors and practices that surrogates were expected to engage in during the pregnancy. As Neiterman (2012) explains, one aspect of "doing pregnancy" involves how one adapts to larger prenatal guidelines that dictate how one should eat, drink, or even sleep. How surrogates adapt their health behaviors and practices involved surrogates' bodies and health, or more specifically, what they did with and put into their bodies. It also can also have implications for intended parents and their children. For instance, smoking and drinking during pregnancy are known health risks that can impact a fetus. When negotiating these decisions within the unique context of the surrogacy relationship, surrogates and IPs therefore once again navigated a blurred line between the surrogate's bodily autonomy and the interests of intended parents. In the first part of this chapter, I begin by briefly describing how intended parents expected surrogates to follow doctor's recommendations, as well as the specific prenatal guidelines that they wanted surrogates to abide by. The remainder of the chapter is split into two parts. The first half is from the perspective of surrogates, and the second is from the perspective of IPs.

Neiterman (2012:373) defines the social ladder of motherhood, "As an array of social perceptions that we have about 'good' and 'bad' mothers," which "to a considerable degree reflects the social structures of inequalities in our society." According to Neiterman (2012), women who are high on the social ladder of motherhood, or women that tend to be labeled as

"good" mothers, are less likely to feel the need to completely conform to larger norms that dictate how one should adapt to pregnancy. Neiterman (2012:379-380) found this is especially true for experienced mothers, since their previous successful experiences of pregnancy firmly establishes their high position on the ladder. Rather than relying on a standard set of practices, experienced mothers can voice disagreement and suggest alternative ways of "doing pregnancy." Since it is a requirement that surrogates have at least one previous successful pregnancy experience, all surrogates are experienced mothers by default, and therefore, occupy a high place on the social ladder of motherhood according to Neiterman (2012). To begin the section on surrogates, I explore their expectations about control and how these expectations were impacted by their status as experienced mothers.

Another part of "doing pregnancy" involves performing, or "ensuring that the process of doing pregnancy is acknowledged and approved by others" (Neiterman 2012:373). However, as Neiterman (2012) explains, women who are high on the social ladder may not only reject certain norms, but also tend to be less diligently monitored in terms of how they do and adapt to pregnancy. Furthermore, their occasional non-adherence to pregnancy norms may also escape social sanction. Comparatively, those who are lower on the ladder are more actively monitored and sanctioned more aggressively. These disenfranchised mothers therefore often attempt to prove to others that they can be trusted, which is why these women feel more compelled to follow pregnancy norms so they may move up the social ladder of motherhood.

After exploring surrogates' expectations about control, I move on to describe surrogates' actual experiences of control over their health behaviors and practices, and more specifically, how the trust they received from their IPs often resulted in a lack of control for many surrogates. I also discuss how trust may not always be complete, resulting in at least some attempts at

control during the surrogate pregnancy. Finally, I finish the section on surrogates' perspectives by examining the unique case of Megan, and how her heightened experience of control over her health behaviors and practices differed from most other surrogates in this study.

In the second half of this chapter, I begin by exploring IP's expectations about control and what exactly impacted these expectations. I then examine giving trust from the IPs' perspective, and more importantly, how many IPs gave trust precisely because of surrogates' successful experiences of pregnancy and the embodied knowledge they gained. While Neiterman (2012) examines how pregnant women's motherhood identity and previous experiences of pregnancy may impact how diligently they follow pregnancy norms or are monitored or sanctioned by others, she does not consider how the identity and previous experiences of childbearing of those on the other side of the accountability dyad may impact their acts of norm surveillance and accountability practices. In this same section, I discuss how trust in surrogates' experiential and embodied knowledge seemed to be related to or compounded by IPs' *lack* of experience and embodied knowledge about pregnancy, which extends on Neiterman's (2012) findings. Related to this, I consider how IP's biological sex and gender may impact their embodied knowledge, and therefore, trust. In the last part of the section on trust, I explore why some intended parents found it hard to trust their surrogates.

To conclude the second half of the chapter that focuses on intended parents, I explore some unique cases of IPs whose surrogates did not fully follow their expectations for health behaviors and practices, and how this involved or impacted IPs' feelings of trust, surrogates past experiences with pregnancy, and the reliance on following doctor's recommendations. Within this section, I also describe how IPs typically did not sanction or try to correct their surrogate's behaviors. I propose several possibilities for this finding, including how lack of sanctioning may

be related to surrogates' status as experienced mothers (Neiterman 2012) and the unique circumstances of surrogacy. I also suggest that lack of sanctioning may be related to IPs' not having their own past experiences with pregnancy, which again extends on Neiterman's (2012) findings.

HEALTH EXPECTATIONS DURING PREGNANCY

In addition to examples of medical professional's involvement in decisions around transfers, reduction, and termination, slightly more than third of surrogates reported that they expected to generally follow doctor's recommendations during the pregnancy, with most of them saying that it was a specific request from their IPs. Slightly more than half of IPs that I interviewed for this study also reported that they expected their surrogates to generally follow doctor's recommendations during the pregnancy. Following doctor's recommendations was one specific health request that could be stipulated in the surrogacy contract. Intended parents, therefore, were able to have some control over surrogates' bodies and health during the pregnancy through the expectation that they follow doctor's recommendations, while also granting or handing over some control to medical professionals.

Part of following doctor's recommendations involved surrogates adhering to specific health behaviors and practices. These expectations were clearly drawn from larger medical and health norms around pregnancy. For example, when speaking about any health requests that IPs expected surrogates to follow during the pregnancy, slightly more than a third of surrogates and slightly more than two-thirds of IPs described what some participants referred to as "standard," "normal," or "basic" health behaviors and practices, or those that are typically recommended to pregnant women in the United States. Examples of standard expected health behaviors and practices included taking prenatal vitamins, limiting caffeine, not eating certain foods like

unpasteurized cheese, hot dogs, or raw fish, the expectation to generally eat a healthy diet, and no drinking, smoking, drug use, or engaging in extraordinary risky behavior. Following doctor's recommendations could also be related to specific and unique circumstances during the pregnancy, such as when a doctor recommends a surrogate engage in bedrest due to complications. Expectations for specific health behaviors and practices was another way that intended parents and medical professionals were able to exhibit some control over decisions that involved the surrogate's body and health during the pregnancy. Like the request to generally follow doctor's recommendations, these health behavior and practice expectations were often outlined and relatively common within participants' surrogacy contracts.

SURROGATES' EXPECTATIONS ABOUT IPS' CONTROL DURING PREGNANCY

While many surrogates were willing to follow intended parents' expectations that they follow doctor's recommendations and basic pregnancy norms, almost half of the surrogates in my study also reported that they did not want their IPs to *overly* control their health behaviors and practices during the pregnancy. For example, Kim was a surrogate who said she would not consume hot dogs, raw fish, would limit caffeine, and would follow doctor's recommendations. Yet, she also said,

> After being on Facebook and sort of reading other people's journeys and things, I kind of realized that most parents give the surrogate freedom to live her life the way she typically lives her life. So, I kind of expected to have the same freedom, that I just live how I typically normally do with certain restrictions, pregnancy restrictions, that are normal for any pregnant person. But I guess I kind of expected to be able to still have my same sort of lifestyle. I was open to adjusting some things if they didn't want me eating certain

> foods or something. But yeah, I pretty much expected to have most of my freedoms still. (Kim – Female Surrogate)

Of the almost half of surrogates in this study who said that they did not want to be controlled, the majority, or five surrogates, cited their past successful experiences and knowledge about pregnancy for why this was the case. Therefore, like the pregnant women in Neiterman's (2012) study whose status as experienced mothers allowed them to not be completely controlled by the norms of pregnancy, surrogates cited their previous pregnancy experiences as a reason that they did not want to be controlled be their IPs.

For example, Laura told me about how she did not match with a particular couple because of their health requests. For one, she said the potential intended mother was "adamant" that she ate organic food, which "wasn't going to work" for Laura. She continued to tell me about why she did not match with that couple.

> [The food request] was one of the reasons. She wanted me doing baby yoga, there was a bunch of stuff. She had had one pregnancy, and she felt that her son was the best, most amazing, perfect child. And she felt that he was the best, most amazing, perfect child because of how she treated her pregnancy. So, she wanted to make sure that this next pregnancy, which she couldn't carry, was treated in the same manner she treated hers… At that point, the idea of cooking separate meals for everyone in my house was just, it was too overwhelming. I wouldn't say [there were] many [requests], there were two or three. But they just, I wasn't looking to alter my lifestyle. I knew how to be pregnant, I had successful pregnancies, it wasn't something that I needed to explore further. (Laura – Female Surrogate)

Laura's potential intended mother strongly believed in certain health behaviors and practices because of her own past successful experience with pregnancy. Yet, Laura also clearly felt that her own way of "doing pregnancy" was successful without having to modify her lifestyle and she was confident in her own abilities as an experienced mother (Neiterman 2012).

Although many surrogates wanted to rely on their own experiential knowledge and therefore did not want an overabundance of expectations or control during the surrogate pregnancy, that did not mean that they were not willing to engage in standard health behaviors and practices. Rather than having their practices surveilled by IPs, surrogates felt they could engage in self-surveillance. For instance, Cynthia said,

> We kind of talked about that as well in the first [match] meeting. And I wanted them to trust me as the pregnant person because I had done it before successfully and my kids came out perfect. And I'm a nurse, so I work in labor and delivery. Prior to that I worked in pediatrics so I'm pretty familiar with the *dos and don'ts of pregnancy* [emphasis added]. So, I really wanted the space to be able to make certain decisions. (Cynthia – Female Surrogate)

My findings, therefore, differ slightly than those of Neiterman (2012). Instead of surrogates using their status as experienced mothers to resist the standardized norms of "doing pregnancy," they instead used it to resist control of their IPs precisely because they were confident in their ability to follow norms without being told how to do so. Jacobson (2016) also found that surrogates desired trust based on the embodied expertise and skills they felt they brought to the surrogate pregnancy, especially when compared to IPs who may have not experienced a pregnancy of their own. As Laura's case shows, however, surrogates may also use their experienced motherhood status to voice disagreement with norms that go above and beyond the

standard, such as eating an organic diet or doing baby yoga. In this way, my findings differ from that of Jacobson (2016) who reported that surrogates spoke of being more cautious with their surrogate pregnancies than they were with their own children. None of the surrogates in my study reported that sentiment to me. Instead, some, like Laura and Kim, wanted to maintain their previous lifestyles.

TRUST FROM INTENDED PARENTS

Most surrogates in my study did not feel overly controlled by their intended parents. One way that surrogates were able to have autonomy over their health behaviors and practices was by receiving trust from their IPs, meaning that their IPs displayed confidence in surrogates' decision-making ability and choices. This finding was reported by a third of surrogates in my study. This group included surrogates who specifically said that they did not want to be overly controlled, as well as those who did not. Jacobson (2016) similarly found that some surrogates in her study received trust during the pregnancy, though this was not always the case. Since surrogates in my study were often not controlled and received trust, it therefore suggests that that their intended parents also viewed them as "good" mothers who could make pregnancy decisions without having to monitor their health behaviors and practices (Neiterman 2012).

For example, Amber was one surrogate who spoke to me about how her IPs generally trusted her health choices. When I asked her whether they had any health explanations for her to meet during the pregnancy, she began by saying,

> They wanted me to eat relatively healthy, but there was no like, "You need to eat organic. We want only this prenatal vitamin." They weren't overly picky on any of that type of stuff. We even went out to eat lunch one time, and I definitely had some bacon and

> chicken mac and cheese. They didn't blink an eye. They were very much... If you want to eat that, that is fine… They had made it known, "We do eat pretty healthy and pretty clean because cancer." But at the same time, they weren't forcing me to change anything either. And I eat relatively healthy, so it wasn't like it was hard for me to eat healthy while I was pregnant either. It's not like I eat junk food all the time. Moderation, if I do eat unhealthy, it's moderation. I can go and totally have a cheeseburger and french fries, but I'm not doing that every day. We eat ground turkey instead of ground beef. There's certain choices, lots of green, balanced, colorful food, just the general recommendations. There's no specific diet I'm on, it's more overall making healthy choices. She just trusted me. She let me eat. They would buy us popsicles and things like that, for my kids. But even when we were out eating and I would be snacking on popcorn with them, because we were at the pumpkin patch or something… Not that popcorn is awful junk food, but at the same time, I wasn't snacking on avocado. But… they were like, "She's good." (Amber – Female Surrogate)

Amber clearly had freedom to make her own diet choices and even indulged from time to time. As Neiterman (2012) contends, "good" mothers are not only less carefully monitored, but their occasional non-adherence to pregnancy norms may not be as negatively sanctioned as those who are low on the social ladder of motherhood. This was clearly the case for Amber.

Elizabeth was a surrogate who specifically did not want to be controlled. For instance, she told me that she did not want to have an "adversarial relationship" with her IPs. She therefore looked for a couple that was "easy going" and not "super controlling" since she was the one "going through this pregnancy," seemingly referring to the fact that she is the one who will ultimately embody the experience. When I asked her to explain what she meant by not wanting

to be controlled, she elaborated by saying, “I really wasn’t interested in having them tell me what I need to eat or not eat. You know, I already had two children. Neither of them had ever had a child so I’m like I got this. I know how to do this...” Although Elizabeth said that her intended parents never had a child, they did in fact already have one child with another surrogate. It therefore seemed that Elizabeth believed it was their lack of *physical* experience of having their own pregnancy that set her apart from her IPs.

As Elizabeth explained to me in her interview, her intended parents did honor her wishes to not be controlled, including when it specifically came to her diet. This was further confirmed when she told me about how her IPs trusted in her diet decisions when she developed gestational diabetes. For some surrogates, health expectations changed over time, such as when a complication arose during the pregnancy, which was the case for Elizabeth. She said,

> I did have gestational diabetes, but I had that with my daughter too and I know how to change my diet to deal with that so I’m able to manage it with my diet just fine… They trusted that. My numbers were coming back fine because I… know how to control it, so everything worked out well. (Elizabeth – Female Surrogate)

Elizabeth not only used her previous experiences and knowledge of pregnancy, but also her experiences with pregnancy complications, to inform her choices.

According to Elizabeth, her IPs had not dealt with gestational diabetes with their first surrogate. When I asked her whether her intended parents knew that she had previously had gestational diabetes when they matched with her, she confirmed that they did. She explained,

> Yeah. They just asked me, “Oh, well what does that mean and what do you do with that?” … I said, “Well, you know, we could end up with a really large baby but I’m really good

> at monitoring my diet. So I told him how I did it with my daughter and that, how I changed my eating and it kept my numbers low… I tested my blood sugar every day, kept it in check, did a good job with that. They trusted I knew what I was doing. (Elizabeth – Female Surrogate)

Not only did Elizabeth's IPs trust her despite her previous diagnosis, but they also seemed to specifically rely on Elizabeth's knowledge and reassurance since they had not dealt with gestational diabetes before, although Elizabeth said they also did their own research as well.

Minor Examples of Lack of Trust and Control

As I discussed in the previous section, Cynthia wanted trust from her intended parents and "the space to be able to make certain decisions" since she had successfully carried children of her own. For the most part, Cynthia reported that she did not feel controlled. She told me,

> She never controlled my diet or said, oh I don't want you to eat a high fat diet or anything like that. She was very much absolutely opposite and anything that I felt like I wanted [in terms of food], she would help me get… I know that some people can get a little funny, but she was, the dad, he really let's her take the lead, that's how everything went. He's a very laid-back person. She's a little bit more controlling or headstrong. I think she wears the pants in that relationship which is fine. And she was still very laid back with my pregnancy. (Cynthia – Female Surrogate)

At the same time, Cynthia's intended mother did seem to have some worries, or a lack of complete trust, about her diet choices. She explained,

> She was a little concerned because like I said, when I'm pregnant, I don't like meat. So, I have to find other forms of protein because I know that my body needs protein. So, I try

> to eat a lot more eggs and things like that. But she was a little bit nervous about my protein intake at one point. And I was pretty pregnant, I don't remember at what point but… we were already with my OB at that point, [my intended mother] asked if we could do a lab just to make sure that my iron levels were good which they were. I knew they would be. But when you're not carrying the baby and you've experienced so much loss I imagine, you just scramble for some sense of control in some of it. She was never like, [Cynthia] you need to eat. I really would like for you to eat six servings of meat a week or anything like that. She knew that I didn't like it, and she would just give me ideas of other things that I could eat. (Cynthia – Female Surrogate)

Still, Cynthia took her intended mother's attempts at control in stride. Even though she again referenced her past successful experiences of pregnancy, she claimed that her intended mother's concerns did not bother her. Nor was her intended mother's approach extreme or long lived. She said,

> But it was never pushy and I never felt like, just let me do this, I've done it already. My two kids were fine, I did it the same way… And then like I said, she was a little concerned and then when my blood came back normal then she backed off, it was more fine. (Cynthia – Female Surrogate)

Yet, while Cynthia said that she never felt resentful despite her successful pregnancy experiences, she did mention how her doctor reinforced her experiential knowledge. She explained,

> And my OB-GYN is really good because I work labor and delivery, so I actually work with her. And so, I think she helped instill some confidence in my decision making as a

> pregnant girl too. She would say things like, "Oh you know [Cynthia] knows exactly what she needs to do and [Cynthia's] done this before…" She was really supportive on my end to make sure that [my intended mother] knew that this baby was well taken care of. (Cynthia – Female Surrogate)

In addition to Cynthia, a few other surrogates described minor examples of IP concern over their health behaviors and practices or intended parents that made suggestions about how to manage the pregnancy, again implying that there was at least some lack of trust and attempts to control in these cases. Though, like Cynthia, most of these surrogates were not overly bothered by those incidents. Megan's experience of control, however, stood out from the rest.

MEGAN'S STORY

While many surrogates had to follow the basic health behavior and practice requests that I describe above, Megan seemed to have the most extensive requests of all the surrogates I interviewed. She also described feeling overly controlled, at one point likening it to being on a tight leash. Megan began by telling me how she approached control over her medical decisions during the pregnancy. She said, "I wanted her to be involved and I wanted to value her opinion." Yet, she also told me, "I wanted to be the sole decision-maker of my own health" and that "it was important for me to be able to have a voice for my own medical decisions." At the same time, her intended mother "wanted everything organic and everything as natural as possible." She therefore had to navigate between having control over her own health behavior and practice decisions and respecting her intended mother's health behavior and practice requests.

For example, Megan was asked to eat an organic diet, although she told me that her intended mother did not bring that up when they matched. Instead, she waited until the day

before her last transfer, which was ten months into their process together, to inform her of her request. She explained,

> Never in those ten months did she tell me that she wanted to now start eating all organic, and when you spring up on me the day before my last transfer, that's a big change. Contractually, I don't have to abide by it... Yet, I want it to be respectful of it. (Megan – Female Surrogate)

Megan did try to eat an organic diet to the best of her ability with the budget she was given by her intended mother, although she said it became a bit of a "project" since she had to look up sales and figure out which organic foods she could afford. She also tried to purchase organic items with her own family's food budget and purchased a warehouse club membership so that she could get cheaper groceries. She said, "I wanted to keep things amicable, and I wanted her to trust and believe that I was really doing the best that I could with what I had."

Later in our interview, Megan expanded on why she felt she should have leeway to make health decisions. Since she was a first-time surrogate, she was appreciative of her intended mother's knowledge and support through the IVF process. She felt, however, that she was the one who had the expertise in terms of pregnancy and therefore wanted more independence, though she was still willing to have a collaborative approach. She said,

> In the case of my IM, she spent six years trying to get to this point. Oh, she has known all the research known to mankind. She's been through the IVF process herself… At first, we had the fertility clinic, and we had a lot of hardships with them, and they were completely frankly unreliable, and she and I relied on each other. It felt really great that she knew names of the medicine, why she felt I should have injections over suppositories, and

> things like that that I didn't know, and I wasn't knowledgeable enough. Then, once I got through the first trimester, you're still dealing with the fertility clinic, but then after that, you graduate, and you go to your regular OB and it becomes a traditional pregnancy. At that point, that's where I felt like we needed to tag team. Okay, at first, she was schooling me. I was letting her take a lead, but now I got this, I've had two kids, you know what I mean? I know how this should go from here and out, and I felt like I wanted to have more freedom, more of a voice, and I felt like she still was micro-managing, maybe that's a better word, micro-managing as part of the process. (Megan – Female Surrogate)

While Jacobson (2016) found that some surrogates in her study received trust, other surrogates she interviewed similarly described issues of IP "micromanagement," just as Megan did. When I asked Megan about how her intended mother micro-managed her, she gave me numerous examples. For instance, Megan said that her intended mother "consistently reminded me of things that I need to do," such as making sure she brought her vitamins to the doctor like she was asked. She explained, "She, in a matter of like two days, reminded me three separate times, and for me, it became annoying. I know what I'm supposed to do, I got it."

Other examples included Megan's intended mother's requests to follow the natural approach she wanted. She explained,

> With my allergies and she was like, "Why don't you try a neti pot instead?" Anything to not do with medicine, which I get, but at the same time, when I'm five months pregnant and it's a hundred degrees and I've tried everything and I'm not sleeping and I'm feeling miserable, I don't give two craps about a neti pot right now, I just need immediate relief. I want to respect her belief and I want her to also understand. (Megan – Female Surrogate)

While Megan wanted to "respect her belief," she also wanted the freedom to use an over-the-counter medication if it was approved by her doctor. In fact, she had purposely added the ability to use over-the-counter medicines in her contract. Earlier in our interview she told me,

> …When the shit hits the fan, pardon my French… if all the natural methods are not working. You better believe it that I'm going to tell my doctor. If he tells me that it's okay for me to take Claritin, I'm going to take that Claritin. It became a point of contention, but it's important. (Megan – Female Surrogate)

Megan's intended mother was also "highly against" her using Clorox wipes. She requested that she use a natural brand instead, which Megan agreed to.

In addition to the request that Megan eat an organic diet, her intended mother also made other suggestions during the pregnancy. She explained,

> …She asked me do I eat kale and I said no, and the next time I saw her, she brought me two different types of kale chips so that I could just try. I felt a little bit disrespected, and I take things with a grain of salt because I know that she wants me to try it, but what part of me telling you I don't like kale makes you believe that I want you the next time you see me to bring me two different types? (Megan – Female Surrogate)

Megan's intended mother also asked her to start drinking kombucha, a fermented tea. She obliged and went to the store to buy it, only to find out that the label said it was not safe for pregnant women. She explained, "Those points became a little bit frustrating because every time that I've heard from her, it started becoming, what kind of podcasts did you listen to now or what the hell did you read in a magazine now that you think it's great for me to try?" She told me that she believed her intended mother was pulling these ideas from podcasts because she also sent

some to her, in addition to books and other information. She said, “I knew where she’s getting it from, I just felt it was a little bit unfounded and what’s the flavor of the month.”

Megan’s intended mother also had a specific request when Megan’s doctor recommended she be on bedrest because of complications she experienced when carrying twins. She said,

> …Towards the end, I had modified bed rest and things like that, so now she had to take it to the next level where it was like, “Don’t even do anything other than get up and pee.” I’m like, I still have to function, I still got kids, I still want to feel like a human being. I actually don’t think that laying down all day is quite frankly healthy for me or the babies. (Megan – Female Surrogate)

While Megan clearly saw a link between her behavior and the health of the children she was carrying, the approach she felt was best to ensure their health was different than that of her intended mother’s. When I asked her if she also checked in on her during that time, she told me, “Yes, a lot and, ‘What’s happening and where are you,’ which I get also, the nervous system started going bonkers.”

Toward the end of her pregnancy, Megan had to stay at a hotel closer to the hospital in case she went into labor. She told me that her intended mother envisioned that she would come over, take care of her, and bring her food. Megan explained how she communicated her feelings about this to her agency, how the stay affected her emotionally, and how it even affected her family life.

> My agency was trying to be very nice. I started having nervous meltdowns going, “She’s suffocating me. I can’t do this. I just want to be left the hell alone.” I was going through, also, the emotional heartbreak, even though I knew that it could be expected that I now

> had to be away from my own family for possibly a month. My own kids and my daughter started school that week. She's a first grader and I'm missing out on all of these things. We had no family here. I had to fly in my mother from South America to be here. Now, I can't spend time with my mom. I know that this is all warm and fuzzy, but I just wanted to be the left the hell alone. We had to have a very tough conversation in me telling her I appreciate it. I don't want anybody coming to see me. It's okay, but I will be by myself because she's like, "I don't want you to be by yourself." Trust me, at that point, all I could do was hold onto the walls and walk to the bathroom. I was in so much pain and I was so ridiculously heavy, and I would rather do that by myself. (Megan – Female Surrogate)

Jacobson (2016:102) similarly found that when surrogates felt that their IPs were "out of control," they reached out to the surrogacy agency to help manage the situation. It is important to note, however, that not all surrogates and IPs use an agency, which was the case for around half of the participants in this study.

Megan said that her intended mother felt that she was pulling back from her. She explained, "I felt really bad, and I felt very stressed where at the time, those last few weeks that things were supposed to be amazing, they actually became the most tense." Despite all that happened, Megan told me she had a fairly amicable relationship with her intended mother after their surrogacy experience ended, especially since they were no longer contractually obligated to each other. She said that ultimately, she wanted people to be educated about surrogacy. At the end of our interview, she spoke about the fact that she believes that there are two sides to the surrogacy debate: those that believe that surrogacy is "perfect" and that there is always happy

ending, or the people who "shit talk" about surrogacy. For her, "There's so much more in between."

INTENDED PARENTS' EXPECTATIONS ABOUT SURROGATE CONTROL DURING PREGNANCY

Just shy of half of intended parents also spoke about the topic of monitoring or controlling their surrogates in relation to their health decisions and lifestyle choices. While Jacobson (2016) examined surrogates' expectations about and experiences of control during the pregnancy as part of her larger study, she largely did not provide the intended parents' perspective. The IPs in my study talked about the issue of control in multiple ways, with the main themes centering around IPs not wanting, expecting, or feeling a need to monitor or control their surrogate and their health and lifestyle. Some also believed that it was not realistic, appropriate, or even feasible to try and monitor or control their surrogate's lifestyle or even the ultimate health outcome of the pregnancy. Sarah's comments on monitoring and control exemplified many of these themes.

Sarah was one of the intended parents who separated her desire to make decisions about her baby from the surrogate's ability to make decisions about her body. She elaborated on this distinction by speaking about how she did not want to control her surrogate on a day-to-day basis. She began by saying,

> As far as decision making... Obviously, most decisions I expected us to make. But anything that would impact her, her body, her experience, I would certainly want her to have input in that. I hoped for a fairly casual, kind of hands-off relationship. I really didn't want to micromanage anybody. Absolutely didn't desire to micromanage anybody.

> I have my own life to deal with. I don't need to be like checking in on somebody's diet and exercise. So, day-to-day, I pretty much wanted to be able to be hands off. I didn't want to work with someone if I didn't trust them enough to just take care of themselves and my child without me having to set up a plan for them. (Sarah – Female IP)

A bit later in the interview, she continued by saying,

> I mean, obviously anything that certainly had to do with the baby, I wanted to be the decision maker on. But outside of that, really as long as it didn't negatively impact the pregnancy, I really didn't want to have much of a say… As long as she's following OB's recommendations and general good medical council then I would much rather not have to stress about that. So, I just envision not having much control over the pregnancy as far as a lot of the minor decisions. (Sarah – Female Surrogate)

Some of the OB recommendation that Sarah wanted her surrogate to follow included not drinking, smoking, and trying to "eat a vegetable one in a while… because [those behaviors] can impact fetal development." Similarly, Ben told me that he also would rather rely on his surrogate following doctor's recommendations rather than "micromanaging" her. He said, "I think it was mostly, follow the doctor's recommendations. Whatever the basic… I think the doctor wanted her to do like certain multivitamins, those sorts. Basically, rather than micromanaging, it was like, let's just do whatever the doctors recommend."

Sarah also spoke to me about picking the right match, or a surrogate that knew how to maintain a healthy pregnancy. When I asked her how she developed expectations about her involvement in the pregnancy, she explained,

> Part of it is selection. I mean, [my surrogate], she's a labor and delivery nurse. I don't worry about her. I really don't. I wouldn't have ever agreed to work with someone that I didn't feel like had a solid grasp of how to manage the pregnancy well. And yeah, like I said, I work in healthcare. I have a pretty solid idea of what pregnancy and delivery should look like. I feel like if anything was worrying me, I could bring it up. But I felt pretty comfortable that I knew how things should go. So, I think it was a little easier to just let them go. (Sarah – Female IP)

Will, another intended parent, said something similar to Sarah in terms of picking the right match and how this affected his approach to monitoring or controlling his surrogate.

> I felt a lot of it was just picking the right person, picking somebody who would take her prenatal vitamins and go to appointments and all that… Since I knew she would do that, I didn't actually feel that much need to be in the process. I kept aware of it. (Will – Male IP)

Although I have already established that most surrogates were not controlled and therefore were likely seen as "good" mothers who did not need to be monitored, I have not yet explored why this was the case from the perspective of IPs. One reason for the lack of controlling behavior on the part of IPs may be that they purposely looked for "good" surrogates that allowed them to feel less compelled to monitor (Neiterman 2012), as was the case with Sarah and Will.

Picking "good" surrogates was likely important to Sarah since she and others did not think it was reasonable or even possible to try and control or change their surrogate's lifestyle or overall health choices. Sarah explained, "I've heard of people doing like whole lists of lifestyle changes and all sorts of craziness. It's not sustainable, in my opinion. You know? You can't ask

someone to make huge changes of their lifestyle for you." When I asked her if the reason lifestyle changes were not "sustainable" was because of the cost, Sarah went on to say,

> Economically [for one], but just… People who ask someone to go all organic, or go vegetarian, or exercise more. I mean, you can't bank on anyone making lifestyle changes. If there's one thing I learned as a healthcare provider, it's that people do not make lifestyle changes easily. I just had no interest in trying to enforce something like that. (Sarah – Female IP)

Similarly, Stephanie said that if a potential IP did not like a surrogate's diet, then that person does not need to match with them, especially since that diet was unlikely to change. She explained,

> Setting expectations is one thing, but telling a woman what she's going to eat on a daily basis is not appropriate… You talk about diet and things of that nature at the time of matching. If you're not comfortable with the way she eats, then you don't need to match with her. Best to take her as she is. If she improves on her own, fine. But if she doesn't, if you matched with her knowing that she eats Kentucky Fried Chicken twice a week and Chick-Fil-A and Burger King the other days of the week, throw in a Taco Bell once in a while, you need to be okay with that, that she's going to do that through your whole pregnancy, especially with cravings and things like that. (Stephanie – Female IP)

Finally, while James wanted his surrogate to make healthy food choices and to not drink, do drugs, or smoke since it "could be detrimental to the health of an unborn child," he also believed that trying to control a surrogate's health choices too much, such as making them eat a vegan diet, could even "backfire." He told me, "You can't make anyone do that. You could try to

encourage or inspire, but what it ends up doing typically is, that person will just lie, and will retaliate almost."

Related to the belief that it is not plausible to control a surrogate's health choices and lifestyle, two intended parents also spoke about how it was not realistic to try and control the ultimate health outcome of the pregnancy. For instance, while Will said that he initially wanted to have control over having a healthy child, he realized that there was only so much he could do.

> The other dimension here is that I discovered in this process what a control freak I am. I never thought of myself as a control freak, but I just realized I want to control everything. I want the outcome I want. You don't really have that in life. You have this fantasy… and I see that so clearly now. These [people on the surrogacy] site, they are such control freaks. They think that they do this and this and this and this and this, it's going to be exactly the result they want and… I'm like, "Give it up, this is not going to work. You're not helping anything..." I wanted to control the birth. I wanted the birth to be healthy. I wanted to figure out how to turn this into a healthy birth and not realizing its nature, it happens. I would look out the window, like, "Okay, well, nothing told that tree to grow there, nothing told these flowers to do…" Or in my more religious moments, which are rare, like God. It's happening all the time and it's happening without any involvement from anybody. Life just grows. That's what it does… (Will – Male IP)

Similarly, while James said he did worry a bit about the surrogate having a healthy pregnancy and that "worst-case scenarios definitely flash through your mind," he also went on to say, "But, what can you do? You just hope for the best… I try to stay pretty level-headed about it, because it's just, so much of it is the unknown, and really outside of your control."

INTENDED PARENTS' TRUST OF SURROGATES

In the pervious section, Sarah talked about not wanting to work with a surrogate that she could not trust, implying that she did trust the surrogate that she ultimately chose. Eight other intended parents spoke about trusting their surrogates, meaning that they were confident of their surrogates' decision-making ability and choices, for a total of nine IPs. In addition to generally finding "good" surrogates did not have to be monitored, five of the nine IPs (a third of all IPs) said that they trusted their surrogates based on their previous pregnancy experiences and knowledge they had gained, and therefore seemed to agree with surrogates' assessment of their "good" and experienced motherhood status (Neiterman 2012). Furthermore, all five of the IPs who cited their surrogate's previous pregnancy experiences as a reason to have trust also did not have embodied experiences of their own. Three of them, one intended mother and two intended fathers, specifically compared their own lack of previous experience or knowledge about pregnancy to their surrogates who did. This, therefore, extends on Neiterman's (2012) findings by suggesting that level of norm surveillance is also affected by the parenthood status of those who do the monitoring. Lack of embodied experience and the trust this elicits may also be affected by biological sex or gender.

Of the five IPs who cited their surrogate's embodied pregnancy experience and knowledge as a reason to trust, one identified as transfeminine, and three identified as male. While some female IPs did have previous experiences of pregnancy, being born a biological male without the needed reproductive organs puts one in a position of not being able to have embodied pregnancy knowledge. Cisgender males also lack embodied knowledge about the female body. Furthermore, men are less likely to have opportunities to be socialized or educated about women's bodies and pregnancy. Finally, even intended mothers who are not carrying the

pregnancy are likely to be held or feel the need to be accountable to the norms of "doing pregnancy" and the social ladder of motherhood during surrogacy (Neiterman 2012). While both male and female IPs trusted their surrogates, males may be able to give trust to surrogates without the fear that deviation from the norm will reflect badly on their status as a parent. While the data I have to examine each of these assertions is limited, I do begin to explore how lack of embodied knowledge as a male impacts trust by examining the cases of John and Will.

Elizabeth, mentioned earlier, was the surrogate who talked not wanting her IPs to tell her how to eat or drink because she had already had children herself, and how they trusted and relied on her experiential knowledge about gestational diabetes. John, the male intended parent who was matched with Elizabeth, spoke with me about his trust for Elizabeth, as well as his other surrogate. He explained,

> We felt so like not the experts on being pregnant or having kids. We completely put our trust in her. Both of them had two children, so they know exactly what they're getting into. They know what they're doing. They know how to have a successful pregnancy, so there was no... They were so enthusiastic and supportive of having the child, and it seemed like they were going to care for this baby as if it was their own, and do the best for the child, as if it was their own. (John – Male IP)

Although John never physically had any children of his own, as I mentioned earlier, he did have two surrogacy experiences. In our interview together, he told me about the ways his first experience informed the second, as well as how it did not. When I asked John about how he developed his expectations for control over medical decisions during surrogacy, he responded,

> I was probably a little skewed because my cousin [who was my first surrogate] and I had such a relationship that we could just call, and be very honest on the phone with each other, so... But just, I guess I got an expectation from going through that with her, and what was appropriate. Just for example, like just to give her a hard time, I called her one time, and I said… "Did we exercise this morning? Did we eat a healthy breakfast?" She just responded, "bite me." It was just that kind of rapport, and again, I was just teasing, where I knew she would do whatever she needed to do. My expectation for the second was probably more grounded in that experience. (John – Male IP)

John also told me that he first started exploring surrogacy with an agency, so he likely utilized some of what he learned from there as well. When I explicitly asked him whether he used any knowledge about pregnancy in his second surrogacy that was gleaned from the first, he told me, "I guess I knew what to expect, and I knew to wait for the first trimester to really get my hopes up, and just… I wouldn't say that I applied anything that… My cousin did this, so I think you should do that, too, certainly not that."

Will, another male intended parent, described being nervous throughout the pregnancy. His fear was further amplified when he learned he was having twins. He explained, "When I learned it was identical twins, I then learned about all these strange and terrible things that can happen... That was a whole other range of things to think about." Two specific issues he was worried about were whether the twins were developing normally and how early they would be born. Yet, when I asked him whether his health behavior and practice expectations changed given his fears, he responded, "I think I just had total confidence that she would do the best thing for the fetuses, and that she knew a lot about [pregnancy]…We were both going to do what the doctor said and stay with it." While Will felt his surrogate knew about pregnancy, he talked about

his own lack of knowledge about pregnancy in another part of our interview. He said, "I didn't know that much about giving birth to babies or having babies or whatever."

His lack of knowledge about the pregnancy process was further illuminated when he spoke to me about the pregnancy appointment experience. He explained,

> I still felt a little bit scared, but we'd hit every milestone. Right? And that was also because I would go to the ultrasounds, and I would just be panicking inside. Then they never tell you what's going on. The ultrasound technicians are, "Oh, here's this," and they're doing all these creepy calculations, like, "Now we're measuring the kidneys" … like, "Now we're looking at part of the brain and this is the toes and," whatever. And then you wait, they won't tell you anything. And then the doctor comes in and he would say, "Perfect as usual." I remember that was like getting your gold star, so yes, I would say it's about 20, 24 weeks I started feeling a bit less scared and more confident and we were able to… and I think she was more convinced earlier that it was all going to be really good than I was, right, because she had been pregnant three times. I think she knows how it works more. (Will – Male IP)

Finally, during our interview, Will also referenced his lack of knowledge about women's bodies as a male and how this affected his feeling of control. He said, "…As a man, I just don't know that much about women's bodies… I was like, 'Okay, I guess you know what you're doing down there.'"

Difficulties with Trust

Though many IPs trusted their surrogates, it was not always easy. One major issue that seemed to impact trust was familiarity with the surrogate. For instance, Samantha talked about

how her trust for her second surrogate, who she knew before surrogacy and described as her "best friend," compared to the trust for her first, who was someone she knew through her brother but was not as close with. She said,

> With… our second surrogate here. I know for a fact that 100 percent she is doing everything she possibly can. Going above and beyond. Because when she puts her mind to something, this girl makes sure it gets done… So, I trust her 100 percent carrying our kid. With [our first surrogate] it was a little hard because we weren't as close. I trusted her but it was just, it was very different. Very different. (Samantha – Female IP)

Similarly, Tom explained, "In the beginning, I think we didn't like the idea of a random person. That's why we didn't look at agencies in the beginning because there was the matter of trust. You had to have some connection to them, but over time, it expanded." These cases suggest that surrogates' status as "good," experienced mothers may not have been enough to elicit trust for some IPs, without at least some preconceived knowledge or experience with how "good" their surrogates actually are.

Sarah, the IP who said that she wanted to find a surrogate she could trust and had confidence in her surrogate since she was a labor and delivery nurse, was the most descriptive about issues of trust. She told me,

> It's an interesting arrangement because it's really not regulated. It's really up to both parties involved as to how organized, I guess I should say, it is. The appeal of an agency is that they do organize everything very well for you, but it's a false sense of security, because it's not regulated by any means. Just because you have an agency making sure the contracts are done and this, and that, and the other thing, really at the end of the day,

> the only thing binding the two parties together is that contract. It's unfortunately just a piece of paper, and the parties can still very badly wrong each other if they really want to. (Sarah – Female IP)

When I specifically asked her about resolving an issue if a surrogate was not doing what was expected of them, she continued,

> It's just there's such a power imbalance once the surrogate is pregnant. The parents very rarely want to rock the boat unless things are really going off the rails. There's a lot of acquiescing that happens. Like I said, this is not personal. [My surrogate] and I had a great adult relationship, but it is really shocking to me how much you just have to trust in luck almost, and how little guarantee, and how little legal framework there is. If things go wrong, you really don't have a whole lot of recourse. It's scary. I didn't really realize how tenuous the whole thing was until I came through and was on the other side of it, and looking back, it's like, this is not a for-sure thing. It's all a whole lot of trust and finger-crossing, and it's scary. (Sarah – Female IP)

Sarah also talked about having to build up trust over time. She finished her thoughts on trust by saying,

> It's honestly to the point where we still have to talk with [our surrogate] and see if she is willing to carry again. I don't know with the hemorrhage, if that's a good idea or not, but honestly, if she is unable to carry again, I don't know if we'll start over with someone else. It's the thought of having to go through everything again, and build that trust up again, knowing how many ways it can break down. It's exhausting to think about. If [our surrogate] has retired, we might be one and done. (Sarah – Female IP)

Sarah's comments largely summarize Jacobson's (2016) assertion that surrogacy contracts, which often lack enforceability and are therefore largely nonbinding, are not enough to guarantee compliance. Rather, trust is built through surrogates' and intended parents' interactions throughout the experience.

In the next section, I explore examples where surrogates did not always follow their intended parents' expectations about health behaviors and practices. I also examine how these incidents involved trust, surrogate's past experiences with pregnancy, and IP's reliance on medical professionals to help establish appropriate health behavior and practice expectations. Finally, I explore IPs' reactions to these instances, as well as how the possible "power imbalance" between intended parents and surrogates that Sarah just described may come into play.

DIVERGING WAYS OF "DOING PREGNANCY"

Although most surrogates seemed to generally follow their intended parents' or doctors' basic health behavior and practice requests and recommendations, there were a few instances where surrogates did not. These incidents concerned IPs to varying degrees. For example, Stephanie was an intended parent who described two examples in our interview together. First, Stephanie discovered that her first surrogate was not taking the "really expensive prenatals" that Stephanie had paid for. She realized this was the case when she visited her surrogate's home so they could go to an ultrasound and saw them still sitting on her counter. She explained,

> I did have to [have a conversation with her] which was very uncomfortable… I broke down crying. I was very emotional about it. I was like "I cannot believe. I'm trusting you to do what you're supposed to do, and you can't even be bothered to take a pill every

> morning to make sure ...” Her son had had very minor, it’s not spina bifida, but it’s where the backbone kind of dimples at the bottom of the spine to make you think that there might have been a folic acid deficiency. Prenatals with folic acid was extremely important for her to take just to make sure something like that didn’t happen again. And here she was not taking them… That conversation was had, and she swore to me she would take them. I never knew whether she did or not. (Stephanie – Female IP)

As seen with Stephanie’s case, when giving trust to surrogates, it is also possible that trust can also be broken.

Stephanie went on to explain why she thought her surrogate did not take the prenatal vitamins. She said,

> She was very young. She was 21. She’d had two flawless pregnancies. Probably didn’t take prenatals then either, and she just didn’t understand. Her experience was nothing could go wrong, and so that’s how she acted. That’s all it was. There was nothing where she was trying to push back or challenge anything. She just was very nonchalant about the whole thing. “This pregnancy’s going to be fine, and it’s going to be full term, and there’s nothing that’s going to happen to the babies, or the pregnancy, or me…” And that was her attitude through the whole pregnancy. (Stephanie – Female IP)

Most surrogates in this study cited their experiential knowledge as a reason that they would follow norms. Relatedly, IPs often trusted them to do so. Yet, Stephanie interestingly attributed her surrogate’s *lack of compliance* to her successful previous experience with pregnancy.

Similarly, when describing another incident, Stephanie felt like her first surrogate did not have enough “common sense” to avoid risky behavior despite her previous experience. She also

attributed the issue to the fact that doctors may not go over what is recommended with their patients. To set her expectations, she felt the need to go over health behavior and practice recommendations more explicitly with her second surrogate given her first surrogacy experience and opinion about doctors. Stephanie therefore relied on her own previous experience with surrogacy (and possibly her own pregnancy experience, as she had her own pregnancy in between her two journeys) to inform her decision. By the time of her second journey, she had also opened her own surrogacy agency. She explained,

> No, I had no restrictions [during my first experience]… anything above and beyond… I was very naïve at the time. A lot of people are like, "Whatever the doctor allows or doesn't allow." The problem is a lot of OBs don't go over that list with people. They don't say you shouldn't be taking Advil, you shouldn't be eating sushi five days a week… So many OBs just do not have that conversation anymore… So knowing that now, for my second journey, we went over every single bit of that. We went over ACOG [The American College of Obstetricians and Gynecologists] recommendations on caffeine consumption, and do I really care if she goes to a Mexican restaurant and eats queso dip, because technically that's not allowed… Where in the first journey I was like, "You know whatever your doctor says. I'm fine with whatever." But there were very specific things that a doctor's never going to go over. Because you've just assumed somebody has enough common sense not to get on bumper cars when you're a surrogate and you're pregnant with twins at ten or eleven weeks along. That's exactly what mine did.

She continued,

> The dummy posted it on social media… So those are the kind of things that, knowing what I know now, I would go over those sorts of things. Does the surrogate like to go to

> Disney a lot and walk in the Orlando heat in the middle of the summer all day for three days straight. We might want to have a conversation about that before you get pregnant with my child. Stuff like that. So that's… what I would take into consideration now when I didn't then. (Stephanie – Female IP)

Although the incident seemed to upset Stephanie, she told me that she did not have a conversation with her surrogate after she rode bumper cars as she had done with the prenatal vitamins because, as she said, "by the time I found out about it, it had already been done."

Also, about a week after that incident, Stephanie and her surrogate found out the pregnancy was considered high risk since her surrogate was pregnant with twins. The surrogate, therefore, had to been seen by a high-risk specialist. Once the surrogate met with him, she was explicitly told not to engage in risky behavior. Stephanie explained, "That's when the physician had the conversation for me. You know… 'Don't go out cutting grass, don't be jolting, don't go ride horses.' He went through this huge list of things not to do for the pregnancy." Once the surrogate was told what to do, Stephanie said, "She took her doctor's recommendations very seriously." She also said that her surrogate followed a "strict paleo diet" without any facilitation from Stephanie. Ultimately though, Stephanie said she was happy with her overall experience and that the babies ended up being perfectly healthy. She said,

> I sound like I've been complaining this entire call about the bumper cars and the prenatals and stuff, but for the most part dealing with human nature, those were our only two little bumps. And we were pretty happy with the way the rest of the pregnancy went. All the pros outweighed the cons when you're trying to find someone to carry a baby for you. (Stephanie – Female IP)

Christopher was one of the IPs in my study who said that he trusted his surrogate's health behaviors based on her experiential knowledge. In our interview together, he talked to me about how his trust resulted in a lack of control over his surrogate. He explained,

> We weren't a family that wanted just her to be on an organic diet or anything like that. The surrogate… had two amazing, beautiful children, so clearly she knows what she was doing and we just put our faith in her to do what was best. It was good seeing that in action. We took her family to Disney in California. They had a security gate that had an X-ray, and she refused to go through it and walk through and opted for the pat down version. That's what I meant by seeing that in action. She really did care for our child like she cared for her own children that she carried, and that was really good to see. (Christopher – Male IP)

Later, when I asked Christopher whether he had any health expectations for his surrogate even though he did not want her to eat an organic diet, he told me about how he did at least expect her to follow doctor's recommendations. For example, Christopher talked about the recommendations to eat a healthy diet, not drink too much caffeine, and limit her soda intake.

While he seemed comfortable with allowing his surrogate to indulge in drinking some soda, he was a bit worried when it seemed to exceed his expectations. He described the incident to me by saying,

> ...She did drink soda. I remember one time she was like, "I just drink one soda a day." I'm like, "That's fine." … For the 20-week ultrasound, I think that we went to go see a movie and we met her there and she's like, "I'm just going to get my soda now." And she

got one of those like buckets of sodas. I was like, “Oh my God, is that safe?” (Christopher – Male IP)

In response, I asked him again if it was true that he trusted her to follow recommendations. He replied,

> I have to be honest with you. I do have trust issues, but I trusted her as much as I could. I can tell you that any question or any doubt or any second guess that I ever had completely went away the second our child was born and seeing her go through, for almost 24 hours of labor, and then delivering of our son. To me, that’s when it all made sense and made me feel a little foolish for having any doubt. Having said that, having somebody else carry your child, especially when they live across the country, makes you vulnerable. (Christopher – Male IP)

Christopher was another IP who talked about trust not being an easy feeling to have. Still, after the experience, Christopher took the fact that his surrogate drank soda lightheartedly. He told me that he still thinks of her when he sees a Dr. Pepper, and that he takes a picture of it to send it to her, knowing that it was her favorite.

In another instance, Christopher thought that his surrogate was engaging in risky behavior during the pregnancy, although it just ended up being a joke.

> She knew well enough to know how to, I don’t want to say push my buttons, because she knew how to mess with me like one of my fraternity brothers. She would say different things like they went skiing, and I’m like, “Oh, so you’re going to be on skis?” She’s just like, “Yes, we’re going up to the mountain. Now we’re losing our connection, I’ll talk to you later.” Then it turns out she did have one of those snowboards, but she was sitting on

> it. She would just mess around with me a little like that. At the time I felt like it was almost the end of the world, but then once she texted me the picture of how she was acting, it was fine. That's when I realized she was just messing around with me. I don't think I was that guy who was questioning everything. I think, in all fairness, because our process was so flawed and you're vulnerable enough going into this to begin with, there was a heightened level of uncertainty and anxiety that probably under normal circumstances wouldn't have been there. (Christopher – Male IP)

One reason that Christopher believed his process was "flawed" was because of the dislike he developed for the fertility center his agency connected him with.

Christopher believed that his first transfer attempt failed because they were not given proper instructions on what was acceptable post-transfer behavior while at the fertility center the first time. Since he and his surrogate were unaware of the restrictions, his surrogate took a short vacation four days after the first transfer, which Christopher knew about since she sent him pictures. This was his surrogate's first time serving as a surrogate. He explained, "She was in the water, but we didn't know that [she shouldn't be]. Had we gotten those instructions, she definitely would not have done that." After Christopher and his surrogate were verbally given the instructions while at the second transfer, he asked the clinic to send them to him in writing when he got home. However, they failed to send the correct information. Therefore, Christopher used Google to write them up himself. He said, "I basically wrote them for our surrogate to follow, and I made [the fertility clinic] fill in all the medical blanks in terms of the medicines you were supposed to take, the dosing, what she can and can't do, and what limits she had." As a result of his experience, Christopher said that he did not "trust [that clinic] at all" and moved his remaining embryos to a different clinic since he did not feel comfortable with them anymore. He

told me, “I would not recommend them… They lost any credibility with me.” Christopher’s case serves as an example of how trust may not only be broken by surrogates, but also by the institutions that are involved in the surrogacy process, and how this may impact the overall surrogacy experience.

Finally, Samantha, another intended parent, also told me about two instances where her surrogate did not follow recommendations. When describing the first example, she said,

> She was a smoker and ended up actually not quitting. She tried and we’d put that, we just decided between the two of us, or three of us, that we weren’t going to make that a deal breaker. This was our one shot. We weren’t going to dictate whether she could smoke or not. I understand there’s a lot of health concerns. But, well, my mom smoked with me. Not that it’s okay. But that, you know, the tradeoff for us was either that or not have a baby. (Samantha – Female IP)

Later in the interview, she continued by saying,

> We would have preferred her to quit, and we did say... I think our contract said that she would try. She did. I think she went on the patches for the first couple of months but then just really struggled after that. She told us. We were like, “Well, it is what it is… Can’t do anything about it now. We’re not going to sit here and try and tell you to quit smoking…” I don’t think she was a heavy smoker, I wouldn’t say. But any smoking is not good during pregnancy. (Samantha – Female IP)

While Samantha saw not smoking as an important aspect of adapting to the pregnancy, her surrogate was either unwilling or unable to quit. Ultimately, Samantha let her surrogate have

autonomy over her health behavior decisions so she could meet her end goal of having a baby through surrogacy.

In another example from Samantha, she again seemed hesitant to control her surrogate's diet. She said,

> As far as food and things like that, the first journey our surrogate had had gestational diabetes. Borderline, but it was controlled with diet. We did take her grocery shopping and stuff. But, again, it was just that blind trust that she would make sure that she took care of that. We would certainly buy her the food or do whatever it took to make sure that she would take care of herself. But we never have demanded, you know, whatever the doctor had recommended or said, and [our second surrogate] is very good about checking that list and making sure she's not eating the wrong food or whatever, but I'm pretty sure [our first surrogate] wasn't. It was just kind of like, "Well it's her body." She's had, both of them had kids before. I haven't. I need to trust them to make those kind of decisions. (Samantha – Female IP)

In this instance, Samantha was again willing to give her surrogate bodily autonomy and trusted her, especially because her surrogate had previous pregnancy experience, whereas Samantha did not.

When I asked Samantha how she felt about the gestational diabetes more specifically, she again reiterated that "we weren't really worried or concerned." Although there were risks that baby could be a larger size and that her surrogate could develop preeclampsia, she was more worried about her surrogate since "the bigger risks were to her than the baby." Although Samantha felt that her first surrogate likely did not have the best diet earlier in the pregnancy, she

did feel that she "started eating a lot healthier" after she found out about the gestational diabetes diagnosis. She said her surrogate managed it well, she was not gaining too much weight, and the baby was only measuring about a week ahead.

Samantha was willing to accept some deviation from norms and trusted her surrogates. Yet, she also seemed to have limits to the trust she was willing to give. For example, Samantha told me that she did not trust her own sister based on how she treated her own pregnancy and because of her previous lifestyle. She explained,

> At one point my sister had offered to carry. Then she ended up having twins naturally and has had issues since and is with a guy. She just never actually stepped up to do it. But I always kind of said I didn't want her to be my surrogate. Which my friend, [our second surrogate], had said… "I knew I could do a better job than your sister." Which is the absolute truth. I don't trust my sister to carry my child. I think like the main things we would basically be looking for is that somebody would carry this child and care about their child's health like it was their own. My sister's lifestyle, I just didn't feel like she would do that. Smoking cigarettes was one thing but my sister's also a pot smoker. She just doesn't take care of her body. …Even with the twin pregnancy, she did some questionable things. I just could never trust her with my pregnancy. (Samantha – Female IP)

At the same time though, she continued by saying, "Because of a situation we're in where we couldn't use an agency, it's not like we could be picky."

Interestingly, despite the one case where Stephanie had a conversation with her surrogate when she did not take her prenatal vitamins, the IPs described above did not seem to sanction or

attempt to correct their surrogate's behavior. This may be explained by several factors. Though Neiterman (2012) argues that a negative assessment of one's pregnancy performance may put one's high status on the social ladder of motherhood at risk, she also contends that "good" mothers' occasion non-adherence to prenatal norms and guidelines may not receive the same level of public reprimand as those who are low on the social ladder of motherhood. Therefore, surrogates' status as "good" mothers resulting from their previous pregnancy experiences may have a protective effect. This argument is supported by Samatha's explanation for why she did not question her second surrogate's eating habits, although she suspected they were not ideal.

Samantha's trust despite her suspicion was also compounded by the fact that she did not have a previous pregnancy experience herself. Stephanie and Christoper also did not have their own pregnancy experiences during the incidents I described above. This suggests that level of sanctioning may also be affected by the parenthood (or even the sex or gender) status of the person on the other side of the accountability dyad. This possibility adds another new element to Neiterman's (2012) concept of "doing pregnancy" and nuance to my earlier suggestion that trust and level of monitoring may be impacted by a lack of pregnancy experience on the part of the non-pregnant individual. Notably, once Stephanie did have her own experience of pregnancy and became an agency owner, she was much more explicit in her recommendations for "doing pregnancy" with her second surrogate. When I asked her whether her experience as an agency owner affected the knowledge she applied to her second surrogacy journey, she replied, "Correct, exactly."

However, the lack of sanctions could also be explained or compounded by the unique circumstances of surrogacy. First, IPs desire to give surrogates bodily autonomy, and embracing the surrogate's own way of "doing pregnancy" may be a part of that, even if it goes against what

IPs would prefer or do themselves, as was the case for Samantha. Furthermore, as Samantha explained, accepting certain non-normative behaviors and practices may be a "tradeoff" that IPs are willing to accept to have a child through surrogacy. Stephanie's comment also supports this explanation when she said, the "pros outweighed the cons when you're trying to find someone to carry a baby for you." Certainly, not everyone is willing to carry a baby for someone else, and as Samantha said, IPs may feel like they can't be "picky."

Intended parents' remarks from earlier sections in this chapter may also play a part. Some IPs, including Stephanie, realize that it is not realistic or even possible to completely change the surrogate's lifestyle or usual habits. They may even fear, as James said earlier, that doing so could "backfire" and that surrogates may "lie" and "retaliate," though that certainly was not a common occurrence for participants in this study by any means. Given the lack of legal regulation over surrogacy, IPs are often left hoping for positive outcomes. As Sarah pointed out in her discussion about trust earlier, legal contracts and agency oversight do not always provide recourse when a misunderstanding or disagreement between surrogates and IPs occur. Sarah further suggested that there is "a power imbalance once the surrogate is pregnant," that IPs may not want to "rock the boat," and "there's a lot of acquiescing that happens."

In short, IPs may fear souring the somewhat tenuous relationship between themselves and their surrogate, especially since there is no national legal framework that guarantees compliance through a surrogacy contract. All things considered, though IPs may sometimes have relatively higher positions of power compared to surrogates within the context of a paid exchange, IPs may sometimes feel a sense of powerlessness as well. Surrogates ultimately bring something valuable to that exchange in the eyes of intended parents who want to have a child—a body that can produce a baby.

CONCLUSION

At the beginning of this chapter, I described how intended parents expected surrogates to follow doctor's recommendations, which included complying with common social and medical norms that dictate how to appropriately adapt to pregnancy through one's health behaviors and practices. Through these expectations, IPs and medical professionals were able to have some control over surrogates' bodies and health. Health behaviors and practices can affect intended parents and their children, which was a belief cited by several intended parents throughout the chapter. At the same time, surrogates also did not want their health behavior and practice decisions to be overly controlled by their IPs, especially because of their previous successful experiences and knowledge about pregnancy. Jacobson (2016) similarly reported that surrogates desired trust because of the skilled expertise that they believed they brought to the pregnancy.

Many surrogates felt that their previous experiences and knowledge were what equipped them to follow norms in the first place without having to be told how to do so by their intended parents. These surrogates differ somewhat from the experienced mothers in Neiterman's (2012) study who were sometimes critical towards and disagreed with standard guidelines related to pregnancy. The unique context of surrogacy, where surrogates' ways of adapting to pregnancy not only affect their bodies and own autonomy, but also, someone else's children, may help explain why surrogates in this study tended to comply with—rather than reject—norms around pregnancy behavior. Furthermore, surrogacy occurs in a context where surrogates are paid by IPs for their services that are tied by contractual agreements. Though contracts may lack enforceability in some instances, Jacobson (2016) found that surrogates did largely view them as legally binding. Other institutions, such as agencies, may also help facilitate negotiations. The ultimate outcome of a surrogate's job is to deliver a healthy baby. Surrogates, therefore, are

likely not only affected by beliefs about "good" and "bad" mothers, but also as "good" and "bad" surrogates within this context.

A few isolated incidents notwithstanding, most surrogates in this study reported not being overly controlled and instead, often received trust. Conversely, there was the case of Megan who had the most health behavior and practice requests and felt more controlled than other surrogates in this study, despite her belief that her previous experience of pregnancy should allow her to have more freedom. Similarly, Jacobson (2016) found that while some surrogates in her study reported receiving trust, others can experience "micromanagement," much like Megan described. Since most surrogates received trust, it seemed that many IPs did agree with surrogates' own assessment of themselves as "good," experienced mothers (Neiterman 2012). This was further confirmed when examining control and trust from the perspective of IPs. Indeed, the most cited reason for IPs trusting their surrogates was precisely because their surrogates had previous experiences of pregnancy and therefore more than adequate working knowledge of how to bring a baby to term.

IPs who cited the importance of their surrogate's embodied pregnancy experience and knowledge did not themselves have experience carrying a baby. Trust, then, was often brokered through a language of embodied knowledge, leaving surrogates empowered to act in what they believed to be the best interest of the child and their own bodies. This extends on Neiterman's findings, as I suggest that it is not only the parenthood status of those that "do pregnancy" that affects surveillance, but also the parenthood and identity status of those that "do" monitoring as well. Of course, many IPs (namely, those with a uterus) may possess embodied knowledge that comes from their experiences with fertility treatments such as IVF, miscarriage, or even their own experiences of pregnancy. How surrogates and IPs negotiate their respective—and perhaps

overlapping—forms of embodied knowledge are beyond the scope of the current research, but future study is clearly warranted to examine the embodied knowledge that *all* parties bring to the surrogacy relationship.

Still, some IPs found it difficult to trust their surrogates. The most cited reason for this difficulty was lack of familiarity with the surrogate. Without knowing one's surrogate well, it may be hard to know whether they meet conventional standards of a "good" pregnant mother. Though rare, IPs did describe a few cases where surrogates, medical professionals, or the institutions involved in surrogacy, such as IVF clinics, did not do what was expected of them. These examples show that trust can indeed be broken. Yet, when surrogates did not follow medical norms, IPs seemed hesitant to correct their surrogates. I propose that this may be explained by the protective effect of surrogates' status as experienced mothers (Neiterman 2012), as well as to the parenthood status and sex or gender of those in the position to sanction behavior. Lack of sanctioning may also be related to or compounded by the unique context of the surrogacy arrangement.

In Chapter V, I explore the final state of the surrogacy process, childbirth. I begin by discussing how surrogates and IPs desire to "do childbirth" by sharing in the birth experience. The remaining part of the chapter focuses on various challenges and issues that may arise when attempting to make that desire a reality.

CHAPTER V: DOING CHILDBIRTH

In the final empirical chapter of this document, I extend on Neiterman's (2012) concept of "doing pregnancy" by examining how surrogates and IPs negotiate and choose to "do" surrogate childbirth. In the first section, I describe surrogates' and IPs' mutual desire to share in the childbirth experience, as well as why this is the case. Negotiations about birth attendance and whether IPs will be present in the labor and delivery room usually begin early in the surrogacy process, such as at the matching phase. Attendance expectations are then often written into the surrogacy contract. As I explore in the remainder of the chapter, however, negotiation about attendance is also often an ongoing process that involves or depends on medical decisions made about the birth, hospital policies, as well as how surrogates and IPs continue to navigate their respective—and sometimes competing—desires and needs.

The negotiation of how to medically "do childbirth" is based on considerations such as the surrogate's health, the health of the child or children, larger medical norms, and the recommendations of medical professionals. Medically based birth decisions, however, also involve and interact with considerations about IPs' birth attendance. I begin this exploration by describing the rate of inductions for participants in this study. Next, I discuss how decisions about whether or when to have a scheduled induction can help ensure IPs' or their family's attendance at birth or meet IPs' scheduling and childbirth timing preferences. For the bulk of the section on inductions, I explore several cases where surrogates did or did not adapt their induction decisions based on their IPs' attendance concerns and scheduling needs and desires. I

end with an alternative example of how the decision to induce was not driven by convenience, as well as one example where a surrogate had her own induction scheduling needs.

While inductions help increase the likelihood that IPs will be present at birth, C-sections, or any birth that takes place within an OR, can create obstacles to attendance. I discuss this issue in the third section of this chapter. First, I describe the rate of C-sections in this study, as well as how this compared to C-sections rates in cases of transnational surrogacy. As Neiterman (2012) argues, social context can affect how one "does" pregnancy. Since all the childbirths in this study took place within a hospital, surrogates and IPs sometimes had to also consider larger institutional policies that limit the number of people allowed in an OR. I first explore how some participants prepared for this reality during their attendance negotiations. I then examine how attendance negotiations also involved the hospital and its staff who sometimes bent their rules to accommodate the unique situation of surrogacy. I conclude with an example of Megan, whose plans to include her intended mother at the birth were disrupted by her need for a C-section and the institutional policy that came with it, which led to a contentious negotiation between her and her intended mother.

In the final section of this chapter, I discuss how surrogates also considered and enforced their own needs during the highly embodied experience of childbirth by expressing their desire for space. In turn, this can affect IPs' ability to be fully involved in the birth process. Surrogate childbirth is a unique situation where individuals, who are sometimes relative strangers before engaging in the surrogacy process together, are present during what is normally considered a intimate and private experience. While surrogates and IPs often talked and developed a bond throughout their journeys, many also only saw each other in person a handful of times before the birth because of the physical distance between them. Regardless of their established friendship, it

is usual for those outside of partners of immediate family members to attend a birth. The uniqueness of the event is also true for the IPs that used extended family members (like a cousin) or friends as their surrogates, since these people are also not normally present during birth.

After describing surrogates' general need for space, I explore what having space meant to surrogates and how it was created during birth. I then describe the various reasons that surrogates desired space. Next, I discuss how surrogates communicated their need for space, as well as IPs' reactions to and their own considerations of surrogates' space needs. Finally, I describe a few instances where IPs were the ones who wanted space at the birth, which seemed to be affected by the gender of the IP. I end by exploring how surrogates' need for space may also possibly be affected by IP gender.

IMPORTANCE OF INTENDED PARENTS' CHILDBIRTH ATTENDANCE

Many surrogates were clearly eager and happy to share the childbirth experience with their intended parents. Half of the surrogates in this study talked to me about their desire to have their IPs present at the birth or the pleasure they experienced when they were. Most of these surrogates indicated that they preferred their IPs to be in the delivery room with them, at the very least during the actual delivery, especially because they wanted to see their IPs meet their baby for the first time and experience their reactions and emotions. For instance, Cynthia said,

> So, everybody was crying and that's what I wanted, I wanted everybody to feel it, and everybody did. And one of my nurse friends that was in there, she was actually taking pictures because she kind of does that… And she captured a lot of really good moments throughout the whole process… But I really thought it was important to document that.

> And [my friend] got a picture of the mom's face when the baby came out and it's just one of those super powerful pictures. (Cynthia – Female Surrogate)

When I asked Cynthia whether the pictures were for her or her IPs, she replied, "For both."

Additionally, six surrogates described the negative emotions they either would or did experience if or when their intended parents were not able to make it to the birth or were not in the delivery room. For example, Olivia said of her intended father couple,

> …I wanted them there. I even had told them if they weren't there in the delivery room, that I will be upset. After my last appointment, we all went to eat, and we were fixing to go do some baby shopping and they started discussing if I wanted them in the room or not. I said, "I do." …Because they were saying that if I didn't want them in the room, they were perfectly fine with that. I want them in the room. If they're not there, I would be hurt. (Olivia – Female Surrogate)

When I asked Olivia why it was important for her IPs to be present, she explained, "Because it was their pregnancy. I wanted to see the end of their pregnancy. I know people who have seen their own children be born, and see dads get emotional about their own children. And I really wanted them to be able to see their children be born." When Olivia delivered her own child, the baby's father was not able to make it since he was in basic training for the military. Olivia also wanted her IPs to serve as a source of support. Olivia's IPs were, in fact, present. She described the experience by saying, "I just heard [the baby] cry and everyone talking about the baby. I really liked it. I got a lot of pictures. It's just very, very precious to see."

Intended parents also wanted to attend the childbirth, which was reported by more than half of surrogates and IPs in this study. In most cases, IPs were present. Since many intended

parents and surrogates lived far from each other, IPs sometimes stayed closer to the surrogate as the due date was approaching to ensure that they would make it. Christopher, an intended parent, described how he arrived before the birth, even though his surrogate was scheduled for an induction, since he was eager to attend. He said,

> We were there a week before, yes. We wanted to be there. I didn't want to miss the birth. I wanted to go out ahead of time because this was her third delivery. They say that once you go into labor, your third one comes fast. I didn't want to chance it so I definitely did everything that I could to be there ahead of time. I didn't know that my son was going to have a 14-inch head and get stuck and delay the birth. I did not want to miss it at all. While we did some things while we were out there, I remember I never wanted to be too far away, and because California is known for their traffic jams, I literally wouldn't go anywhere. We did a lot of bowling, I think there was an olive museum factory that we toured. I just did whatever was local in the area. (Christopher – Male IP)

When the moment arrived, Christopher was just as intent on being able to see his child be born. He explained, "I got out of the shower [at the hospital] and her husband was knocking on our door saying it's go time. I just looked at [my husband] and said, 'You look fine, make it fast, I'm out of here. I'm not missing it.'" Alternatively, John, another intended parent, described how he felt when he missed the birth of his first surrogate child. He said, "…When my daughter was born, she was three weeks early. So, we got on a plane and rushed to Connecticut, and we got there four hours after she was born. We were not in the room, which was difficult for me, disappointing to me."

IPs not only desired to attend and witness the birth, but also hoped to be or were actively involved as well. For instance, IPs wanted and were able to be the first to hold their children and

to engage in practices like skin-to-skin (where the baby is placed on the bare chest of the parent) and rituals like cutting the cord after birth. This was reported by nearly half of surrogates and IPs. For example, Sarah, an IP, described her experience to me. She said,

> …As soon as baby came out, they wiped her off. I guess, [my husband] did cut the cord, I think. Yes, I think so. God, it's such a blur… Then, they put her on my chest, and we sat and we stayed in her room for probably about 20 minutes, just snuggling and getting to know each other. (Sarah – Female IP)

In our first interview, before our follow-up where she described the actual birth, Sarah described why it was important for her to be the first to hold her child. She explained, "That's my child. I want them to come to me first."

INDUCTIONS AND BIRTH ATTENDANCE

Of the 36 surrogate childbirths reported by participants in this study, 20 of those births involved various forms of induction. Forms of induction included membrane stripping, or when a medical professional manually separates the amniotic sac from the uterine wall and cervix, manually rupturing or breaking the amniotic sac (or "water"), or through medication such as Pitocin (Mayo Clinic 2024). Sometimes multiple methods were used to induce labor. One intended parent, Stephanie, also said that her surrogate intended to be induced, though the birth had not yet happened at the time of our interview, and one surrogate, Cynthia, was scheduled to be induced but ended up contracting on her own the night before. Though Cythia did not receive medication like Pitocin, they did break her water to augment the labor. This means that more than half of all childbirths in this study were induced, which is more than 20 percent higher the national induction rate of 31.9% in the United States in 2022 (Osterman et al. 2024).

Furthermore, the U.S. induction rate ranged between 22.3% and 23.8% from 2005 to 2015 and only started to significantly rise towards 30% thereafter, which is important to note since some of these surrogate births fell within this time frame (Simpson 2022).

At times inductions were scheduled, though there were a few instances where they were unplanned due to a medical issue that arose during the pregnancy, such as when the surrogate was told they had to induce directly after a medical appointment. No matter who ultimately decides on an induction or whether the induction decision is backed by medical reasoning or purely elective, scheduled inductions can help ensure IPs' and even their family members' attendance at the birth. This is significant since both surrogates and IP wanted to share in the childbirth experience. For instance, when I asked Stephanie whether she and her second surrogate, who was five weeks pregnant at the time of our interview, had discussed any plans for the birth, she said, "Just it will be an induction assuming that it's not spontaneous." They planned to induce at 39 weeks and one day. She explained,

> That's pretty much what the surrogate wants. We all understand that there's a higher risk for C-section when you do induce, but she has had two pregnancies induced now. [The induction medication] Cervidil did what it's supposed to do, and the delivery was easy and quick. She has a history of that and that's why I'm okay with induction. (Stephanie – Female IP)

Even if it was what her surrogate wanted, the induction could also be beneficial in terms of ensuring Stephanie's attendance. She said, "[This surrogacy experience] will again be about six or seven hours away. So, we're really hoping the induction works so that we can actually make it there." If she did make it, Stephanie planned to either witness or catch the baby coming out and be the first to do skin-to-skin.

Sarah was an IP whose surrogate was scheduled for and did have an induction slightly after 39 weeks. During our first interview, she told me about how she suggested her surrogate go on leave a couple weeks prior to the birth, which she was willing to compensate her for. Sarah suggested the leave not only because she felt guilty about her surrogate feeling uncomfortable on her behalf, but also because she wanted to make sure she would be there for the birth. She explained, "Part of it is because she lives five-and-a-half hours away. If she goes into labor, there's a good chance we might not make it down for delivery. So, rest. Relax. Stay home." As she described in the previous section, Sarah did make it to the birth. Finally, it was clear that Tom's surrogate was initially going to have an elective induction to help guarantee his attendance since he said, "When you are so far from them, you have to schedule inductions for the birth." Still, he arrived a week before it was scheduled, which worked out since the doctor moved up the induction date during an appointment Tom attended with his surrogate since she was starting to dilate and had an added risk of gestational diabetes.

Inductions can also help accommodate other intended parent scheduling needs and desires regarding attendance. For example, Diane said, "[The surrogate] was two days, technically two days past due [when she gave birth]. We did have her induced a day after the due date and it was mostly because of just the scheduling because we were sitting there waiting." She and her surrogate started talking about the possibility of induction three weeks before the birth since "timing was important" and Diane did not have a lot of time available to take off from work.

Since the timing of a birth can affect IPs' or even their family members' ability to attend or the amount of time they must continue to wait to meet their child, it is not surprising that some surrogates felt pressure or the need to be agreeable when deciding whether or when to induce.

This was the case for three surrogates who described four different incidents to me. For example, Amy said,

> I was a little annoyed about the delivery, because I guess I wasn't quite ready to go, even though I was 39 weeks and 5 days, which is pretty far along, but I felt pressured to be induced, because his parents were here and her mom was coming in, and I guess in Jewish families, it's a big deal to be around when the baby comes out. I mean, it wasn't for me and my kids, so I was like, "All right, whatever." (Amy – Female Surrogate)

As Amy explained, the intended father's parents were scheduled to leave the area soon, but ended up pushing back their flight to the next day so they could stay and meet the baby once it was born. The pressure Amy felt, however, seemed to be more on a personal level, rather than coming directly from her IPs. She explained,

> Even though I opted to be induced, if I said, "I don't think the baby's ready," or "I don't want to be induced," I think they would have been okay with it, but I know his parents really wanted to meet the baby before they left, because I have a feeling they had a financial stake in this. It was a family thing. (Amy – Female Surrogate)

Amy not only felt obligated to her intended parents, but also the intended father's family, since she suspected that they had helped to fund the surrogacy experience. She continued by saying, "I mean, they were both kind of like, 'It's up to you,' so it was definitely unsaid. It was kind of put on me to be like a people pleaser, I guess."

Heather, another surrogate, initially had planned to induce once she was past her due date. Although she tried to get input from the intended parents about the decision, she ultimately decided on her own since she felt she was not getting a clear answer from her IPs. However, after

telling them about losing the mucus plug that blocks the cervix, which is sign that the body is preparing for pregnancy, the family arrived in town suddenly, anticipating that she would go into labor naturally. She explained,

> And then I wake up the next morning to a text that says that they're coming to [my city], and I was like, "Why?" Because I'm not in labor, and I didn't mean to make it seem like I was in labor… And so, she's like, "Don't worry about it. We're just here just in case," and I said that was a lot of pressure, that I was nowhere near being in labor, like I wasn't contracting at all. And she said, "Don't worry about it. Rest, relax. If you don't go into labor today, we'll check into a hotel." (Heather – Female Surrogate)

When Heather's intended mother called to check in on her again later in the evening and asked her to go get another cervical exam, less than 24 hours after her last one, she ended up offering to move up the induction. She described the conversation to me by saying,

> [I told her] we could schedule an elective induction if that's what you guys want to do since you're already here, you brought your family, you checked into a hotel, and you sound very excited. Do you want to just go ahead and proceed? And that's when she said, "Yes, could we please do that?" So, I did another cervical exam, and set up the induction for the following Thursday… And then I delivered on Saturday. So that's kind of how the new induction time comes around. (Heather – Female Surrogate)

Although the induction process began a little before midnight on Thursday, as Heather explained, she did not give birth until early Saturday morning, which "was longer than [she] ever experienced before." When I asked her if the initial pressure that she felt once her IPs arrived in

town affected her decision to offer to move up the induction date, she responded, "Probably yes, only because they were here and waiting and very excited on the phone."

Susan was another surrogate whose third set of intended parents wanted her to have an elective induction since they were traveling all the way from Taiwan. While she initially said yes, it was clear that it was not something that she ultimately wanted to do. She told me,

> My counselor [from my agency] had called me and said, "Oh, you know, how do you feel about inducing?" And I just said, "Oh yeah, you know, that's fine," but I knew the doctor would also have to give the okay… So, I just said, "Okay," just to be agreeable… I knew he wasn't going to go off the handle and be like, "Yeah, let's schedule one today." He just said, "Oh, no. I can't do that. I have protocol to follow," which was fine. So, I kind of let him take the fall basically because I didn't really need to be induced. And I let him tell them that. (Susan – Female Surrogate)

She continued by saying,

> I wasn't overdue or anything like that… I mean, I already knew what the protocols were regarding, you know, when they would do inductions. So, I had that in the back of my mind. I had the hope also, that if he did want to do it just because the parents wanted it per say, he would talk to me first and say, "Well, is this something you really want to do, or is this something they want to do?" before he would agree to it. (Susan – Surrogate)

Ultimately, Susan went into labor naturally a day before the induction date that her IPs had requested. Her IPs, however, were still able to make the birth. She described the experience to me and said, "The mom was there, and we just kind of really bonded over that, because the dad

left… And she was just very supportive, and very concerned about me… Yeah, and she was crying and so, that was very, very rewarding to experience that with another woman."

To be clear, Susan was not completely against inductions. In fact, she was induced for her first two surrogate births. She explained,

> There was a couple times that I had to be induced, and so I didn't question that, I just went with it since that was going to be best. I didn't really feel it was my place to question what a medical doctor was saying, especially in regard to somebody else's child. (Susan – Female Surrogate)

She also was generally eager for her and her IPs to share in the birth experience. For instance, she was disappointed when her first couple could not make it to the birth because she had to have an unscheduled induction after concerns developed during a prenatal appointment. When I asked her why it was important for her IPs to be there, she replied, "Because you want to see, you know, them being there and what's going on. See their faces when their baby's born... that's kind of like the moment you've been waiting for."

Susan's eagerness for her intended parents to attend the birth also became clear when she described being worried about whether her fourth set of IPs would make it during our first interview together. At the time, her agency counselor was helping to negotiate the birth plan and was encouraging her IPs to come stay near her about a week before the due date since there was a nine-hour drive between them. Her IPs' initial plan was to start driving once she went into labor, which concerned Susan. In a follow-up interview after her fourth surrogacy experience was complete, I asked her how the birth worked out given her concerns.

Susan told me that her IPs had eventually agreed to arrive when she was 40 weeks. They did, and they attended the 40-week prenatal appointment together. While there, she found out that she was only dilated about three centimeters, and her midwife asked if she wanted to have her membrane stripped in hopes of speeding up the birth. While she opted not to do so, she did schedule an induction for about a week later. She said, "I agreed to the induction because I was like, 'Well they're here...' If I actually make it that far, then I'll do the induction." During the appointment, the intended mother did not raise any objections to either of those decisions. Later that evening, Susan was surprised to learn that her IPs planned to leave within a few days, before the induction date, since they did not have more time off from work until after the baby arrived. She explained, "And I was like, 'I'm sorry, what?' The kid's not here yet and they didn't tell the counselor this, or the agency, or anybody, as far as we knew they were here for the birth." She was even more shocked to learn that her intended mother may not even make it back at all. She said, "I'm like, 'What? She's not coming back for her kid?' He's all, 'Do both of us have to be here to sign the birth certificate?' And I'm like, 'I don't know.' And I mean, I was nice to them to their face. I was just like, 'Oh yeah, that's understandable.'"

Susan hoped that she would go into labor before her intended parents left, but unfortunately, she did not. Once they were gone, she rescheduled her induction date for the upcoming holiday weekend, a few days later than originally planned, hoping that would be better for her IPs and would allow them to attend the birth. She reached out to her agency to see if they could talk to them about the new date. She explained, "And instead of [the agency] doing that, they just had me talk to her, I texted her and it just went into this back and forth." She continued,

> And she was like, "Well see if you can get an induction for Thursday or Friday [instead of over the holiday weekend]." And I was like, "First of all, they already told you

> Thursday's booked, they don't have anything. And Thursday would've been the next day." Which is like, are you crazy? And she's like… "If they don't do it then the patient's always right. And you need to talk to a manager." And I didn't say this, but I was like, "No, I'm not doing that. I'm not going to get upset, and aggravated, and go over my doctor's head because they're not giving you the induction date you want, even though the baby's perfectly healthy." I'm not doing that, that's not the kind of person I am. (Susan – Female Surrogate)

Susan's intended mother also requested that she now get her membrane stripped, even though she was there when this was first offered at the 40-week appointment and seemed okay with Susan not doing it. Susan told me about why she eventually acquiesced,

> And I asked the doctor, I said, "Well, she wants to do the membrane stripping." And he said… "I'll do it if you want to do it, but I don't recommend it. But if you want to do it, that's fine." And so, I thought about it, I'm like, "Well," I'm like, "Okay, I'll just do it." That's the only thing I can give her. I wasn't going to give her the induction when she was nine hours away. She never said, "I'll definitely be there…" I was like, "You know what? No." I have a feeling you're just going to have me do [the induction earlier], if I could even get in, and then just not be here. (Susan – Female Surrogate)

In the evening after Susan had her membrane stripped, her intended mother again asked to move up the induction. Eventually, Susan tried to accommodate that request as well. She said, "She was all, 'Can you get an induction tomorrow?' I'm like, 'I'll check.' So, all I did was just try to leave a message and I was like, 'I'm sorry for calling, but she was wondering if there's an induction available tomorrow.' I'm like, 'this is nuts.'"

Before she could get an answer on the new induction time, Susan ended up going into labor later that night. She called her intended parents and let them know she was going to the hospital to get checked out. The labor happened quickly, and the baby was born within about an hour. Susan's IPs did not make it. In exchange for missing out on experiencing the birth with her intended parents, Susan resigned to spending time with the IPs' baby instead. She described her reasoning to me by saying, "…If I'm going to miss out on having you there and missing that moment with you seeing your child be born, then the exchange is I'm going to get some time with your kid." After the birth, Susan nursed and did skin-to-skin with the baby as she waited for her IPs to arrive. She said, "So that was nice, and it was different, that we got to do that. So that was my special time instead of getting that special time with the parents being there."

When I asked Susan how it was that she ended up in such a tense negotiation with her IPs when she had originally asked her agency to step in, she replied,

> Yeah. I don't know what happened. I just remember telling my case manager, I'm like, "Could you talk to her?" And then I guess she talked to my counselor and my counselor was like, "Well, it's better if it comes from you. And you should write them a letter about how sad they're making you." I didn't do that, I was like, "That's really awkward." So, I just told her, I said, "Well I didn't write them a letter, but we did text about it..." Because I didn't really want to be in that position because all that ended up happening was just me going back and forth with her saying, "You really don't want to miss this, can you please make it? [The induction is on] a Sunday. Can you just tell [your work] I went into labor on Saturday?" So yeah, it was just a lot of this back and forth that I didn't really want to be involved in. (Susan – Female Surrogate)

When I inquired about it, Susan said that she did not express any disappointment to her agency about not stepping in. Susan also told me that, in retrospect, she wished that she did not agree to the membrane stripping, although it was better than having an induction using medication.

Of course, not all induction decisions negotiated by participants in this study involved attendance and scheduling concerns or pressure, or at the very least, no additional incidents were reported to me by participants. There were, for instance, cases where induction decisions were driven by or included concerns for surrogates' own health or to alleviate their own discomfort, although when these were scheduled, it could still be a possible boon for IPs. There were even instances where intended parents were the ones who were hesitant to induce when the surrogate wanted it. Finally, there were also cases where natural birth occurred.

Drew (who is transgender) and his second set of intended parents were willing to wait for the baby to arrive on its own, despite their mutual desire to share in the birth experience. As Drew said, "[I] very much expected them to be in the delivery room because that's kind of a big point." During his first surrogacy experience, Drew had an unplanned induction after the doctor suggested it during a routine pregnancy appointment. For his second surrogacy journey, he made sure to find intended parents that would allow him to have some bodily autonomy and follow the more natural approach to pregnancy and childbirth that he prescribed to. When his second surrogate pregnancy went well past his due date, I asked him whether it was a concern. He replied,

> It concerned me because [the IPs] very much wanted to be there, they wanted to be in the room as long as possible and they had travel constraints because of their jobs. They both work in [a] University, so kind of a high-strung place, and they didn't want to use more of their time off prior to birth so that they could maximize time with her afterwards. So, it

was a little bit stressful like okay, come on… And the usual discomfort of the 40 weeks. (Drew – Trans Male Surrogate)

Still, Drew and his intended parents were intent on not having an induction to speed up or plan the process ahead of time. Instead, his IPs used Google to explore ways that Drew could induce his labor using non-medical methods. When I asked him if any of this caused him to feel any pressure, he said, "No, they were very much, 'Pregnancies can go two weeks over, we know that. Until it gets to be two weeks past, we're not going to induce. That's not even a discussion.'" He continued, "Induction, we all wanted to avoid an induction. Thus, their mad Googling of how to induce it at home."

There is one additional case worth mentioning. While IPs may be the ones that have induction scheduling needs or desires, it is also possible that surrogates can have them too. This was true for Laura, although her IPs did not seem willing to compromise. She described an incident with her first set of intended parents,

> I remember one point, my father wound up needing emergency surgery, and it was overlapping with the induction date. I had mentioned this to my doctor, and she said, "Well, we can put it off until after your dad's surgery," and the couple was most certainly not in favor of it. Which I do get, but I remember one thing that was said to me… I can still hear her saying it to me, and she's like, "I don't know why you would think your family situation matters to us right now." And I got that. I totally got it, you know, to put off the birth of their child for even one more minute was too long, but in the same instance like, what was I supposed to do? I'm kind of torn between two things, so. …She wound up sharing a room with me at the hospital, and a whole bunch of things afterwards, and then left and I never heard from her again. So, yeah, it's, like I said, it's

> what it is. It doesn't in any way, shape, or form make me bitter to the whole surrogacy process. In some ways it was a blessing that this happened to me on my first journey, because then I didn't get any false sense of expectations for relationships for any subsequent journeys. (Laura – Female Surrogate)

Despite the negative experience, Laura went on to pursue five more surrogacy experiences.

NEGOTIATING BIRTH ATTENDANCE AT THE HOSPITAL

Of the 36 births in this study, 12, or about a third, were Cesarian deliveries. This closely matches the US C-section rate of 32.1% in 2022 (Osterman et al. 2024). From 1996 to 2009, the C-section rate increased by 60%, reaching a peak of 32.9% in 2009, and has remained steady at about a third of all births since (Osterman 2022). Four C-section births started as an induction and therefore were also counted in the previous section.

Alternatively, for some surrogates outside of the United States, the C-section rate can reach 100%. For instance, Hannah, an IP and owner of a U.S. surrogacy agency that utilized surrogates in Mexico, told me that, "All our deliveries are done via scheduled C-Section as long as the babies read the scheduling memo." When I asked her why this was the case, she replied, "Convenience. It's so the IPs can be present at the birth." Yet, she also said in cases where the surrogate begins to give birth before the scheduled date, C-sections are still used, though IPs are not usually able to attend. Scholars who have studied surrogacy in Mexico (Hovav 2020) as well as in India (Deomampo 2016; Pande 2014; Rudrappa 2015) have also reported a nearly universal use of C-sections. Again, one reason these scholars found this to be the case was to accommodate IPs' schedules, especially if they are traveling internationally.

Like inductions, C-sections in this study were also sometimes scheduled in advance, which could also help ensure IPs make it to the hospital in time for the birth. For instance, Elizabeth, a surrogate who wanted to have a C-section because of her previous birth history, said,

> I told them that [a C-section] was a requirement and of course they were thrilled because you can plan that… They actually missed the birth of their first child because one of their cousins who carried the child went into labor early, so they missed it. They didn't want to miss his birth so… (Elizabeth – Female Surrogate)

John, who was matched with Elizabeth, was the IP that was quoted early in the chapter describing his disappointment with missing his first surrogate's birth. To be clear, no surrogates reported feeling pressure to use a C-section just to ensure IPs' birth attendance. In fact, some participants explicitly reported wanting to avoid a C-section, although the procedure was accepted when deemed medically necessary.

Though a scheduled C-section could help ensure IPs to make it to the hospital, it did not mean they would always be allowed to be present in the room during birth. C-sections, as well as other births that pose a risk for surgical intervention, such as a high-risk twin births or when a baby is breech (when a baby is bottom or feet down), are all performed in the OR. Most hospitals only allow one support person to be in the room in those situations. Cynthia, one of the surrogates who talked about the disappointment she would feel if her intended parents could not be there while she was giving birth, did so when discussing the possibility of a C-section if the baby stayed in a breech position by the time her labor arrived. She explained,

> What would happen is I would deliver in the OR even vaginally in case it turned into a necessary C-section. Which I don't like that concept because that means that they can't

> have everybody at the birth that they want to have. We would be a lot more limited in who can be there. So, at one point, I called my mum crying because I was like, this just isn't the way I want it to go. And I know working [as a labor and delivery nurse] more than anybody that it doesn't go the way you want it to go, it goes the way it goes. But for that to happen to me was a little bit harder for me to, I guess, adjust to. (Cynthia – Female Surrogate)

Cynthia ended up doing a procedure called a version, or when a medical professional attempts to turn the baby to the correct delivery position (ACOG 2019). It was successful, and as she described earlier in the chapter, her IPs were able to attend the birth.

Because of the limitation, a few surrogates and intended parents reported planning for the event by discussing who would be in the room if only one person was allowed to be present. For instance, when I asked whether Susan and her IPs had discussed the possibility of a C-section, which she ultimately did not have, she said,

> The only thing that was discussed in the counseling session was, "[Susan], who do you want in the room?" I mean, we hope that doesn't happen because it's never happened, but if it did then they only let one person in the room, who would you pick? So, that's the only thing we discussed really, regarding the C-section. (Susan – Female Surrogate)

Of the eight cases (three hypothetical and five actual) where surrogates and IPs reported who they or their surrogates would or did chose if only one person was allowed in the OR, surrogates chose their partner or another support person almost every time. Amber's intended parents were understanding of her choice, though she also did not ultimately have a C-section.

> Really anything through the delivery, they let me control. They were even not opposed to—we had a C-section discussion, like if this ends up in a C-section, they said explicitly, they want my husband in the room with me. They understand, they want my husband and they do not want to be in there. Not because they didn't want to see their child, but they wanted him to be the first on the list, to be in there. (Amber – Female Surrogate)

One IP, Samantha, did say that her second surrogate told her that she wanted her in the room rather than her own husband, despite Samantha suggesting that it should be him, while her first surrogate chose her mother. Emma, another IP, also said that her surrogate initially said that she would be the one to attend, although she later changed her mind and picked her husband.

Negotiations about who is allowed in the OR not only happened between surrogates and IPs but involved the hospital staff as well. In nine OR births, IPs were present in the room. Therefore, in most cases where the surrogate said they would pick their partner or another support person and a C-section did happen, IPs were still able to be present. Of those nine cases where IPs were present, all but three participants reported that someone at the hospital made an exception despite the usual rule of only allowing one person. (Since the rule is largely universal, it is likely safe to assume that an exception was made in all cases, even if the participant did not report as much.) Kim said,

> …[The intended] mom and dad, they let them both in. Actually, the hospital's policy is to only let one person in, but they have a special, like a nurse liaison or something. They had a specialty program at this particular hospital for special circumstances-type births, like surrogacies, adoptions, babies that are going to be born that they know are going to need medical interventions, or things like that. They have this nurse that takes care of everything. Our one request from her was, "Can you make this happen so that they can

> both be in the OR for the C-section?" She did so… That was awesome. They both got to be there. (Kim – Female Surrogate)

Still, IPs' involvement in an OR birth could be more limited, such as being relegated to a certain portion of the room or only being allowed in while their babies were being delivered. Olivia explained, "They put the parents in the corner and my dad said they did not let them move. If they started to step away from the corner, everyone was telling them to get back in the corner."

For one participant though, the OR limitation did result in conflict with her intended mother when an exception was not made. Megan originally planned to allow her intended mother in the room during a vaginal birth, although not for the entire time. Once they found out it was going to be a C-section, however, the fact that her intended mother was not going to be allowed in at all because of the OR limitation became a "point of contention." She explained,

> I chose my husband, that was a big fight. That was a big ordeal because she kept asking the doctors, she kept asking the agency, she put me on the spot and we had to tell her at least 12 times, I'm not exaggerating, "This is already decided, why are you still harping on me?" (Megan – Female Surrogate)

She continued,

> I don't want to take that moment away from her, they're her babies, but in my husband's words, he goes, "If the shit hits the fan, her face is not going to be the last face that you're going to see." Given the complications that I had, you better believe it that I was happy my husband was there. (Megan – Female Surrogate)

As an alternative, Megan arranged for her husband to video when the babies were removed from her belly, and they shared them with her intended mother.

THE DESIRE FOR SPACE DURING CHILDBIRTH

Although many surrogates were eager to share the childbirth experience with their intended parents, seven surrogates also reported wanting or enjoying having some space during the childbirth. Additionally, three IPs said that their surrogates wanted space, for a total of ten participants. Having space had various meanings for surrogates that could sometimes overlap. For eight surrogates, space meant having their IPs periodically leave the room during labor or only allowing them in for a certain amount of time. For instance, Heather said,

> There were a few occasions that they were asked to leave, and they were asked to leave like not in a mean way or anything, but like, just at first when things weren't progressing, it's like they were kind of sleeping on the one sofa that there was. Obviously, we're not doing anything, we can call you when things progress more. And so, they went home, and then the next day it was kind of like, "Well, this might be a longer process than we all expected. Why don't you guys go have lunch? We'll call you if anything changes." But once things really started getting more active and close, they were there. (Heather – Female Surrogate)

Megan not only wanted space from her intended mother by having her periodically leave the room if she was to deliver vaginally, but she also wanted space from her intended mother's family during the birth. She explained, "It would just be her and my husband, nobody else. I say this because when we did the heartbeat confirmation, she brought in her parents. I met her father while I'm laying in a stirrup bed with my legs spread open and we're having a conversation." Megan ended up requiring a C-section, which as she explained earlier, resulted in a dispute about whether her intended mother could be in OR at all.

For two surrogates, space also meant not having to talk or interact the entire time, while three surrogates wanted space away from their bodies or more intimate body parts. Teman (2010) similarly found that while surrogates wanted to involve their IPs in the pregnancy and birth, they also sought to protect parts of their body that they felt were intimate or private. Ben, an intended parent, described the situation with his surrogate,

> I could tell just based on our conversation that she didn't feel comfortable about having someone—some people are really involved in the childbirth. They're cutting the umbilical cord, things like that. That wasn't that important to us, and I could tell that she would rather not have us be so intimately involved with her body if that makes sense. It turned out that the time between when she went into labor and gave birth was less time than it took to drive from [our city] to [hers]. It was never really an issue, but we were fine with waiting anyway, outside of the room or whatever, even if we did show up. (Ben – Male IP)

While Ben was willing to wait outside the room, space not to talk or away from bodies or body parts was also accomplished by asking IPs to leave for periods of time, or by creating physical or symbolic space between surrogates and their IPs even when they were there. For example, Amber expected her IPs to be present, but also did not want to have to engage with them after a certain point. She said,

> I had told them a little bit about how I am in labor, how I'm active and talking. But at some point, I'm just going to shut down. And not in a "I gave up" way, but I'm just going to become quiet. I'm not going to talk. I'm just going to zone in on everything that's going on in my body, and don't be offended. Go over there, play a board game. I don't want you to try and talk to me. So, I had very much already told them, this is how I am

> during labor and delivery. I'm going to be up and talking and jovial, and then all of sudden, I'm not. I'm going to be done. That's actually pretty much exactly what happened. Which was nice. (Amber – Female Surrogate)

In addition to not wanting to talk or having space away from one's body or specific body parts, surrogates had other specific explanations for wanting space. Just like Amber, who said she did not want to talk because she was going to "zone in" on what was going on with her body, Joyce, the surrogate from Australia, said she did not like a lot of people and noise in the room since she wanted to "focus on" what she was doing. Sarah, an IP, said her surrogate wanted to be able to sleep, and Megan, a surrogate said she wanted to "rest as much as possible." Megan also mentioned that when she was in pain, she wanted "to be left the hell alone." Samantha was an IP whose surrogate had a past traumatic birth experience where the blood vessels in her eyes "blew out." As a result, her surrogate made sure to have an option in their contract that stated she had the discretion to choose if and when to let Samantha and her husband in the room. Ultimately, Samantha and her husband were present for the entire process since Samantha's surrogate ended up having a scheduled C-section instead. Heather, who was quoted earlier saying that she asked her IPs to leave a few times, but "not in a mean way," initially wanted her IPs to be present throughout the entire labor process. However, this changed once the situation became "awkward" after she felt her intended parents failed to engage with her and make conversation.

While most surrogates wanted space despite having a positive relationship with their intended parents, Laura developed a strained relationship with one set of IPs towards the end of their experience. Her IPs were adamant that she have a scheduled C-section since one twin was breech, while Laura and her doctor felt that she could try to deliver them vaginally and then do a C-section if necessary, which was what ended up happening. Because their relationship "fell

apart at the end," she only wanted them present during the labor for short periods of time. She said,

> By contract, I had to let them in the room for delivery, but I didn't have to let them in the room for labor, and so they'd come in, and the nurses knew, give them five minutes and clear them out, because they were doing nothing good to my blood pressure. They were really stressing me out. But even so, when it came time and I wound up having a C-section with their twins, I was willing to let them into the operating room, because I still felt like it was the right thing to do. But when push came to shove, the husband handed my husband the scrubs and told him to go in with me. So, they weren't there for that, which probably was a good thing, but I wouldn't have kept them from it. That was never my goal. (Laura – Female Surrogate)

Similarly, Megan's desire for her intended mother to only be in the room for up to fifteen minutes at a time up until the moment of vaginal delivery, if that was to be the case, was likely related to the fact that she felt "suffocated" towards the end of their relationship, as she explained in Chapter IV. Likewise, she feared that her intended mother would become "overly supportive" during the birth.

In addition to wanting space because of her strained relationship with her IPs, Laura also talked about creating the option for space more generally. She explained,

> If I was being induced, I'd always show up early, ahead of time, to make sure that I could have a talk with the nurses and let them know what was going on, and make sure that they understood, and make sure that we had codewords set up, or code actions if I wanted some alone time and wanted people out of the room. (Laura – Female Surrogate)

Drew, another surrogate, also talked about establishing "safe words" for his second surrogacy experience so that he could have some alone time if needed. Other surrogates expressed their need for space more directly with their IPs. In turn, IPs were often supportive, understood, and respected surrogates' need for space. Samantha, whose surrogate was weary about her and her husband's presence because of her past traumatic birth experience, described her intentions before we had a follow-up interview after the birth,

> We're just going to kind of play it by ear. I know that that's not the best plan. But it's what's going to work for us. Because we want to respect her wishes. At the end of the day, as long as that baby is coming to us and we get to be the one to hold it first. Hopefully cut the cord. But, again, you know, not all births go the way you planned?... But certainly, I'm not going to force her to do that. Because it's her body. Once that baby's out, it really doesn't matter. I guess, is what I'm saying. (Samantha – Female IP)

There were also a few IPs who reported being considerate of surrogates' space, even when they did not directly ask for it. For instance, Tom made sure to ask his surrogate if it was okay with having a birth photographer in the room.

Finally, there were a few instances where IPs were the ones that wanted or created space at the birth, especially because it was such an intimate experience and involved the surrogate's intimate body parts. Interestingly, all these cases were reported by or involved intended fathers. James, a male IP, spoke about why he did not feel he needed to be in labor and delivery room. He said,

> But, as far as being in the room for the birth, do not feel the need to do that. Because I think it's just such an intimate—if we feel the comfort level with the surrogate and she

> feels that comfort level with us, then sure. It's not the most important part for me. I know that sounds sort of removed. (James – Male IP)

In another example, John described his feelings about his surrogates' decision to get C-sections by saying,

> To be honest, probably the C-section was—I'm a little embarrassed, but just—I didn't want to use a woman's vagina, if that sounds terrible. Yeah, it was just that—okay, that's her domain, and that's kind of her private thing, and I just know in both cases, it was C-section… It really wasn't that much of an issue or wasn't even a decision that we had to make, but I think in the back of my mind, it was a little bit of a relief that I didn't want to get that personal. The C-section seemed to be less personal than using their vagina to have my child be delivered to. (John – Male IP)

Part of John's concern was that a vaginal birth would mean that the surrogate felt more connected to the baby. Both Hovav (2020) and Pande (2014) found that medical professionals may have similar beliefs about the emotional connection caused by vaginal birth, which was one reason for the high use of C-sections among the surrogates they studied. John, however, was also weary of experiencing a vaginal birth. He said,

> To be honest, I would have been really—I don't want to sound like, stereotypical, but I would have been afraid to see vaginal birth. Again, the whole squeamish thing, the vagina thing, and everything, but then I—this, to me, was much more palatable, or much more—I sound like such a jerk. I'm sorry. But it was sterile, and it was just more like... Yeah, it was more enjoyable, because we were there, and it wasn't intimidating… (John – Male IP)

Similarly, Amber was a surrogate whose intended father seemed to want space from a direct view of the vaginal birth process. She explained,

> We had actually talked about how dad, he gets a little… and I had no desire to really have him down there either. But [he] would be the first person to grab baby from the doctor, cut the cord, all of that. Because mom was going to be right there in the thick of it. (Amber – Female Surrogate)

Like Amber, Kathleen's intended mother was also more actively involved in the birth than the intended father. She described her by saying, "The intended mother was—she was kind of like my husband in the room… [She was] holding my hand, and wiping my brow, and giving me ice chips, and just being there in that respect." Alternatively, she said the intended father "was in the corner of the room behind me. He's like, 'I'm just here being a fly on the wall.'" Similarly, Sarah, an intended mother, also said that her husband "hid behind [the surrogate's] leg so he wouldn't see anything," In both these cases, it was unclear if this was because of how the husband felt, the surrogate's wish, or both. As Amber indicated, surrogates' need for bodily space may also have a gender component as well. Relatedly, in terms of IPs considering surrogate's need for space, Samantha offered to have her husband stand up by her surrogate's head when her surrogate seemed concerned about them attending the birth, although she later realized the issue was likely more related to her past traumatic birth experience.

CONCLUSION

In the first section of this chapter, I discussed how surrogates wanted and were pleased to have their IPs attend the birth, and how IPs desired to be there and actively involved as well. Part of "doing childbirth," therefore, involved facilitating involvement. To make IP attendance at the

birth happen, however, surrogates and IPs had to navigate potential obstacles that could hinder IPs' attendance despite both parties' intentions. One issue was the timing of the birth. Since IPs sometimes lived far away from surrogates, it could be hard to get to what could be a spontaneous event in time. One way this was resolved was by arriving and staying near the surrogate when it was getting close to the potential due date. Another possible solution was to use the precise timing of an induction as a potential way to know when to arrive, ensure attendance, or fit the birth into IPs' overall schedule. If IPs or their families did arrive before the birth, inductions can also be used to bring on the birth so that they do not have to continue waiting. Deciding how to "do childbirth," therefore, also involved induction decisions, which not only included medical considerations, but attendance considerations as well.

Using inductions in these ways, however, sometimes resulted in feelings of pressure among some surrogates, whether or not the pressure or decision to induce came directly from or was initially initiated by IPs. Surrogates clearly felt a need to be agreeable, with Susan's fourth surrogacy experience being the most remarkable example. Susan's effort to be cooperative was even present when she *did* resist her third set of IPs' request for an elective induction since she initially said yes and then used her doctor, as well as medical norms, to "take the fall" for her. Furthermore, I presented the alternative case of Drew, where he and his intended parents wanted to and did avoid an induction, despite the baby being overdue and their wish to experience the birth together. Finally, I described the case of Laura whose IPs did not want to accommodate her own scheduling needs. This, however, was the only time where a surrogate described such an incident to me.

In the next section, I discussed another possible obstacle to navigate that could impede IPs' attendance: OR births. While the scheduling aspect of C-sections could help IPs make it to

the birth on time, hospital imposed OR limits could also mean that IPs may not be allowed in the room. Some IPs and surrogates discussed this possibly in advance. In both hypothetical and actual scenarios, surrogates most often chose their partners or another support person as the single person to be allowed in. For most participants though, this did not come to fruition, either because again, the situation was hypothetical, or because someone at the hospital ultimately allowed IPs to be in the room as well, although their presence could be limited to a certain area of the room or the period when the babies were removed from the belly. Negotiations about attendance, therefore, not only involved IPs and surrogates, but medical professionals as well. Although many IPs seemed willing to accept surrogates' choices and support needs during OR births, it is also possible that conflict can arise, as was the case with Megan. Since Megan's was one of the few cases, if not the only, where the limitation was imposed, it is possible that conflicts may arise more frequently.

Finally, when deciding how to "do childbirth," surrogates also considered their own needs. Despite sometimes feeling pressure to accommodate IPs' attendance goals and scheduling needs and desires, surrogates were willing to express their agency regarding their need for space, even though it could mean limiting IP's full attendance during the birth. Surrogates often communicated their need for space directly to IPs, while some opted for a more indirect approach by using code words and other individuals. Surrogates had various reasons for wanting space. Many were related to the fact that childbirth is a highly embodied experience that happens to and through surrogates' bodies. Surrogates wanted to focus on the task at hand, time to rest and even sleep, or space because they were in pain, away from their bodies or intimate body parts, or because they were afraid of what would happen to their body during birth. A few times, space was related to surrogates' relationship with the IPs.

Although the data is somewhat limited, there may also be gender differences when it comes to involvement with and space during childbirth. For one, intended fathers could be more hesitant to experience the more intimate aspects of the childbirth experience than intended mothers, especially in terms of surrogates' intimate body parts. Some surrogates may also specifically want space between their bodies and intended fathers. Finally, intended parents may sometimes consider their surrogate's need for space based on their or their partner's gender. It would be useful for researchers to examine these possible gender differences in more detail in future surrogacy studies.

CHAPTER VI: SUMMARY AND CONCLUSION

In the previous empirical chapters, I drew on interview data from 18 surrogates and 15 intended parents to explore how surrogates and IPs negotiate medical control and autonomy throughout the surrogacy experience. To do this, I used Neiterman's (2012) concept of "doing pregnancy," while also applying it to the areas of IVF, abortion, and childbirth, or what I refer to as "doing surrogacy." In this final chapter, I begin by providing a summary of the major empirical findings of this dissertation. I then move on to discuss how "doing surrogacy" complicates, as well as extends, Neiterman's (2012) original concept. Next, I summarize how my research fills a gap in the larger sociological surrogacy literature. Finally, I discuss the practical implications of my findings, the limitations of this study, and possible directions for future research before ending with some concluding remarks on the overall significance of this project.

A BRIEF REVIEW OF "DOING PREGNANCY"

Neiterman (2012) argues that when "doing pregnancy," individuals draw on and hold themselves and others accountable to larger medical norms. At the same time, however, Neiterman (2012) found that there is a possibility for individual agency, or the resistance or rejection of pregnancy norms, especially for those that are preconceived to be "good" mothers. According to Neiterman (2012), perceptions of "good" motherhood are affected by one's pervious experiences of pregnancy, as well as larger social status hierarchies. One's social and motherhood status can also affect how diligently one is monitored or the amount of public reprimand received when breaking norms. "Doing pregnancy" can also be affected by the

context in which the "doing" of pregnancy takes place. As she explains, the "rights" and "wrongs" of pregnancy are not necessarily universal and vary between and within different social contexts. As such, different audiences may have differing beliefs about the proper ways to do pregnancy. Therefore, the "rights" and "wrongs" of "doing pregnancy" can be negotiated in interaction with others, and different audiences may evaluate performance of pregnancy differently. Similarly, the person who "does pregnancy" may also choose to ignore an assessment of their pregnancy work depending on who the audience is and the relationship one has to that person.

SUMMARY OF MAJOR FINDINGS IN EMPIRICAL CHAPTERS

In Chapter III, "Doing IVF, Selective Reduction, and "Termination," I first briefly discussed how surrogates and IPs tended to delineate medical control and decision-making. While many surrogates generally expected to cede control over medical decisions to their intended parents, especially since they often believed it was "their [the IPs'] baby, pregnancy, and delivery," surrogates also wanted to have authority over decisions that could impact their own body and health. Relatedly, though many IPs also said that they wanted to control most decisions, they also spoke about respecting surrogates' right to make decisions about their body and health, with some even citing the surrogate's body and health as being the most important. While it may seem then, that surrogates and IPs often agreed on the delineation of control, the main finding of this study revealed that decisions related to preventive and medical care made throughout the surrogacy process can have simultaneous and sometimes competing implications for surrogates' bodies and health as well as IPs and their children. The negotiation of how to "do surrogacy," therefore, means navigating this complex reality. In the remaining portion of Chapter

III, I began my exploration of this larger issue by examining how surrogates and IPs made embryo transfer and abortion decisions within this context.

In the section on embryo transfers, I began by presenting two cases of surrogates who felt pressured to transfer more than one embryo in the interest of becoming pregnant for their IPs. Berend (2016) also found that surrogates often experienced pressure via IPs to transfer multiple embryos, which was not only compounded by IPs' own eagerness to achieve a pregnancy, but surrogates' as well. In my study, however, I found that many surrogates were willing to exercise autonomy by expressing their desire to limit the number of embryos to be transferred or the number of children they were willing to carry, even when they felt pressure or knew their decision could compete with IPs' interests. Some of these surrogates specifically cited their right to bodily autonomy or the possible impact on their body and health when discussing their choices. A few intended parents also reported considering their surrogates' bodies and health, and therefore decided that only transferring one embryo was the best way to mitigate any possible health issues, including for the surrogate. While Berend (2016) discussed how surrogates must balance their IPs' interests with their own self-protection, she did not speak about how IPs also balance their own interests with their desire to protect their surrogates.

The issue of selective reduction and termination is another area where surrogates and intended parents must navigate between possible competing interests. Despite the commonly held belief that it is the IPs' child, around a third of surrogates in this study had limits as to when they would agree to abortion. A similar number of IPs, however, also said that they did not want to abort in certain situations. There were also surrogates and intended parents that wanted or were willing to reduce or terminate to protect their own or their surrogate's health. Interestingly, sometimes participants fell into both groups. While Berend (2016) discussed surrogate's

opposition to abortion in her study, she did not discuss the reasons they may want to pursue it. Nor did she consider the abortion views of intended parents. Both Berend (2016) and I similarly found, however, that matching with like-minded individuals that had similar abortion views or stipulations was one way to navigate the overlapping implications in this area.

In Chapter IV, "Doing Pregnancy," I considered the issue of control over health behavior and practice decisions. These decisions involved what surrogates did with or put into their bodies, which could impact their health, and in turn, could also impact the health of intended parents' children. I first described how surrogates were expected to follow doctor's recommendations and normative health behaviors and practices during the pregnancy. Surrogates generally agreed to follow these stipulations. At the same time, many surrogates also said that they did not want their IPs to control or monitor their health behaviors and practices too much, especially since they already knew how to successfully follow pregnancy norms based on their previous pregnancy experiences. Rather than rejecting norms outright as many experienced mothers did in Neiterman's study (2012), surrogates instead often engaged in self-surveillance and were confident in their abilities to do so because of their previous experience.

Jacobson (2016) similarly found that surrogates desired trust and autonomy to make decisions because of the experiential knowledge and skills they felt they brought to the surrogate pregnancy, especially when compared to IPs who may not have experienced pregnancy themselves. Jacobson (2016) also found, however, that many surrogates reported being more cautious during surrogacy than they were with their own pregnancies. None of the surrogates in my study reported similar sentiments. Rather, my findings indicate that surrogates treated the surrogate pregnancy similarly to how they treated their own, precisely because of their perceived success during those instances. My findings are also similar to the findings of Ziff (2021) who

agreed that surrogates can still feel in control when engaging in health practices and behaviors that are required of them. Although surrogates in her study were required to follow a strict and demanding IVF medication protocol, they also felt in control of their bodies through their active execution of those demands and the embodied expertise that they developed when doing so.

As my interviews with surrogates revealed, many surrogates, for the most part, did not feel controlled and instead, often felt trusted by their IPs during the pregnancy, though some did experience minor incidents of control or a lack of trust that punctuated the pregnancy experience. Megan's story, however, illustrated how a high level of control can and did happen during her pregnancy. Megan, for instance, ate an organic diet and avoided chemical-based cleaners at her intended mother's request. Her intended mother also made other suggestions, such as when she asked Megan to use a neti pot instead of taking over-the-counter medication, and sent her health podcasts, books, or other information. By the end of the pregnancy, Megan felt "suffocated" by her intended mother who was frequently checking in on her. Jacobson (2016) also found that some surrogates experience "micromanagement" on the part of their IPs, which was a word that Megan also used to describe her experience. Alternatively, other surrogates in Jacobson's (2016) study reported that they were not overly controlled and instead received trust, just as many surrogates in this study did. Jacobson's findings on trust, however, largely do not explore giving of trust from the IPs' perspective. For one, she does largely does not explore how surrogates' embodied expertise affected IPs' own expectations about the need to control surrogates' health behaviors and practices. Jacobson's (2016) also largely does not discuss how intended parents' *lack of experience* with pregnancy, including due to their sex or gender, may be related to their giving of trust.

Many IPs in my study said that they trusted their surrogates, either because they intentionally sought out "good" surrogates that they knew would self-monitor and engage in appropriate health behaviors and practices, or more often, because they simply trusted in the surrogates' previous pregnancy experience and knowledge. IPs, therefore, afforded and agreed with surrogates' status as "good" mothers because of their previous experience, which allowed surrogates to have control. As Neiterman (2012) explains, "good" mothers may not be monitored as diligently as those who are lower on the social ladder of motherhood. All the IPs in my study who cited their surrogate's embodied knowledge about pregnancy as a reason to have trust also did not have previous experiences of pregnancy themselves. Since those who are biologically male lack embodied pregnancy knowledge and socialization about the female body and pregnancy, it makes sense that they made up the majority of this group. Therefore, level of norm surveillance may not only be impacted by the past pregnancy experience and identity of the pregnant woman as Neiterman (2012) contends. Trust in and monitoring of another's performance may also be affected by a *lack of* previous pregnancy experience and the identity of the person who is in the position to monitor the performance of "doing pregnancy." This final point extends Neiterman's (2012) original argument, as she did not consider how norm surveillance is affected by the identity and parenthood status of the other side of the accountability dyad in this way.

For a few IPs, though, a lack of familiarity with the surrogate did result in trust difficulties, suggesting that surrogates past pregnancy experiences was not enough for some. At the end of Chapter IV, I described how relying on trust, past experiences of pregnancy, or doctor's recommendations can be problematic, especially if surrogates and IPs have differing ideas about the proper ways of "doing pregnancy." A few IPs reported that their surrogates did

not follow or seem to know common pregnancy norms or what doctor's recommendations typically were, despite or even because of their past experience. This may be compounded by the fact that some doctors fail to explain the rules and norms of "doing pregnancy." Yet, when surrogates did not engage in the larger norms that were expected of them, these IPs typically did not "sanction" or try to correct the surrogate's behavior. There could be several possible explanations for this finding.

For one, the lack of sanctioning on the part of IPs could be due to the protective effect of surrogates' "good" mother status resulting from their previous experiences of pregnancy. According to Neiterman (2012), not only are "good" mothers less diligently monitored, their occasional non-adherence to prenatal norms and guidelines may not result in the same level of public reprimand. Again, however, Neiterman (2012) does not consider how public reprimand or sanctioning may be related to or compounded by the parenthood status of the other side of the accountability dyad. I suggest that level of sanctioning may not only be related to the performer's motherhood status, but also the parenthood status and identity of those who are in the position to hold others accountable to norms. It is notable that all the IPs that did not choose to sanction their surrogates did not have previous experiences of pregnancy themselves. Moreover, intended parents may rarely sanction a surrogate who breaches convention for fear of upsetting the surrogate or undermining what can often be a fragile parent-surrogate dynamic. Furthermore, IPs wished to grant autonomy to surrogates. Some also believed that changing surrogates' usual behaviors is not appropriate, difficult, or may even result in dishonesty or retaliation. Ultimately, IPs want to fulfill their wish to have a baby. As a result, they may be willing to accept certain non-normative behaviors and practices as an exchange for meeting this goal.

In the final empirical chapter of this document, Chapter V, "Doing Childbirth," I focused on IP involvement during childbirth and how this intertwined with medical decision making. Though both surrogates and IPs desired to "do surrogacy" by sharing in the childbirth experience, they still had to navigate between each other's individual interests, as well as the interests of the larger institution in which birth took place, the hospital. First, I described how some surrogates sacrificed their autonomy by agreeing to an induction or moving their induction dates in order accommodate their IPs' scheduling needs and desires. While not as extreme as the experiences of some transnational surrogates who are subjected to C-sections to accommodate IP attendance without much power to object (Deomampo 2016; Hovav 2020, Pande 2014; Rudrappa 2015), this finding points to the fact that surrogates in the U.S. may face similar, albeit somewhat implicit, pressures via their IPs. Surrogates in the U.S. may also feel an internalized pressure to allow IPs to be a part of the birth experience, especially since they often desire them to be there as well. Unlike some transnational surrogates, the surrogates in my study did have the opportunity to make the final call on induction decisions, though some still chose to accommodate their intended parents. Alternatively, one surrogate did resist her IPs' request to induce so that they could make it to the birth. I also discussed the case of Drew who did not feel any pressure to induce even though the baby was overdue and he and his IPs mutually desired to share in the birth.

Next, I discussed how C-sections and other OR-based births can lead to involvement negotiations not only between surrogates and IPs, but also hospital staff. Since OR births limit the number of people who can be present during birth, some IPs and surrogates had to decide how to navigate this possibility. Surrogates were often willing to express their autonomy by choosing their partner or another support person to attend, even if this meant that their IPs could

not. However, since hospital staff often recognized and affirmed IPs' status as parents, they often made special accommodations that would allow IPs to be present. This point is supportive of Teman's (2010) findings that medical professionals may acknowledge and help establish the parenthood identity of intended parents. However, when exceptions are not made, it can possibly lead to a conflict of interests, which was the case for Megan and her intended mother.

Despite their desires for IPs to be present, many surrogates also said that they wanted some space during birth, which was another way that they were able to protect their bodies and express their autonomy. For most, having space meant that their IPs were asked to periodically leave the room, but it also could relatedly mean not having to interact with their IPs during the entire labor or space from their bodies and intimate body parts. Similarly, Teman (2010) found that Israeli surrogates desired to protect the personalized and intimate parts of their bodies that, unlike the surrogate child, they believed did not belong to the intended parents. Much like Teman's (2010) findings, the surrogates in my study had to find a way to protect their personal boundaries, including but not limited to their intimate body parts, while still allowing intended parents to be a part of the birth process.

I found that reasons for wanting space were diverse and included the desire to focus on one's body and the birth, to rest or sleep, to not have to interact while in pain, or because of a past traumatic birth experience or the relationship (or lack thereof) with IPs. Most surrogates made their desire for space known to their IPs, though some utilized third parties such as medical staff or a partner to create or protect their need for space. In response, IPs were largely supportive and respected surrogates' space needs. Some IPs even considered the surrogates' need for space on their own, without any direct requests. Finally, I considered how some intended parents, specifically, intended fathers, seemed to be the ones who wanted space from the

intimacies of the labor process and surrogates' bodies. There was also some evidence that surrogates specifically wanted to create space between their bodies and intended fathers as well.

EXTENDING "DOING PREGNANCY": THE CONTEXT OF SURROGACY

Throughout this dissertation, I have both utilized and extended Neiterman's (2012) concept of "doing pregnancy" through my exploration of surrogacy arrangements. First, I applied the concept of doing not only to pregnancy, but the entire surrogacy medical negotiation process, including decisions about IVF, abortion, and childbirth. I refer to these various medical decisions as "doing surrogacy." Furthermore, by interviewing and considering both sides of the accountability dyad, I came to suggest that the identity and parenthood status of the non-pregnant individual may also affect the negotiation and accountability process when "doing surrogacy." "Doing surrogacy" is also a unique situation that also requires a reconsideration of the context and ways that "doing pregnancy" is typically negotiated.

Unlike with the pregnant women in Neiterman's (2012) study, IPs who often hold surrogates accountable have a claim to the children growing inside surrogates' bodies. Surrogates often acknowledged this claim, and as a result, expected IPs to have some control over medical decisions. At the same time, surrogates also desired and IPs respected their need for bodily autonomy, though IPs also wanted to have some control themselves. Their mutual agreement on control, however, did not negate the fact that one's act of autonomy can still have implications for and affect the autonomy of the other. Since these implications can sometimes be competing, the "rights" and "wrongs" of "doing surrogacy" were not always clear. Surrogates and IPs had to navigate this unique terrain when making decisions about how to do IVF, abortion, pregnancy, and childbirth. Overall, the findings of this study suggest that other relationships where norm accountability is at play may be affected by differing yet shared claims to the pregnancy,

pregnant body, and baby. For instance, this may be the case for pregnant women and their partners or even those who are pregnant with someone's child that they are not in a relationship with.

"Doing surrogacy" is also unique in that there are various norms systems, institutions, individuals, and additional factors that mediate and are involved in the surrogate-IP negotiation process. For instance, when "doing surrogacy," the individuals involved may not only draw from larger medical and social norms, but surrogacy norms as well, including but not limited to the normative delineation of control in these arrangements I just described. This may further complicate determining the "right" way to "do surrogacy." Furthermore, the negotiation process may take place within and be influenced by the policies of other institutions such as fertility clinics, hospitals, and agencies. Similarly, there are also others involved in the negotiation process, such as medical professionals and agency employees. Both surrogates and IPs may utilize or be supported by these various norm systems, institutions, and other individuals in terms of their desired ways of "doing surrogacy" and therefore, may be able to express control, autonomy, and meet their own interests.

Surrogacy also occurs within the context of a paid exchange that is mediated by the surrogacy contract, which can affect accountability both symbolically and legally. At the same time, surrogacy laws—or lack thereof—can affect whether surrogacy contracts are enforceable and upheld in court. As Jacobson (2016) explains, this is why establishing trust is so important in surrogacy relationships. Relatedly, surrogates and IPs may have established relationships, such as being family members or friends, or at the very least, establish a relationship over the year or more that they work together. As Neiterman (2012) explains, those who "do pregnancy" may

take the assessment of their pregnancy work by family members of friends more seriously than those who are mere strangers.

CONTRIBUTION TO THE SURROGACY LITERATURE

While several studies have recently examined the issue of surrogate control and their ability to enact agency in the context of transnational surrogacy arrangements (Deomampo 2016; Hovav 2020; Lozanski and Shankar 2019; Majumdar 2014; Pande 2010, 2014; Rudrappa 2015), transnational surrogacy is unique in terms of surrogates' relative positions of power within the arrangement and the larger structural context in which surrogacy takes place. Furthermore, transnational surrogates and their intended parents are often separated by large distances and perhaps even cultural and language barriers that limit their interactions. These studies, therefore, largely do not assess how control may be affected by an intimate relationship with intended parents.

Teman's (2003, 2009, 2010) study of domestic surrogacy in Israel does help illuminate the surrogate and intended parent relationship, including in terms of medical control and agency, but again, the context of surrogacy in Israel is unique. For instance, in Israel, surrogacy contracts are valid in a court of law and the surrogate can be held to that contract through financial means (Teman 2010). As Jacobson (2016) points out, since U.S. surrogacy contracts can largely be unenforceable in some contexts, they are not enough to fully elicit trust or control over surrogates' behaviors in the eyes of IPs. This results in other attempts at control like the "micromanagement" of the surrogate pregnancy. Surrogates in Israel are also influenced by a strong pronatalist ideology which encourages the surrogate to detach from the pregnancy so she may protect her own motherhood identity (Teman 2003, 2010). In turn, this detachment leads Israeli surrogates to appoint a great amount of control to intended parents over medical decisions

that involve the fetus (Teman 2010). As Berend (2016) found, though surrogates in the United States may be able to separate gestation from feelings of motherhood, it does not negate the fact that they may also want to protect their own bodily and self-interests when making medical decisions, including those that can affect intended parents and their children.

Still, the work of Jacobson (2016), Berend (2016), as well as Ziff (2021) who also explores surrogacy in the U.S., only provide piecemealed clues as to how surrogates may experience control or autonomy during various parts of the surrogacy process. Further, their studies largely do not examine the perspective of IPs and their expectations about and experiences of autonomy and control. My work brings in the perspective of IPs and, in so doing, extends the existing literature on surrogacy to create a more complete picture of surrogates' and intended parents' expectations for, negotiation, and experience of medical control and autonomy throughout the entirety of the surrogacy process in the context of the United States.

PRACTICAL IMPLICATIONS

This research has implications for those who are or will be involved in surrogacy arrangements, including surrogates, IPs, and the institutions and individuals that mediate their relationships. My study highlights how medical decisions made during surrogacy involve both the surrogate's body and health and implications for IPs and their children, as well as the key areas that this may occur. This information may be particularly useful for those engaging in surrogacy for the first time, and especially those who are not utilizing a surrogacy agency that has experience in anticipating these issues.

How these two sets of implications are interwoven should not only be considered when discussing and making decisions during the matching and contract phase, but as the surrogacy

journey continues to evolve based on the unique circumstances of the IVF process, pregnancy, and childbirth. Relatedly, when matching or creating a contract, the various parties involved in surrogacy should try to anticipate as much as possible how the changing circumstances of IVF, pregnancy, and birth may impact or could change their initial agreements and account for them before any issues arise. For instance, how might embryo transfer decisions change, if at all, if there are multiple unsuccessful attempts at achieving a pregnancy? Similarly, what happens if the surrogate baby is overdue, and how might the decision be affected by IP attendance goals?

Finally, it is important for those involved in surrogacy, especially IPs and others who want to and are attempting to support surrogates' autonomy, to be cognizant of the indirect, implicit, and internalized pressure that surrogates may face since it is not always readily apparent. Ultimately, while it may not be possible for everyone's interests to be met or for each person involved to have complete autonomy and control, at the very least, the issues I described throughout this study can be discussed and decided upon in an open and honest way.

LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

By conducting in-depth interviews with surrogates and intended parents, I was able to develop a robust understanding of the ways that surrogates and IPs negotiate medical control and autonomy. The generalizability of this research, however, should be limited to surrogates and IPs who negotiate their relationship in the United States surrogacy and medical system. As previous scholars of surrogacy outside of the U.S. have shown, the larger social and medical context, laws, and ways of "doing surrogacy" are notably different than that of the United States (Deomampo 2016; Hovav 2020; Lozanski and Shankar 2019; Majumdar 2014; Pande 2010, 2014; Rudrappa 2015; Teman 2003, 2009, 2010). The context in which surrogacy occurs, in turn, affects the surrogate-IP relationship and experiences of medical control and autonomy.

One possible source of bias that may have impacted my findings involves my use of Facebook to recruit most of the participants in this study. Berend's (2016:228) study of an online surrogacy site, which she described as largely disbanding and moving to Facebook towards the end of her research, points to the fact that surrogates use online sites to create and negotiate "collective understandings of surrogacy-related events, behaviors, and feelings." Similarly, Teman's (2019:292) recent research of Israeli surrogates found that digital technologies are "narrowing the possible stories surrogates can tell, with a single story crowned and disseminated through social media and mainstream media." She reports that this "single story" tends to include: "1) an intimate bond between surrogates and intended parents; 2) an epic birth, and 3) a happy ending, told publicly" (Teman 2019:282). She also found, however, that obviously not all surrogacy experiences fit this narrative. Finally, Roberts (1998) work suggests that both surrogates and intended parents are aware of the critiques surrounding surrogacy, including that the surrogate is subjected to control, and attempt to subvert these critiques through their narratives. The findings of these three authors therefore suggest that social desirability may have been at play in this study, especially because of my recruitment through social media.

Considering the above findings, it is possible that recruitment from places other than Facebook may have resulted in a different or more nuanced narrative than the one presented in this document, perhaps reflecting more heightened experiences of control and a resulting lack of agency. As I described in my chapter on the methods, I attempted to have and therefore presented a neutral stance when introducing myself to my participants and describing the research topic I was interested in. A few questions about "what I was looking for" made it clear that at least some participants were worried about me painting surrogacy in a negative light. By explaining that I wanted to tell their story in their own words, and that I did not have any preconceived notions

about what I was going to find, hopefully alleviated their concerns. Some of the heightened experiences of control that I described in this document attest to the fact that surrogates were willing to describe both positive and negative aspects of their journey. Furthermore, the fact that my findings match some of the earlier findings about control and agency from other researchers that have studied surrogacy in the U.S. suggest that participants were honest as well (Berend 2016; Jacobson 2016; Ziff 2021). Still, it may be pertinent to conduct additional research with participants recruited via other means to further confirm my findings.

Another issue related to recruitment was the small number of biologically male participants in this study. Though I was able to report on some interesting ways that sex and gender possibly impacted IPs' embodied pregnancy knowledge, their trust in surrogates, and need for space during childbirth, the limited number of biologically male participants did not allow me to make firm conclusions about these sex and gender effects. While there are studies that focus on gay men who use surrogacy (Bergman et al. 2010; Blake et al. 2016; Blake et al. 2017; Carone et al. 2017; Dempsey 2013; Jacobson 2018; Maya and Ben-Ari 2023; Murphy 2013; Riggs 2018; Riggs et al. 2015; Smietana 2017; Tuazon-McCheyne 2010; Ziv and Freund-Eschar 2015), I have yet to find any studies that explore how male biology, masculinity, or sexual identity affect medical negotiation during surrogacy. Filling this gap can be accomplished in a few ways.

For one, though female IPs seem to be the main person who interacts with and negotiates with surrogates in the context of heterosexual IP relationships (Berend 2012, 2016; Blyth 1994; Ragoné 1994, 1996; Teman 2010, 2019), a study that includes or focuses on male partners in heterosexual families that utilize surrogacy can explore the ways that males are, at least peripherally, involved in medical negotiation, appointments, or the childbirth. One could also

explore their reasons for possibly letting their female partners take the lead in terms of negotiation. A surrogacy study that includes more male IPs that are in same-sex or other non-heterosexual relationships, either as the entire sample or as compared with female IPs in heterosexual relationships, would also be worthwhile given the preliminary findings that I have described. It may also be useful to ask surrogates who have worked with both males in same-sex and other relationship types and heterosexual female IPs about any possible differences they have experienced in terms of medical negotiation, as well as how sex and gender may affect surrogates' own feelings about the IP relationship.

Finally, though recruitment was open to all races, my sample is mainly composed of white individuals, both in terms of surrogates and intended parents. Since there are no statistics that detail the population of those involved in surrogacy in the United States, I am not able to ascertain how representative my sample is. However, anecdotal evidence suggests that surrogates and IPs who engage in surrogacy are largely white (Jacobson 2016:48). Still, a study that focuses on non-white women and men involved in surrogacy would be valuable and may elicit somewhat different results than what I found here, especially since people of color have a distinctive historical experience and overall relation to the U.S. medical system and medical professionals.

Finally, US-based surrogacy research is still somewhat limited and has only started to grow more substantially in the last decade through the work of scholars like Berend (2016), Jacobson (2016), and Ziff (2021). However, besides the work of Ziff (2021), most of these studies do not exclusively focus on medical control and autonomy. Therefore, I suggest that the current momentum of research on surrogacy in the United States should continue by exploring the medical negotiation process as this study has attempted to do. One way that this can be done is by conducting a larger ethnographic study of the surrogacy medical negotiation process. While

qualitative interviews allowed me to explore the perspective of surrogates and IPs, there are many other individuals and institutions involved in surrogacy that affect medical negotiation. For instance, while this study did include participants who used agencies, as well as a small number of IPs who were also agency owners, a study that includes fieldwork within surrogacy agencies and more interviews with agency owners and employees would better illustrate how they are involved in this process. Some participants reported that their agencies had support groups where they were able to discuss their experiences. Sitting in on these group sessions where an agency worker is also present would provide valuable insight.

Similarly, though participants did speak about some of the ways that medical professionals were involved in medical decisions, this was only from the perspective of surrogates and IPs and not medical professionals themselves. It may be advantageous to interview medical professionals that work at fertility clinics and hospitals that have experience with surrogacy as part of a larger ethnographic study. Fieldwork at fertility clinics and hospitals would also be useful as well. Finally, while some participants did allow me to explore the "before" and "after" of negotiation using follow-up interviews, I largely was not able to explore negotiation in real time. For some participants, a significant gap in time had occurred between our interview and their last surrogacy experience. Having to recall surrogacy journeys after quite some time could have resulted in loss in nuance and detail since participants may have forgotten certain aspects of their experience, or relatedly, only remembered the more significant events that occurred. Though I attempted to circumvent this issue with a thorough interview questionnaire and prompts, an ethnographic study where a researcher is present when these negotiations take place, or at the very least, follows a larger number of participants more closely throughout their experience, would also be ideal.

Though statistics on surrogacy are lacking, it is clear that the practice of surrogacy is on the rise (CDC 2023). Furthermore, while surrogacy laws in the U.S. continue to evolve, there are still many states where surrogacy is practiced that have little to no regulatory structure to help guide or protect those who engage or are involved in surrogacy (Creative Family Connections, n.d.). As this study shows, control and autonomy are complex issues worthy of consideration. It is therefore pertinent to understand the dynamics of the surrogacy negotiation process from the perspective of surrogates and intended parents. In doing so, it can help to create an ethical and informed experience for all involved.

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APPENDIX A

HUMAN SUBJECTS APPROVAL FORMS

RE: IRB # 17-344 entitled "Negotiating Pregnancy: How Surrogates and Intended Parents Negotiate Medical Control over the Surrogacy Experience"

Hello,

I am pleased to inform you that the Kent State University Institutional Review Board reviewed and approved your Application for Approval to Use Human Research Participants as a Level II/Expedited, category X project. **Approval is effective for a twelve-month period:**

July 27th, 2017 through July 26th, 2018

For compliance with:

- DHHS regulations for the protection of human subjects (Title 45 part 46), subparts A, B, C, D & E

**If applicable, a copy of the IRB approved consent form is attached to this email. This "stamped" copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB tries to send you annual review reminder notice by email as a courtesy. **However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials.** Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date. Visit our website for forms.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact the Office of Research Compliance at Researchcompliance@kent.edu or 330-672-2704 or 330-672-8058.

Bethany Holland | Assistant |330.672.2384| bhollan4_stu@kent.edu
Tricia Sloan | Coordinator |330.672.2181 | psloan1@kent.edu
Kevin McCreary | Assistant Director | 330.672.8058 | kmccrea1@kent.edu
Paulette Washko | Director |330.672.2704| pwashko@kent.edu
Doug Delahanty | IRB Chair |330.672.2395 | ddelahan@kent.edu

RE: IRB #17-344 entitled "Negotiating Pregnancy: How Surrogates and Intended Parents Negotiate Medical Control over the Surrogacy Experience"

Hello,

The Kent State University Institutional Review Board (IRB) has reviewed and approved your Annual Review and Progress Report for continuing review purposes. The protocol approval has been extended and is effective**:**

July 7, 2018 through July 26, 2019

For compliance with:

- DHHS regulations for the protection of human subjects (Title 45 part 46), subparts A, B, C, D & E

**A copy of the IRB approved consent form may be attached to this email if the study is still recruiting in person. This "stamped" copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

Federal regulations and Kent State University IRB policy requires that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB will try to send you an annual review reminder notice by email as a courtesy. **However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials.** Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact our office at 330-672-2704 or researchcompliance@kent.edu.

John McDaniel | IRB Chair |330.672.0802 | jmcdani5@kent.edu
Tricia Sloan | Coordinator |330.672.2181 | psloan1@kent.edu
Kevin McCreary | Director | 330.672.8058 | kmccrea1@kent.edu

RE: IRB #17-344 entitled "Negotiating Pregnancy: How Surrogates and Intended Parents Negotiate Medical Control over the Surrogacy Experience"

Hello,

The Kent State University Institutional Review Board (IRB) has reviewed and approved your Annual Review and Progress Report for continuing review purposes. The protocol approval has been extended and is effective**:**

July 27, 2019 through July 26, 2020

For compliance with:

- DHHS regulations for the protection of human subjects (Title 45 part 46), subparts A, B, C, D & E

**A copy of the IRB approved consent form may be attached to this email if the study is still recruiting in person. This "stamped" copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.*

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HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact our office at 330-672-2704 or researchcompliance@kent.edu.

John McDaniel | IRB Chair |330.672.0802 | jmcdani5@kent.edu
Tricia Sloan | Coordinator |330.672.2181 | psloan1@kent.edu
Kevin McCreary | Director | 330.672.8058 | kmccrea1@kent.edu

APPENDIX B

STUDY RECRUITMENT FLYER

APPENDIX C

SURROGATE INFORMED CONSENT FORM

Informed Consent to Participate in a Research Study

Study Title: "Negotiating Pregnancy: How Surrogates and Intended Parents Negotiate Medical Control over the Surrogacy Experience"

Principal Investigators: Dr. Clare Stacey (Principal Investigator) and Jessica Cebulak, MA (Co-Investigator)

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose: The purpose of this study is to better understand how surrogates and intended parents define, experience, and negotiate medical control throughout the surrogate pregnancy and birth.

Procedures:
Single Interview Participants: For this project, you are being asked to complete a single qualitative interview. During the interview, the co-investigator will ask you a number of questions about your experience as a surrogate. You will only have to complete this interview once. The interview should last anywhere from an hour to ninety minutes.

Longitudinal Interview Participants: For this project, you are being asked to complete a series of four qualitative interviews over a period of about a year. Interviews will occur approximately every three months. During each interview, the co-investigator will ask you a number of questions about your experience as a surrogate. The first and last research interview in this process should last anywhere from an hour to ninety minutes. Interviews two and three should last anywhere from a half hour to an hour. The total potential time commitment over all four interviews is anywhere from three to five hours.

Audio and Video Recording and Photography:
The interview(s) that you provide from this project will be recorded using an audio recording device or program. The co-investigator will use the recording(s) to transcribe your interview(s) into a word document so that it may be analyzed for this study. Your recording(s) and

transcription(s) will be labeled with a unique participant number, and will be stored on the co-investigator's password protected personal computer. If a mobile recording device is used to record your interview(s), the recording(s) will be transferred to the co-investigator's computer as soon as possible and will be deleted from the mobile device. Your participant number will be linked with your name on a separate, password protected word document. This document will also be stored on the co-investigator's personal computer. After the study is complete, the document linking your name to your study materials will be deleted. However, de-identified recordings and transcriptions will be kept and secured on the co-investigator's computer after this study is complete.

Benefits:
This research will not benefit you directly. However, your participation in this study will contribute to the sociological understanding of the surrogate-intended parent negotiation process. This information may also be helpful to future surrogates, intended parents, surrogate agencies, or medical professionals. Finally, this study may also help the broader public to better understand the process of surrogacy and what it entails.

Risks and Discomforts:
Your participation in this study should pose no more risk to you than encountered in your everyday life. However, some of the questions that you will be asked during your interview(s) are of a personal nature and may cause you embarrassment, stress, or can be upsetting. Furthermore, speaking about potential negative aspects of your surrogacy relationship may add to or create stress in your relationship. You may ask to see the topics or questions to be discussed during interviews before deciding whether or not to participate in this study. During interviews, you are free to skip any questions or to stop the interview at any time. Finally, you may choose to stop participating in this project at any time in the process. The co-investigator may also choose to discontinue participation if she feels that risks to the participant are becoming too large.

If the intended parent(s) you are working/have worked with is/are also participating in this project, any information you share will remain confidential. In order to protect participants' privacy, all interviews in this study will be performed separately and individually. The co-investigator will remain a neutral party at all times and will not give opinions or advice regarding the surrogate-intended parent relationship, or on any other matter discussed during interviews. The co-investigator will also refuse to serve as any kind of liaison of messages between individuals participating in this project.

The Institutional Review Board (IRB) considers pregnant women and their fetuses to be a vulnerable research population. If you are pregnant or will be pregnant while participating in this project, your risks of participation are minimal, and will entail the possible elements described

above. This research poses no direct harm to the fetus. We will not be collecting any medical records as a part of this project.

Privacy and Confidentiality:
Your study related information will be kept confidential within the limits of the law. All study materials (i.e. interview recordings, transcriptions, data analysis materials) will be labeled with a unique participant number and will be stored on the co-investigator's password protected personal computer. If a mobile recording device is used to record your interview(s), the recording(s) will be transferred to the co-investigator's computer as soon as possible and will be deleted from the mobile device. Your participant number will be linked with your name on a separate, password protected word document. This document will also be stored on the co-investigator's computer. Only the co-investigator will have access to raw data. Any other identifying information (e.g. signed consent forms) will be kept in a secure location by the co-investigator. Research participants will not be identified in any publications or presentations of research results; pseudonyms will be used. After the study is complete, the document linking your name to your study materials will be deleted. However, de-identified study materials will be kept and secured on the co-investigator's computer after this study is complete.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

Voluntary Participation:
Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

Contact Information:
If you have any questions or concerns about this research, you may contact Jessica Cebulak at 773-799-4114 (or by e-mail at jcebula1@kent.edu) or Clare Stacey at 330-672-2044 (cstacey@kent.edu). This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330-672-2704.

Consent Statement and Signature:
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. If I am completing my interview(s) on the web, I understand that the completion of my interview(s) will be indicative of my consent to

participate in this research study. I understand that I may print a copy of this consent statement for future reference.

Participant Signature	**Date**

APPENDIX D

INTENDED PARENT INFORMED CONSENT FORM

Informed Consent to Participate in a Research Study

Study Title: "Negotiating Pregnancy: How Surrogates and Intended Parents Negotiate Medical Control over the Surrogacy Experience"

Principal Investigators: Dr. Clare Stacey (Principal Investigator) and Jessica Cebulak, MA (Co-Investigator)

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose: The purpose of this study is to better understand how surrogates and intended parents define, experience, and negotiate medical control throughout the surrogate pregnancy and birth.

Procedures:
Single Interview Participants: For this project, you are being asked to complete a single qualitative interview. During the interview, the co-investigator will ask you a number of questions about your experience as an intended parent. You will only have to complete this interview once. The interview should last anywhere from an hour to ninety minutes.

Longitudinal Interview Participants: For this project, you are being asked to complete a series of four qualitative interviews over a period of about a year. Interviews will occur approximately every three months. During each interview, the co-investigator will ask you a number of questions about your experience as an intended parent. The first and last research interview in this process should last anywhere from an hour to ninety minutes. Interviews two and three should last anywhere from a half hour to an hour. The total potential time commitment over all four interviews is anywhere from three to five hours.

Audio and Video Recording and Photography:
The interview(s) that you provide from this project will be recorded using an audio recording device or program. The co-investigator will use the recording(s) to transcribe your interview(s) into a word document so that it may be analyzed for this study. Your recording(s) and

transcription(s) will be labeled with a unique participant number, and will be stored on the co-investigator's password protected personal computer. If a mobile recording device is used to record your interview(s), the recording(s) will be transferred to the co-investigator's computer as soon as possible and will be deleted from the mobile device. Your participant number will be linked with your name on a separate, password protected word document. This document will also be stored on the co-investigator's personal computer. After the study is complete, the document linking your name to your study materials will be deleted. However, de-identified recordings and transcriptions will be kept and secured on the co-investigator's computer after this study is complete.

Benefits:
This research will not benefit you directly. However, your participation in this study will contribute to the sociological understanding of the surrogate-intended parent negotiation process. This information may also be helpful to future surrogates, intended parents, surrogate agencies, or medical professionals. Finally, this study may also help the broader public to better understand the process of surrogacy and what it entails.

Risks and Discomforts:
Your participation in this study should pose no more risk to you than encountered in your everyday life. However, some of the questions that you will be asked during your interview(s) are of a personal nature and may cause you embarrassment, stress, or can be upsetting. Furthermore, speaking about potential negative aspects of your surrogacy relationship may add to or create stress in your relationship. You may ask to see the topics or questions to be discussed during interviews before deciding whether or not to participate in this study. During interviews, you are free to skip any questions or to stop the interview at any time. Finally, you may choose to stop participating in this project at any time in the process. The co-investigator may also choose to discontinue participation if she feels that risks to the participant are becoming too large.

If the surrogate you are working/have worked with is also participating in this project, any information you share will remain confidential. In order to protect participants' privacy, all interviews in this study will be performed separately and individually. The co-investigator will remain a neutral party at all times and will not give opinions or advice regarding the surrogate-intended parent relationship, or on any other matter discussed during interviews. The co-investigator will also refuse to serve as any kind of liaison of messages between individuals participating in this project.

Privacy and Confidentiality:
Your study related information will be kept confidential within the limits of the law. All study materials (i.e. interview recordings, transcriptions, data analysis materials) will be labeled with a unique participant number and will be stored on the co-investigator's password protected

personal computer. If a mobile recording device is used to record your interview(s), the recording(s) will be transferred to the co-investigator's computer as soon as possible and will be deleted from the mobile device. Your participant number will be linked with your name on a separate, password protected word document. This document will also be stored on the co-investigator's computer. Only the co-investigator will have access to raw data. Any other identifying information (e.g. signed consent forms) will be kept in a secure location by the co-investigator. Research participants will not be identified in any publications or presentations of research results; pseudonyms will be used. After the study is complete, the document linking your name to your study materials will be deleted. However, de-identified study materials will be kept and secured on the co-investigator's computer after this study is complete.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

Voluntary Participation:

Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

Contact Information:

If you have any questions or concerns about this research, you may contact Jessica Cebulak at 773-799-4114 (or by e-mail at jcebula1@kent.edu) or Clare Stacey at 330-672-2044 (cstacey@kent.edu). This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330-672-2704.

Consent Statement and Signature:

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. If I am completing my interview(s) on the web, I understand that the completion of my interview(s) will be indicative of my consent to participate in this research study. I understand that I may print a copy of this consent statement for future reference.

_____ _____

Participant Signature **Date**

APPENDIX E

INTERVIEW GUIDE

Demographic and Introductory Questions

Demographics:

- What is your age? (You can either tell me or I can read off an age range list and you can tell me when to stop.)
    - 18 to 24 years
    - 25 to 34 years
    - 35 to 44 years
    - 45 to 54 years
    - 55 to 64 years
    - Age 65 or older
- How would you describe your race or ethnicity? (Are you Hispanic?)
- How would you describe the race or ethnicity of your surrogate/IPs?
- What is your highest level of education?
- What is your occupation? Do you work part/full time?
- What is your relationship or marital status?
- How many children do you have?

Surrogacy:

- How many surrogacy experiences have you had?
- Was this/were they (a) gestational surrogacy experience(s)?
- Was this/were they (an) altruistic or compensated journey(s)?
- When did that/those experience(s) take place?
- Where did your experience(s) take place?
- Can you briefly describe the surrogate/IP(s) you worked with?

Main Interview Guide

My broader goal is to explore how your surrogacy experience developed over time, from when you first met, to the pregnancy, and finally the birth and beyond. My questions are designed to try and capture this process and will loosely follow that topic order. Therefore, I am going to ask you about (read topic lists).

Introduction and Early Expectations:

- Can you tell me about how you first decided to get involved with surrogacy/surrogacy was the choice for you?

- Can you tell me about some of the personal qualities you were looking for when choosing your IP(s)/a surrogate (e.g., health, personality, relationship expectations, etc.)? Tell me about two or three of the most important qualities you were looking for.

- How did you end up meeting and choosing your IP(s)/surrogate?

- Before the surrogacy experience began, how involved did you expect (your IPs) to be in terms of the day-to-day experiences of the pregnancy and childbirth?
    - What did you envision that relationship or interaction to be like?
    - What are some of the things you expected to share with them/to be shared with you?
    - How did you develop those expectations?

- Similarly, how much control or involvement did you envision yourself/your IP(s) to have in terms of the medical and/or health decisions surrounding the pregnancy and childbirth?
    - What did you expect that relationship or interaction to be like?
    - How did you develop those expectations?

Pregnancy Expectations and Experience

- Either before the pregnancy began or in its early days, were there any specific medical or health concerns surrounding the pregnancy or childbirth?
    - Can you tell me about one or two of your largest concerns?
        - How did those concerns develop?
    - Did you discuss these with your IP(s)/surrogate?

- Similarly, before the experience began, were there any health or medical expectations, either formal or informal, to be met during pregnancy or childbirth (e.g., health behaviors, testing during pregnancy, medications, etc.)?
    - How did you develop those expectations?
    - How did you negotiate that with your IP(s)/surrogate?

- As the pregnancy moved along, did any of these initial health or medical concerns or expectations change over time (i.e., grow or diminish)? How so?

    - What contributed to these changes?

- Did any new concerns or expectations develop over time?
    - How come? What happened?

- Can you tell me about one or two of the larger health decisions that you had to negotiate during the pregnancy and how that negotiation process played out?

- Who else did you speak to about these concerns, issues, or decisions, other than your IP(s)/surrogate? Tell me about one or two of the main people that you reached out to and what you spoke about.

- Thinking back to your early expectations about your IP(s)/your involvement in the health, medical, and daily aspects of the pregnancy and what we just now talked about, did the process go as expected?

Childbirth Expectations and Experience

Some people desire or expect a more "natural" childbirth experience, some people are open to or want a more "medical" or "medicalized" experience, and some people don't care or fall somewhere in between. Now, I am going to ask you about your orientation towards childbirth.

- First, let me ask you, what does that mean to you to say that someone has a more "natural" vs. "medical" childbirth experience? Briefly, how would you define or describe a "medical" versus a "natural" birth?

- Was this your first pregnancy? (*If yes, jump to next question*)
    - (*For those with previous pregnancies*) How would you describe your orientation or expectation for that childbirth, more towards the natural end, more towards the medical end, somewhere in between, or didn't care?
        - How did you envision that experience to go?
        - How did you develop those expectations?
        - How did it actually go?

- (How about the surrogate birth?) What were your early expectations for the childbirth early in the surrogacy experience? What did you envision it to be like?
    - How did you develop those expectations?

- What about your IP(s)/surrogate? What were their expectations?
    - How did you two come to negotiate that?

- Did you or your IPs'/surrogate's orientation or expectation for the birth plan change over time as the pregnancy moved along, or did it stay the same?
    - How so? What happened?
    - Did you talk about it with your IP(s)/surrogate? How did that go?

- Did the birth experience or plan go as expected? What happened?

- Were there any medical or health decisions that you and your IP(s)/surrogate had to negotiate during childbirth?
    - How did those negotiations proceed?

- Did anyone else involved in the negotiation or decision-making process?

- Given your early expectations for the birth compared to what actually happened, how satisfied would you say you were with your childbirth experience? How did you feel about it after it was over?

Conclusion:

- So, where does your relationship with your IP(s)/surrogate currently stand after the birth?
    - Is this where you expected, envisioned, or wanted it to be as you imagined it before the surrogacy experience began?

- Overall, given everything that we just discussed, how satisfied are you with your surrogacy experience?
    - What are the biggest contributors to these feelings?

- Is there anything important or unique about your experience that I did not ask you about that you would like to share with me?